Maternal and Child Health Services Title V Block Grant

Wyoming

FY 2019 Application/ FY 2017 Annual Report

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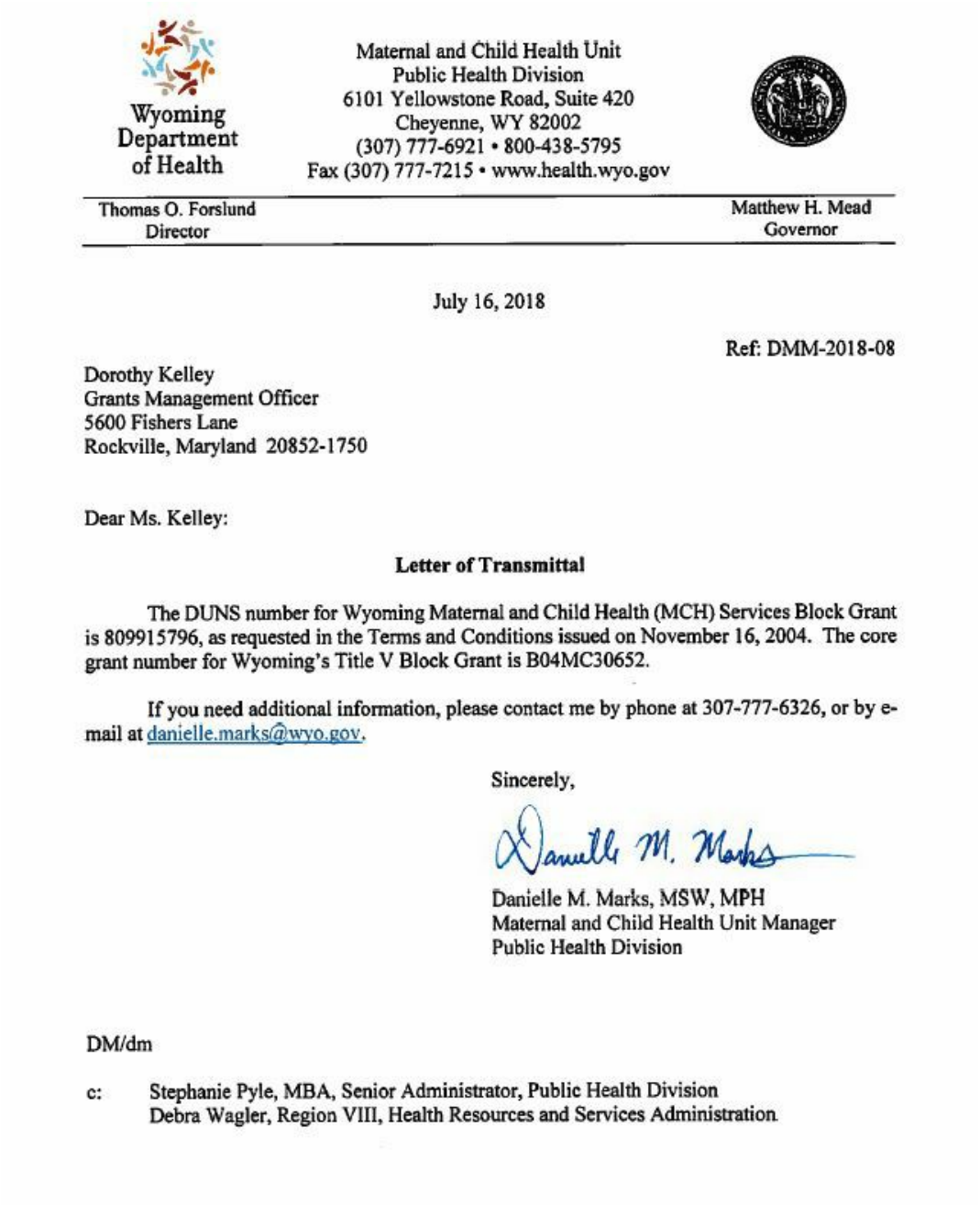
I.A. Letter of Transmittal



Wyoming Department of Health

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Thomas O. Forslund
Director

Matthew H. Mead
Governor

July 16, 2018

Ref: DMM-2018-08

Dorothy Kelley
Grants Management Officer
5600 Fishers Lane
Rockville, Maryland 20852-1750

Dear Ms. Kelley:

Letter of Transmittal

The DUNS number for Wyoming Maternal and Child Health (MCH) Services Block Grant is 809915796, as requested in the Terms and Conditions issued on November 16, 2004. The core grant number for Wyoming's Title V Block Grant is B04MC30652.

If you need additional information, please contact me by phone at 307-777-6326, or by e-mail at danielle.marks@wyo.gov.

Sincerely,

Danielle M. Marks

Danielle M. Marks, MSW, MPH
Maternal and Child Health Unit Manager
Public Health Division

DM/dm

c: Stephanie Pyle, MBA, Senior Administrator, Public Health Division
Debra Wagler, Region VIII, Health Resources and Services Administration

I.B. Face Sheet

The Face Sheet (Form SF424) is submitted electronically in the HRSA Electronic Handbooks (EHBs).

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix F of the 2018 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the *"Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms,"* OMB NO: 0915-0172; Expires: December 31, 2020.

II. Logic Model

Please refer to figure 4 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms," OMB No: 0915-0172; Expires: December 31, 2020.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

Executive Summary

Program Overview

The Wyoming Title V Program is organized within the Public Health Division (PHD) of the Wyoming Department of Health (WDH). Structurally, the Maternal and Child Health (MCH) Unit's programs are divided according to the population groups they serve: women (ages 15-44) and infants (ages 0-1), children (ages 2-11), youth and young adults (ages 12-24), and children and youth with special health care needs (CYSHCN). This structure aligns well with the Title V population domain framework and assures dedicated resources within each domain.

The Wyoming Title V Program receives approximately $1,200,000 in federal Title V funding annually. This funding supports programming for an estimated population of 579,315 (2017 estimate, American FactFinder, U.S. Census) spanning 97,813 square miles.

The most recent five-year needs assessment resulted in the selection of seven MCH state priorities for 2016-2020. They include:

- Prevent infant mortality
- Improve breastfeeding duration
- Improve access to and promote use of effective family planning
- Reduce and prevent childhood obesity
- Promote preventive and quality care for children and adolescents
- Promote healthy and safe relationships in adolescents
- Prevent injury in children

The MCH Unit and MCH Epidemiology Program used the six-step Peterson and Alexander Needs Assessment process to guide the completion of the 2015 five-year needs assessment and subsequent strategic planning. Due to small staff capacity and limitations related to the Unit's ability to respond to all MCH population needs, an internal planning group developed and implemented a scoring matrix to assess each potential priority on magnitude/extent of the problem, availability of public health strategies, the role of MCH (i.e. MCH responsibility), presence of health disparities, life course connection, and political will/capacity. MCH involved internal and external stakeholders, including community stakeholders in 10 of 23 counties, in the review of state health indicators and potential priorities, requesting input using a variety of methods (e.g. partner surveys, community meetings) throughout the 2-year process. MCH Epidemiology is working to establish a systematic review of data to continuously identify emerging issues.

Following selection of state priorities, the MCH program managers researched and selected evidence-based strategies to address each priority and accompanying National Performance Measure (NPM) or State Performance Measure (SPM). Each program maintains an action plan which is presented at least annually to WDH leadership as well as to program partners.

The mission of Wyoming MCH is to improve the health and well-being of Wyoming families and communities by supporting and collaborating on public health activities that benefit the health of mothers, infants, children, youth, and young adults, including those with special health care needs. The MCH Unit assures access to community level

services such as care coordination services for families with children and youth with special health care needs and home visitation services for all families. Doing so is particularly challenging in a rural/frontier state like Wyoming but is made easier due to a strong partnership with Public Health Nursing (PHN) at the state and local level.

The MCH Unit leverages partnerships and both federal and non-federal funding to address Wyoming state priority needs. Although the MCH Unit receives a small Title V award, matching state and other funds, as well as the work and resources of our partners, increases our capacity to achieve outcomes related to state priority needs.

Through statutory requirement, the MCH Unit and Public Health Nursing (PHN) jointly receive Temporary Assistance for Needy Families (TANF) funding from a partner agency, the Wyoming Department of Family Services, to support the implementation of home visiting and breastfeeding support activities. The MCH Unit also benefits from $2,375,591 in state funds required to meet 1989 maintenance of effort. These state funds primarily support delivery of home visitation and care coordination services by PHN in all 23 Wyoming counties.

The MCH Unit currently receives and/or utilizes federal funding from the Rape Prevention Education (RPE) grant, Personal Responsibility Education Program (PREP), State Systems Development Initiative (SSDI), Preventive Health and Health Services Block Grant (PHHSBG), and Pregnancy Risk Assessment Monitoring System (PRAMS). The MCH Unit does not manage Wyoming's Title X and Maternal Infant Early Childhood Home Visiting (MIECHV) grants; however, MCH staff partner closely with the grantees. In 2016, the Early Childhood Comprehensive Systems (ECCS) grant was awarded to a reduced number of states and Wyoming was not funded.

Summary of Priority Needs and Related Activities by Population Domain

Women/Maternal Domain		
State Priority Need	**NPM/SPM**	**Status of NPM/SPM**
Prevent infant mortality	NPM 14.1: Percent of women who smoke during pregnancy	In 2016, 14.6% of women smoked during pregnancy compared to 17.6% in 2012 (National Vital Statistic Services (VSS)).
Improve access to and promote use of effective family planning	SPM 3: Number of Wyoming birthing hospitals billing Medicaid for immediate postpartum (IPP) long-acting reversible contraception (LARC)	In 2017, one hospital successfully billed Medicaid for IPP LARC.

In FY17, the Women and Infant Health Program Manager (WIHPM) attended a train-the-trainer session for Smoking Cessation and Reduction in Pregnancy (SCRIPT). The WIHPM will use data to target training on this evidence-based program within PHN offices and possibly within federally qualified health centers (FQHCs). The SCRIPT program will also help to increase referrals to the Wyoming Quitline, a goal shared by the Tobacco Prevention Program.

Throughout 2017, the MCH Unit participated in the Association of State and Territorial Health Officials (ASTHO) Increasing Access to Contraception learning community. In partnership with one of the largest birthing facilities in the

state, the Centers for Disease Control and Prevention (CDC) assigned MCH Epidemiologist piloted a hospital assessment of procedures/policies/practices related to IPP LARC in order to understand barriers to implementation. Continued efforts to reduce barriers to access in this pilot will inform the development of a Wyoming-specific IPP LARC implementation guide.

Perinatal/Infant Domain		
Priority	**NPM/SPM**	**Status of NPM/SPM**
Prevent infant mortality	SPM 1: Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU) (VSS)	In 2016, 68% (62/100) of VLBW infants in Wyoming were born at facilities with the appropriate level of care compared to 51.9% in 2015. The 83.7% target set by Healthy People (HP) 2020 remains unmet.
Improve breastfeeding duration	NPM 4a: Percent of infants who are ever breastfed (National Immunization Survey (NIS))	In 2014, 88.3% of infants were ever breastfed compared to 89.7% in 2012.
Improve breastfeeding duration	NPM 4b: Percent of infants breastfed exclusively through 6 months (NIS)	In 2014, 32% of infants were exclusively breastfed through 6 months compared to 27% in 2013.

The Levels of Care Assessment Tool (LOCATe) continued to inform the work of the Women and Infant Health Program (WIHP) in 2017. Assessment results revealed opportunities for quality improvement efforts with hospitals (e.g. implementation of patient safety bundles). Six hospitals participated in a Utah Project Extension for Community Healthcare Outcomes (ECHO) focused on maternal hypertension. The WIHPM also continued to lead the Coordinated Efforts to Improve Maternal and Infant Health workgroup with a new emphasis in 2017 on the emerging issue of maternal mortality and the development of Perinatal Quality Collaborative (PQC) infrastructure.

See ***MCH Success Story*** for additional details.

Child Domain		
Priority	**NPM/SPM**	**Status of NPM/SPM**
Promote preventive and quality care for children	NPM 6: Percent of children (9-35 months) receiving a developmental screening using a parent-completed tool in the past year (National Survey of Children's Health (NSCH))	In 2016, 27.6% of children ages 9 to 35 months received a developmental screening using a parent-completed tool in the past year. Due to changes in the NSCH, data are not comparable between 2016 and 2012.
Prevent injury in children	SPM 2: Rate of hospitalization for (non-fatal) injury per 100,000 children (1-11 yrs) (Wyoming Hospital Discharge Data)	In 2016, the non-fatal injury hospitalization rate for children was 32.3 per 100,000 children ages 1-11 years. Due to the change from ICD-9 to ICD-10 coding, data from the previous year are not comparable.
Reduce and prevent obesity in children	SPM 5 (formerly NPM 8): Percent of children (6-11 years) who are physically active at least 60 minutes per day (NSCH)	In 2016, 29.3% of Wyoming children aged 6-11 were physically active everyday for 60 minutes or more. Due to changes in the NSCH, data are not comparable between 2016 and 2012.

The Wyoming Child Health Program (CHP) used two methods to increase developmental screenings: implementation of the Help Me Grow (HMG) model and distribution of Ages and Stages Questionnaire (ASQ) screening tools to partners. During FY17, the Child Health Program Manager (CHPM) worked with the HMG Leadership and Sustainability Team to begin implementation of the four Core Components of HMG: Child Health Care Provider Outreach, Family and Community Outreach, Centralized Access Point, and Ongoing Data Collection and Analysis. The number of HMG calls a month has increased during the first year of implementation.

In FY17, the CHPM worked closely with Safe Kids Wyoming (SKW) to identify evidence-based strategies for preventing the top causes of unintentional injury. These strategies were incorporated into the contract with SKW contract in Fall 2016 and a toolkit was provided to all SKW coalitions and partners in Spring 2017.

In FY17, MCH convened representatives from WDH and Wyoming Department of Education (WDE) to plan

collaborative efforts to improve physical activity among children. Due to reduced staff capacity, MCH leadership decided to transition NPM8 to a SPM beginning in FY19 in order to reduce reporting burden while still maintaining partnerships to address the state priority need of reducing obesity in children.

Adolescent Domain		
Priority	**NPM/SPM**	**Status of NPM/SPM**
Promote healthy and safe relationships in adolescents	SPM 4: Percent of teens reporting 0 occasions of alcohol use in the past 30 days (Wyoming Prevention Needs Assessment (PNA))	In 2017, 63.8% of Wyoming High School students reported zero occasions of alcohol use in the past 30 days compared to 68.2% in 2016. The target for 2018 is 72%.
Promote preventive and quality care in adolescents	NPM 10: percent of adolescents with a preventive services visit in the last year (NSCH)	In 2016, 75.7% of adolescents, ages 12 through 17, had a preventive medical visit in the past year. Due to changes in the NSCH, data are not comparable between 2016 and 2012.

In late 2016, two staff from WDH received training in Communities that Care (CTC), an evidence-based framework that uses prevention science to increase protective factors in communities. Due to staff turnover, efforts to bring CTC to Wyoming to address youth alcohol use are on hold. The new Youth and Young Adult Health Program Manager (YAYAHPM) will research available evidence-based strategies to meet this state priority need beginning in FY18.

The Personal Responsibility and Education Program (PREP) provides training on Making Proud Choices, Reducing the Risk, and Understanding Adolescence: Seeing Youth through a Developmental Lens curriculum as strategies to promote healthy and safe relationships in adolescents.

Since May 2017, the MCH Unit participated in the Association of Maternal and Child Health Programs (AMCHP) Adolescent and Young Adult Health (AYAH) Collaborative Improvement and Innovation Network (CoIIN). The Wyoming State Team membership includes MCH Unit staff and representatives from Medicaid, Kid Care CHIP (Children's Health Insurance Program), WDH, Wyoming Family Voices, Wyoming American Academy of Pediatrics (WY-AAP), Wyoming Primary Care Association (WYPCA), Optum (Medicaid contractor), youth, and young adults. The team selected the University of Michigan's Adolescent Centered Environment Assessment Process (ACE-AP) as a strategy to improve the quality of the adolescent clinical environment. Four Wyoming clinics were selected to receive mini-grants from the AYAH CoIIN budget and technical assistance from the University of Michigan to identify and respond to opportunities to improve adolescent well visits.

Children with Special Health Care Needs (CSHCN) Domain		
Priority	**NPM/SPM**	**Status of NPM/SPM**
Promote preventive and quality care in children and adolescents	NPM 11: Percent of children with and without special health care needs having a medical home (NSCH)	In 2012, 63.5% of children (ages 0-17) without special health care needs had a medical home. In 2012, 42.8% of children (ages 0-17) with special health care needs had a medical home.
Promote preventive and quality care in children and adolescents	NPM 12: percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care (National Survey of Children with Special Health Care Needs (NS-CSHCN)	In 2016, 17.9% of adolescents with special health care needs received services necessary to make transitions to adult health care. 14.3% of adolescents without special health care needs received the same services. Due to changes in the NSCH, data are not comparable between 2016 and 2012.

In 2017, the MCH Unit implemented the Wyoming Parent Partner Program (PPP) as a strategy to increase access to medical home. In addition, the CHP began an environmental scan of medical home activities around the state and subsequently established partnerships with the Clinical Quality Directors of both the WYPCA and the Wyoming Institute for Population Health. Meetings with the Medicaid Patient Centered Medical Home (PCMH) team have resulted in increased opportunities for collaboration. The CHPM provided support for a PCMH partner training in September 2017 and presented on Title V priorities. Due to limited staff capacity and slow progress related to this complex NPM, the MCH leadership team decided to discontinue the NPM beginning in FY19.

In order to improve transition among children and youth, MCH and partners have reviewed available transition resources from *Got Transition* in order to develop a Wyoming specific toolkit for providers and consumers. A comprehensive training on transition was developed and will be presented to PHNs during a future CSH Program web-training.

III.A.2. How Title V Funds Support State MCH Efforts

Wyoming Title V funding builds the MCH Unit's capacity to address MCH state priority needs. Funding is leveraged with state and other federal funds to assure available staff capacity to address each population domain and to provide epidemiologic support. Without Title V funding, the Wyoming Department of Health (WDH) would significantly lack workforce capacity and expertise to address MCH state priority needs, needs which align with other WDH agency-level priorities focused on supporting children's health, responding to public health problems such as tobacco use, and strengthening Wyoming's rural health care infrastructure.

Title V funding is blended with other sources to meet programmatic needs. For example in 2017, the MCH Unit contributed funding to support development of the Family Health phone application, an application primarily funded by Wyoming Medicaid to increase consumer awareness and management family health recommendations including well visits and screenings for all ages. While the project was not led by MCH, flexibility in Title V funding allowed for MCH to support the project due to its alignment with *all* NPMs. The application's inclusion of all life stages also aligned with the core principle of life course. Another example of successful use of Title V funding to support statewide MCH efforts is the cross-division promotion of Bright Futures, 4th Edition.

III.A.3. MCH Success Story

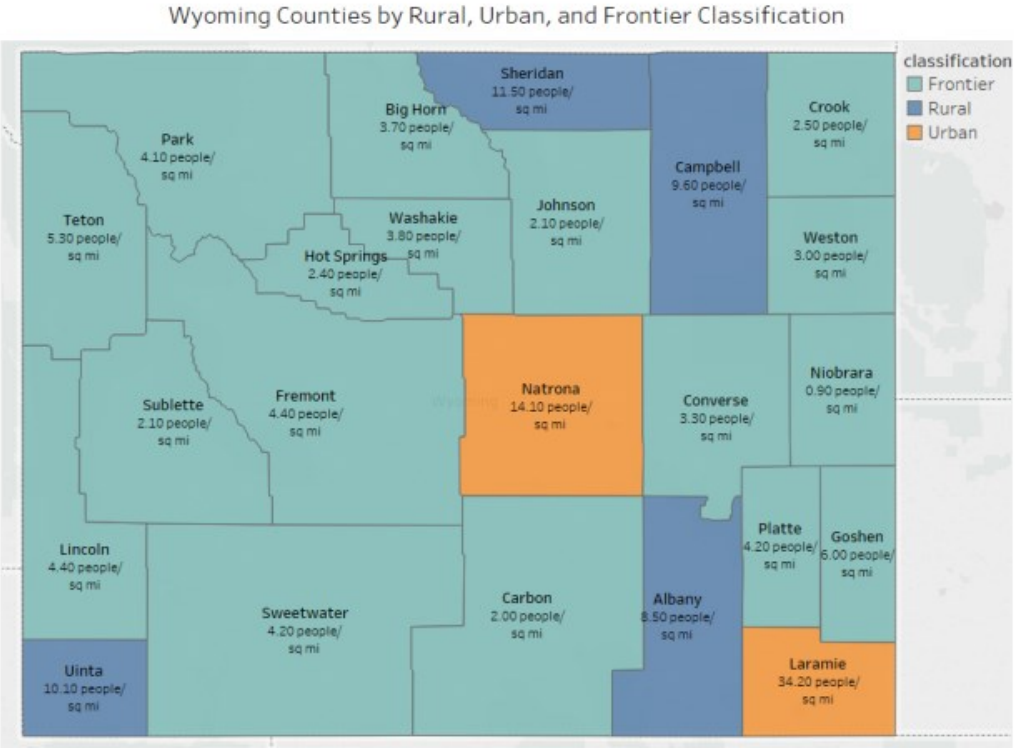
The MCH Unit intentionally uses its core principles to guide decision-making and resource allocation. In 2017, the Women and Infant Health Program (WIHP) used available Maternity Practices in Infant Nutrition and Care (mPINC) data (**core principle: data-driven**) to select five areas of focus for a breastfeeding mini-grant and hospital recognition program named Wyoming 5-Steps to Breastfeeding Success. The program is based on the evidence-based Baby Friendly Hospital Initiative and the Colorado Can Do 5 Program. The development of the grant program, and the review of applications were guided by the Breastfeeding Grant Committee, a collaboration (**core principle: engagement**) between MCH, Women, Infants, and Children (WIC) Unit and the Chronic Disease Prevention Program. Each partner shared a commitment toward improving statewide breastfeeding rates. The mini-grant opportunity was released to all Wyoming hospitals, another step towards building hospital engagement. The request for applications resulted in four applications. All applications were funded due to leveraged funding (**core principle: sustainability**) from Title V and a grant provided by the Association for State and Territorial Health Officials (ASTHO) "Improve State Health Agency Capacity for Breastfeeding Promotion and Support" learning community. Ongoing TA and site visits have ensured that barriers to implementation are addressed and adequate evaluation data is collected.

III.B. Overview of the State

Geographically, Wyoming is the tenth largest state in the United States (U.S.) spanning 97,813 square miles. There are 23 counties ranging from the Great Plains to the Rocky Mountains. The Wind River Indian Reservation (WRIR), located toward the center of the state, is home to two federally recognized tribes, the Eastern Shoshone and the Northern Arapaho.

Wyoming is the least populous state in the U.S. with an estimated population of 579,315 (2017 estimate, American FactFinder, U.S. Census). The population is predominantly White alone (93.7%). The remaining population is Black or African American alone (1.7%), American Indian and Alaska Native alone (3.6%), Asian alone (1.4%), Native Hawaiian and Other Pacific Islander alone (0.2%), some other race (2.2%), and Hispanic or Latino (9.7%) (2016, American FactFinder). Of the population aged 5 years and older, 92.4% speak only English at home, 7.5% speak a language other than English, and 5.0% speak Spanish.

Almost one quarter of the population is under 18 years of age. More than 90% of persons over 24 years of age have a high school education or higher. A quarter of this group have a Bachelor's degree or higher. The median household income is $59,143. Persons in poverty are estimated to be 11.6% of the population (2016, American FactFinder).

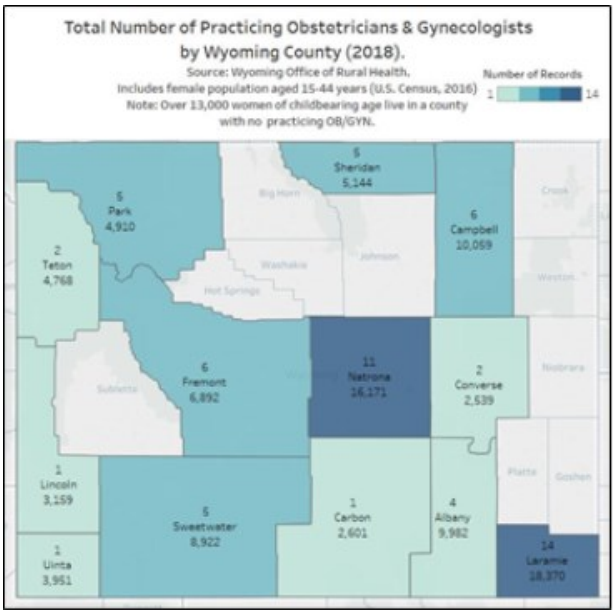


Wyoming is a rural/frontier state. Two counties, Laramie and Natrona, each have a town with over 60,000 people and are considered urban. Seventeen of the remaining 21 counties are considered frontier with less than 6 persons per square mile. These 17 counties are home to 44% of the population (2010, American FactFinder).
In the recent past, the economy in the state suffered from the weak demand for oil, warmer weather, and increases in domestic supply for natural gas. However, the most recent unemployment rate (2017, Q3) is 4.0 percent; lower than the U.S. level of 4.3 percent. Wyoming experienced an overall decline of 0.4 percent (or 1,170 jobs) in total employment in the third quarter of 2017 compared to the previous year, however Wyoming's mineral extraction

industry had a growth of 12.4 percent in the same period; representing 2,230 more jobs (Economic Analysis Division, WY).

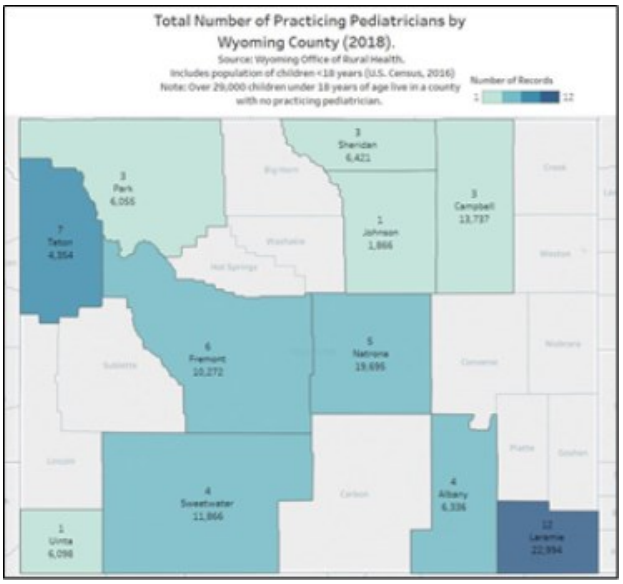
According to America's Health Rankings (2018), Wyoming's strengths include a low percentage of low-risk cesarean deliveries, low percentage of concentrated disadvantage, and a high prevalence of protective family routines and habits among children aged 0-17. Per the same Health Rankings report, Wyoming's challenges include low immunization coverage among children, high teen suicide rate, and low prevalence of cervical cancer screening.

The top two leading causes of death (n=89) for children between ages 1-24 years in Wyoming are unintentional injury (n=35; 39.3% of deaths) and suicide (n=18; 20.2% of deaths). Homicide is a distant sixth leading cause with totals suppressed due to small numbers (Web-based Injury Statistics Query and Reporting System (WISQARS), Centers for Disease Control and Prevention (CDC)).



The American Community Survey (2016, U.S. Census) reports that the percent of Wyoming residents who were uninsured was 11.5%; higher than the U.S. (8.6%) in the same year and ranked as 7th highest in the nation.

According to the Kaiser Family Foundation (as of December 31, 2016), Wyoming had a total of 39 Primary Care Health Provider Shortage Area (HPSA) Designations, with 145,580 residents residing in primary care shortage areas. There were 29 Dental HPSA designations in the state with a total of about 70,000 Wyoming residents residing in these areas. Finally, the state had 22 Mental Health designations with nearly three-quarters (72%) of residents living in a mental health shortage area.



There are currently 63 physicians practicing Obstetrics and Gynecology (OB/GYN) in Wyoming and 49 practicing Pediatrics. Ten counties have no OB/GYN and 12 counties have no Pediatrician. There are 202 family practice physicians in the state, of which 48 practice in Natrona County, 36 in Laramie County, and 14 in Fremont County. Ten counties have fewer than 5 family practice physicians.

Results of the recently administered CDC-developed Levels of Care Assessment Tool (LOCATe) found that Wyoming lacks Level III facilities for both neonatal and maternal levels of care. This requires families to travel long distances for health care, miss work, and coordinate care for children left at home.

Health Equity in Wyoming

The definition used for health equity by Healthy People 2020 is the "*attainment of the highest level of health for all people*". Health equity removes barriers such as poverty and discrimination. It equalizes opportunities for good jobs, a quality education, safe neighborhoods, and access to health care.

Due to the unique nature of the state, a number of barriers to measuring health equity exist. Small population numbers (particularly for minorities) at the state and county level make stratification by geographic region, race, and ethnicity challenging. Wyoming continually monitors maternal and child health (MCH) outcomes for minority populations (primarily for American Indian/Alaskan Native and Hispanic/Latino) through the calculation of calculating rolling rates and data aggregation. Too often, even with multiple years, numbers are too small to report.

As stated in the 2018 Robert Wood Johnson County Health Rankings & Roadmaps, Wyoming fares well compared to the nation for children in poverty (12% versus 20%) but the proportion of children in poverty varies widely by county, with rates ranging from 7% to 20%. When race is examined, American Indian children were the most likely to live in poverty (> 20%) while White children were at lowest risk (9%).

Wyoming's overall high school graduation rate (2014-2015 Cohort) was lower than the national rate (79% versus 83%). American Indian youth were about half as likely to graduate from high school (45%) as White youth (82%) followed by 73% of Hispanic youth (Wyoming State 4-Year Graduation Rates, 2014-2015).

Agency Organizational Structure and Role

The MCH Services Title V Block Grant is managed by the MCH Unit within the Community Health Section (CHS) and Public Health Division (PHD) of the WDH. The mission of the WDH is to promote, protect, and enhance the health of all Wyoming residents. The 2014-2018 WDH priorities include:

- Implement Medicaid reform, including improving health outcomes while containing cost and redesigning waivers to increase access;
- Redesign the mental health and substance abuse system to improve outcomes;
- Focus on Wyoming's significant public health problems (e.g. suicide and tobacco and alcohol use) to improve overall health outcomes;
- Maintain Wyoming's emergency response capability;
- Strengthen Wyoming's rural health care infrastructure to ensure access to appropriate, cost-effective, quality care;
- Enhance the continuum of long-term care options for the elderly to support healthy aging in the most appropriate setting; and
- Support the health of Wyoming children.

The PHD is working toward public health accreditation and has set several strategic priorities to address the division's mission to promote, protect and improve health and prevent disease and injury in Wyoming:

- Promote understanding of the relevance and value of public health;

- Foster programmatic excellence;
- Support the integration of public health and health care;
- Foster a competent, flexible workforce; and
- Build a sustainable, cohesive organization

Several work groups continue to address each of these PHD strategic priorities. For example, the workgroup working to foster a competent, flexible workforce facilitates completion of an assessment of the Core Competencies for Public Health Professionals by all staff. This valuable tool helps staff identify opportunities for professional development related to public health practice.

As part of the accreditation application, WDH is working to complete the required state health assessment (SHA) and the state health improvement plan (SHIP). A member of the MCH Epidemiology staff is on the leadership team for the assessment. The goal is to incorporate life course indicators as the foundation of the SHA.

The MCH Unit provides leadership for state and local level efforts that improve the health of the maternal and child health population. In 2016, the MCH Unit updated its vision, mission, and core principles.

MCH Vision: Wyoming MCH envisions a Wyoming where all families and communities are healthy and thriving.

MCH Mission: The mission of Wyoming MCH is to improve the health and well-being of Wyoming families and communities by supporting and collaborating on public health activities that benefit the health of mothers, infants, children, youth, and young adults, including those with special health care needs.

Core Principles for Wyoming MCH:

- **Data Driven:** MCH Strives to use data, best available evidence, and continuous quality improvement to guide programs and policies.
- **Engagement:** MCH strives to address health priorities by empowering, leading, investing in, and advocating for community-engaged systems with diverse partnership.
- **Population Health:** MCH strives to achieve optimal health with targeted interventions and policies that link health outcomes with social determinants of health.
- **Health Equity:** MCH strives to eliminate health disparities in order to achieve health equity.
- **Life Course Perspective:** MCH strives to improve MCH services, policies, and practices through a life course lens.
- **Sustainability:** MCH strives for sustainability by investing limited resources strategically in public health interventions that are community-engaged and data driven.

Wyoming's Title V allocation is based on the total numbers of women of childbearing age (15 to 44 years), infants and children ages 0 to 18, and the number of individuals ages 0 to 44 living in poverty.

The 2015 MCH Needs Assessment resulted in the selection of seven priorities for 2016-2020:

- Prevent infant mortality
- Improve breastfeeding duration
- Improve access to and promote use of effective family planning
- Reduce and prevent childhood obesity
- Promote preventive and quality care for children and adolescents
- Promote healthy and safe relationships in adolescents
- Prevent injury in children

Medicaid expansion in Wyoming has not been approved by the state legislature. Wyoming has only one insurer, Blue Cross Blue Shield (BCBS), participating in the Federal Health Insurance Marketplace.

The MCH Unit's Children's Special Health (CSH) program offers care coordination and limited gap-filling financial assistance as the payer of last resort for enrolled clients who meet medical and financial eligibility criteria. In order to be eligible for assistance, families must first apply for Medicaid, Kid Care CHIP (Children's Health Insurance Program) and the Federal Marketplace. The program provides reimbursement to eligible providers for covered services provided to eligible clients.

State statutes relating to MCH

Three state statutes impact the work of MCH. The Newborn Screening (NBS) statute, Wyoming Statute (Wyo. Stat). § 35-4-801 and 802, mandates newborn screening be available to all newborns and that WDH provide necessary education on newborn screening to hospitals, providers, and families. WDH bills the hospitals/providers per initial screen. These funds are then used to contract with the Colorado Department of Public Health and Environment (CDPHE) Laboratory Services Division for analysis and communication of results to the provider and Wyoming MCH. Additionally, funds are used for contracts with a courier to transport the blood spots to CDPHE and contracts with specialists to provide follow-up for abnormal screens.

The second statute, Wyo. Stat. § 35-27-101, 102, 103, 104, Public Health Nurses (PHN) Infant Home Visitation Services, was passed in 2000. The statute directs PHN to contact eligible women to offer home visitation services as part of the Healthy Baby Home Visitation (HBHV) Program, a program consisting of two models. The initial intent of the legislation was to expand Nurse Family Partnership (NFP), an evidence-based home visiting model, to all twenty three counties using Temporary Assistance to Needy Families (TANF) funds. Due to fidelity requirements and a small birth cohort in some communities, NFP was provided in thirteen counties until State Fiscal Year (SFY) 2017 during which 11 counties implemented NFP. During 2016, MCH and MCH Epidemiology completed a process evaluation of NFP to determine which counties have the birth cohort and capacity to deliver the model with fidelity. As of July 1, 2017, five counties (Albany, Campbell, Carbon, Natrona, and Sweetwater) deliver NFP. All counties deliver the program's second model, Best Beginnings (BB), a home-grown home visiting model based on the research-informed Partners for a Healthy Baby curriculum developed at Florida State University.

The third related statute, Wyo. Stat. § 42-5-101, Family Planning and Birth Control, grants WDH with the ability to provide gap-filling contraceptives. The geography of the state, combined with the small population, poses challenges for assuring reproductive health services are available in all counties. During the 2017 Wyoming legislative session, restrictions for spending state general funds on contraceptives were added to the budget through a footnote. MCH supported gap-filling contraceptive purchases for counties with little to no Title X services in State Fiscal Year (SFY) 2016 and through SFY 2017 but discontinued support in SFY 2018 in order to reevaluate best strategies for increasing access to the wide range of contraceptive options. MCH will continue to partner closely with Wyoming's Title X grantee, Wyoming Health Council (WHC), to improve access to family planning services.

III.C. Needs Assessment

FY 2019 Application/FY 2017 Annual Report Update

Ongoing Needs Assessment Activities

Between 2013 and 2015, the MCH Unit and MCH Epidemiology Program met at least monthly to plan and complete the required five-year needs assessment. After priority selection and strategic planning finished, the meetings stopped. In an effort to prioritize ongoing needs assessment activities and provide a forum for ongoing collaboration, the MCH Unit and MCH Epidemiology Program began monthly meetings in June 2017. In early 2018, the team developed and released a collaboration survey to assess the strength of MCH partnerships. The survey also assessed partner awareness of current MCH state priority needs and level of agreement with statements related to the MCH Unit's core principles.

MCH program managers are expected to review action plans at least quarterly to review progress and identify and respond to challenges. MCH program managers present to WDH leadership at least annually on these action plans. Program managers plan to present to program-specific advisory groups annually in an in-person or virtual format.

MCH Epi is working to better monitor trends and identify emerging MCH issues. Currently, MCH Epi works closely with Wyoming Vital Statistics Services (VSS) to improve systematic review of selected measures to more quickly identify changes to trends or areas for concern. Data including Hospital Discharge, Pregnancy Risk Assessment Monitoring System (PRAMS), Behavioral Risk Factor Surveillance System (BRFSS), National Survey of Children's Health (NSCH), and Prevention Needs Assessment (PNA) are reviewed annually upon release, and more in depth on an ad hoc basis. More systematic review of these data sources is currently planned using Tableau data visualization software.

The release of new Title V guidance in December 2017 presented an opportunity for MCH leadership to review current National Performance Measures (NPM) for fit considering staff capacity, the role of MCH, current activities, current partnerships, and current progress. The team decided to discontinue NPM 11 (medical home), NPM 2 (low-risk Cesarean delivery), and transition NPM 8 (physical activity) to a State Performance Measure to address the 'Reduce and Prevent Childhood Obesity' state priority need.

MCH Population Needs

Women's/Maternal

PRAMS data indicate a continued reduction in maternal smoking. In 2016, 11.2% of new mothers reported smoking during the last three months of pregnancy. Despite the reduction in smoking during pregnancy, Wyoming's rates of maternal smoking are persistently higher than the US rate. Disparities in maternal smoking exist by maternal race, education, and income.

Preconception health of Wyoming women is of concern for Wyoming women and their infants. Data from the BRFSS (2016) indicate that less than half (46.0%) of women of reproductive age (18-44 years) had a healthy Body Mass Index (BMI).

Data from PRAMS indicate that hypertensive disorders during pregnancy are also of concern for Wyoming mothers. PRAMS data (2012-2016) revealed that 4.2% of respondents were diagnosed with high blood pressure or hypertension *before* their most recent pregnancy. When hypertension *during* pregnancy was examined, 11.2% of

Wyoming women reported this condition. Several PRAMS respondents commented on the barriers to high-risk maternal care in their community.

Due to small numbers it is difficult to monitor trends in Wyoming's maternal mortality rate; however aggregated data suggests that the Wyoming maternal mortality rate from 2005-2016 may be higher than the national rate.

Perinatal/Infant

Infant mortality in Wyoming was 5.0 deaths per 1,000 live births in 2015, slightly lower than the US rate. Despite the overall lower rate, disparities by maternal educational attainment and race persist. Neonatal mortality (death within the first 28 days of life) accounted for 65% of Wyoming infant deaths. As noted above, preconception health is one contributing factor to infant mortality in Wyoming. In addition, Wyoming VSS has noted an increase in the number of sleep related infant deaths in the last two years. PRAMS data from 2016 indicate that 22.1% of infants rarely or never sleep alone in a crib and 84.9% of infants are put to sleep on their backs.

Wyoming's 2016 preterm birth (<37 weeks) and low birth weight (LBW) rates of 9.5% and 8.5%, respectfully, are similar to the national rate. LBW rates are highest among women over 35 years old, in non-metro areas, and who are uninsured. Preterm rates are highest among women with less than a high school education, over 35 years old, and who are Native American.

Child

Unintentional injury remains the leading cause of death for children 1-11 years in Wyoming. Because of Wyoming's small population and small number of childhood deaths, data on childhood injury outside of fatalities is vital to informing programmatic efforts. We rely on state hospitalization and outpatient discharge data for non-fatal injury information. Issues related to Wyoming's rural and frontier nature have lead to challenges collecting accurate and consistent non-fatal injury data. In addition, the switch from ICD-9-CM to ICD-10-CM in Wyoming hospitals lead to difficulty in classifying injury hospitalizations. MCH Epidemiology continues to work to understand reporting across the state, how the change from ICD-9-CM to ICD-10-CM impacts surveillance efforts, and to work to improve data quality for injury surveillance efforts.

Thirty percent of Wyoming children (6-11 years) were active for 60 minutes everyday, similar to the US rate (NSCH, 2016). Due to small numbers, Wyoming was unable to observe any disparities in physical activity based on sex, special health care needs, race, ethnicity, or income.

Only 27.6% of Wyoming parents reported that their child (9-35 months old) received a developmental screening in the last year (NSCH, 2016). This low screening rate and the low rate of EPSDT (early periodic screening detection and treatment) screening in Wyoming are concerning.

Adolescent

As seen nationally, the Wyoming teen birth rate continues to steadily decline. However, the Wyoming teen birth rate (26.2 births per 1,000 women aged 15-19, 2016) remains higher than the national rate (20.3 births per 1,000). In addition to an overall decline in Wyoming teen birth rates, racial disparities in Wyoming teen birth rates have also decreased. In 2007, Native American and Hispanic teen birth rates were three and two times higher compared with the White rate, but have each dropped to below two times higher in 2016.

The Wyoming adolescent suicide rate (21.9 deaths per 100,000, 2004-2016) is almost two times the national rate and continues to increase. Additionally, Wyoming has a high rate of motor vehicle crash fatalities among teens. Other risky behaviors among teens have remained fairly constant over the last eight years, including reports of bullying (70% report no bullying) and marijuana use, about 90% of youth report zero occasions of lifetime use. We have seen

an increase in teens that have never used cigarettes; up from 73% in 2012 to 79% in 2016 (Wyoming PNA).

Since the loss of the Youth Risk Behavior Surveillance System (YRBSS) in Wyoming, infrastructure and capacity for data surveillance of the adolescent population specifically around monitoring healthy and safe relationships among youth and young adults remains low. Wyoming has worked to identify data sources and systems that will fill the gaps in monitoring the health and wellness of the adolescent population left after the loss of this data source.

Children with Special Health Care Needs

Wyoming Children with Special Health Care Needs (CSHCN) continue to experience disparities in overall health and access to necessary services. Only 17.9% of Wyoming CSHCN received the necessary services to transition to adult health care. Wyoming exceeds the nation in CSHCN who receive needed care coordination (75.9% v. 62.3%). Wyoming CSHCN who qualify are served through the CSH program which provides care coordination.

Emerging Issues

Maternal Mortality

The number of pregnancy related deaths was relatively low for several years, but in 2014 we noticed an increase that persisted into 2015. Wyoming's rate from 2011-2015 was 60/100,000. Data for 2016 indicate a decrease in the rate.

Infant Mortality

Although infant mortality is an existing MCH priority, two additional issues have been raised, preconception health and sleep related deaths.

Adolescent Suicide

In 2016, Wyoming had the eighth highest adolescent (12-24 year old) suicide rate (18 per 100,000) in the nation. Wyoming saw a large decrease in adolescent suicide from 2015 to 2016, 27 adolescent suicides in 2015 to only 16 adolescent suicides in 2016. However, preliminary 2017 numbers show a return to previously higher numbers. Since 2004 the Wyoming rate of adolescent (ages 12-24) suicide has significantly increased from 11 deaths per 100,000 to a high of 27 deaths per 100,000 in 2015 ($p<.001$), nearly three times higher than the U.S. rate of 10 deaths per 100,000.

Insurance Coverage

The Wyoming legislature has chosen not to expand Medicaid; many families are uninsured as a result. Wyoming's premiums are the highest in the nation according to an Urban Institute report from the Robert Wood Johnson Foundation on Premium increases. Some premiums in Wyoming increased by more than 70% between 2017 and 2018. According to the 2016 NSCH, 5.9% of Wyoming children are uninsured; however, 24.8% of Wyoming children do not have adequate insurance coverage. The rate is higher among Wyoming children with a special health care need (29.6%).

Opioids

As with other states, opioid use in pregnant women and neonatal abstinence syndrome (NAS) are an emerging concern in Wyoming. These issues will be monitored to ensure they are addressed as needed.

Title V Program Capacity Updates

Staffing changes in the MCH Unit in FFY17 including the hiring of a new Title V Director and filling a vacant program manager position. In FFY18, the MCH unit filled 3 additional vacancies, including 2 program managers and an

administrative assistant.

Twelve full-time staff work on behalf of the Wyoming Title V program. This includes three MCH Epidemiology staff and one CDC-assigned MCH Epidemiologist. All staff work at the state office in Cheyenne, WY.

Structurally, the MCH Unit's programs are divided according to the population groups they serve: women (ages 15-44) and infants (ages 0-1), Children (ages 2-11), Youth and Young Adults (ages 12-24), and Children and Youth with Special Health Care Needs (CYSHCN). This structure assures available capacity to address all population domains.

Currently, MCH does not have a family/parent representative on staff.

Title V Partnerships and Collaborations Updates

Other MCHB investments
MCH applied for and was accepted as a host site for the MCH Title V Summer Internship Program. Two graduate student interns joined the MCH team in May/June 2018 and will work with MCH, Medicaid and other key stakeholders to develop a plan to implement Bright Futures, 4th Edition as part of a broader cross-division goal of improving statewide EPSDT rates.

MCH continues to partner with Parents as Teachers, the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) grantee in Wyoming to build a network of home visiting organizations.

The State Systems Development Initiative (SSDI) supports the data work of Title V by partially funding an MCH Epidemiologist. SSDI also supports data collection and quality efforts; including partially funding Wyoming Vital Records participation in the State and Territorial Exchange of Vital Events program, improving quality control in the Vital Records data collection system, supporting data collection for PRAMS and developing important data linkages.

Other Federal investments
MCH continues to partner with Wyoming's Title X grantee, WHC, to ensure optimal coordination of activities related to family planning. The MCH Unit met with the WHC following the release of the Title X grant application.

Other HRSA programs
The Wyoming Primary Care Association (WYPCA) is a key partner in MCH's infant mortality reduction and family planning promotion efforts. The Child Health Program (CHP) partnered with WYPCA to provide training on the new National Committee for Quality Assurance Patient Centered Medical Home (PCMH) standards released in early 2017.

The Genetics Clinics offered through Title V works closely with the Mountain States Regional Genetics Collaborative, funded through HRSA's Genetics Services Branch, to improve services to Wyoming patients requiring genetics care.

State and Local MCH programs
MCH continues to have a direct presence in 22 of 23 counties through an MCH MOU which provides funding to counties to provide home visiting and other MCH services related to Wyoming MCH priorities. Services are provided by PHNs.

Other programs within the Department of Health
In order to improve communication and collaboration between MCH and MCH Epidemiology and ensure that the MCH needs assessment is an ongoing process, the MCH Unit Manager and MCH Epidemiology Program Manager

re-instituted monthly staff meetings in 2017.

In late 2016, the MCH Unit Manager and Unit Manager of the Rural and Frontier Health (RFH) Unit began discussions about possible collaboration. Two key areas of collaboration arose: (1) collaborating to incorporate telehealth into the provision of regional genetics clinics, and (2) identifying common goals between the MCH supported Healthy Baby Home Visitation Program and the RFH Unit administered Community Service Block Grant.

The MCH Unit and Wyoming Medicaid actively partner to address infant mortality, improving access to and promoting the use of effective family planning and promoting preventive and quality care for children and adolescents.

Tribes
MCH and MCH Epidemiology continue to provide support to members of the Fremont County Fetal and Infant Mortality Review (FIMR) Advisory Committee (formerly the planning committee) to implement FIMR in Fremont County, the county where the Wind River Indian Reservation (WRIR) is located.

MCH tribal nurses serving both the Northern Arapaho and Eastern Shoshone tribes offer gap-filling financial assistance and care coordination services as part of the CSH Program. CSH Benefits and Eligibility Specialists provide training and support to the nurses to improve and sustain programming.

The Wyoming PRAMS project continues to sample all births to Native American women. Wyoming PRAMS staff attend tribal health fairs and work with leadership of the tribal health programs to provide data for review and use in tribal programs.

Needs Assessment Summary Update

Process Summary: Between 2013-2015, an MCH Planning Group consisting of internal MCH staff (e.g. Title V Director, Program Managers, MCH Epidemiology staff) involved internal and external stakeholders, including community stakeholders in 10 of 23 counties, in the review of state health indicators and potential priorities, requesting input using a variety of methods (e.g. partner surveys, community meetings) throughout the 2-year process. Potential priorities were assessed according to five key factors: magnitude/extent of the issue, availability of public health strategies and MCH responsibility, health equity, life course impact, and political will/capacity. The team also completed the Capacity Assessment for State Title V (CAST-5) for each potential priority and a strengths, weaknesses, opportunities, and threats (SWOT) analysis for each potential national performance measure (NPM), the results of which were shared with stakeholders and considered in the selection of final priorities. Wyoming MCH Priorities were selected and approved by a steering committee in 2015.

During the next year, program managers researched evidence-based strategies to address each priority and accompanying NPM or State Performance Measure (SPM) and participated in technical assistance (TA) opportunities at both the regional and national level related to the development of evidence-based strategy measures (ESMs), a new requirement of MCH 3.0 and current Title V block grant guidance. To further assist the Unit in strategic planning, a Request for Proposals (RFP) was created and disseminated in search of a consultant to guide MCH through the strategic planning process and into implementation. Lolina, Inc. was awarded the contract in early 2016.

Strategic Planning Update: In April 2016, the MCH Unit met twice with Lolina, Inc. to build a foundation for strategic planning work including assessments of team and individual strengths. Beginning in 2015 and continuing through early 2016, each program reviewed available research on evidence-based strategies for each MCH priority and selected NPM or SPM. The programs relied on the 'Strengthening the Evidence' tools and where available, Collaborative Improvement and Innovation Network (CoIIN) tools such as change packages and driver diagrams to provide guidance for strategy selection. On May 9, 2016, MCH programs met with Lolina, Inc. to complete a first draft of population specific action plans and on May 25, 2016, advisory groups comprising 10-15 stakeholders per program met to review potential evidence-based strategies and measures and provide feedback.

In July, October, December 2016 and April 2017, each program conducted an internal review of progress on their respective action plans. The goal is to hold internal action plan reviews quarterly and convene program-specific advisory groups annually to review and guide each program's action plans.

MCH Population Needs: Updates to data included in our original needs assessment are included below:

Women's/Maternal

- 14.1% of new moms reported smoking during the last three months of pregnancy (Pregnancy Risk Assessment Monitoring System (PRAMS) 2014);
- Among Wyoming reproductive age women (18-44 years), less than half (46.0%) had a healthy Body Mass Index (BMI) (Behavioral Risk Factor Surveillance System (BRFSS), 2016) (cross cutting); and
- In 2014, 26.0% of pregnant women gained adequate weight during pregnancy; 53.7% gained excessive and 20.3% gained insufficient weight (PRAMS).

Perinatal/Infant

- In 2016, Wyoming (9.5%) met the preterm (<37 weeks) Healthy People (HP) 2020 goal of 11.4% (Vital Statistics Services (VSS));
- In 2015, 17.8% of Wyoming births were low-risk Cesarean deliveries (VSS); and
- Between 2012-2016, the Wyoming infant mortality rate was 4.7 per 1,000 live births compared with 5.8 in the US in 2014 (VSS)

Child

- 59.4% of children received care in a medical home (National Survey of Children's Health (NSCH), 2011-2012) (cross cutting);
- Among children ages 10-11 years old in Wyoming, 40.6% were reported to be overweight or obese; 73.8% of children 6-11 were reported to have exercised at least 4 out of the last 7 days (NSCH, 2011-2012) (cross cutting);
- Of middle school students in Wyoming, 56.1% reported being bullied on school property, the highest of any participating state (Youth Risk Behavior Surveillance System (YRBSS) middle school, 2013); and
- Leading causes of death among children include: unintentional injury, malignant neoplasms, congenital anomalies, and homicide (Web-based Injury Statistics Query and Reporting System (WISQARS), 2005-2015).

Adolescent

- The teen birth rate in Wyoming is 26.2 per 1,000 teens girls aged 15-19 (VSS, 2016);
- 8.0% of Wyoming high school students reported intimate partner violence (YRBSS, 2015);
- Wyoming adolescents are less likely than the adolescents nationally to self-report being overweight or obese (28.9% v. 31.5%), and more likely to report meeting the physical activity recommendations of 60 minutes per day, 5 or more days per week (YRBSS, 2015) (cross cutting);
- Parents reported that 60% of adolescents 12-17 had experienced at least one adverse childhood experience in Wyoming (NSCH, 2011-2012);
- Wyoming's suicide rate among teens is more than double the national rate (19.2 compared to 8.7 per 100,000 teens) (VSS and WISQARS, 2004-2015); and
- Wyoming's death rate due to motor vehicle crashes (MVC) is double the national rate (29.7 v. 15.5 per 100,000) (VSS and WISQARS, 2004-2015).

Children with Special Health Care Needs

- Only 42.8% of children with special health care needs (CSHCN) received care in a medical home compared with 63.5% of non-CSHCN (NSCH, 2011-2012); (cross cutting)
- CSHCN were less likely to receive a well-child visit in the previous year compared with non-CSHCN (78.9% v. 87.7%) (NSCH, 2011-2012);
- 27.1% of CSHCN have a health condition that consistently and often greatly affect their daily activities (National Survey of Children With Special Health Care Needs (NS-CSHCN), 2009-2010); and
- Under half (47.4%) of all CSHCN aged 12-17 received the necessary services for transition to adulthood (NS-CSHCN, 2009-2010).

Cross-Cutting/Life Course

- Cross cutting measures are reported within individual populations

1. **State's Health Care Delivery Environment Updates**

Medicaid expansion in Wyoming has not been approved by the state legislature. No efforts to expand Medicaid took place during Wyoming's 2017 session due to uncertainty around the future of the Affordable

Care Act (ACA).

2. **Title V Program Capacity Updates**

   a. **Organizational Structure**

   An updated organizational structure is attached. The primary updates related to Title V is the hiring of a new MCH Unit Manager/Title V Director in October 2016, new MCH epidemiologists in Summer 2016, and a new WIHPM in February 2017. In addition, one CSH Benefits and Eligibility Specialist now spends 50% of her time supporting the PRAMS program.

   b. **Agency Capacity Updates**

   Beginning July 1, 2017, WDH and Wyoming Department of Family Services (DFS) will be combined under current WDH leadership.

   In 2016, the WDH State Epidemiologist position became vacant and was filled in 2017. The new State Epidemiologist and Public Health Sciences Section Chief is a board certified pediatrician and trained epidemiologist and was previously an Epidemiologic Intelligence Service Officer in Wyoming where she worked closely with the MCH Unit and MCH Epidemiology Program. She is also the current acting State Health Officer.

   In 2017, the WDH State Health Officer and PHD Senior Administrator resigned after 5 years with the department.

   MCH continues to have a direct presence in 22 of 23 counties through an MCH MOU which provides funding to counties to provide home visiting and other MCH services related to Wyoming MCH priorities.

3. **MCH Workforce Development and Capacity Updates**

   The Youth and Young Adult Health Program (YAYAHP) is hoping to increase the number of paid youth volunteers supporting MCH programs and the number of youth and young adult members of the Wyoming Youth Council.

   Currently, MCH does not have a family/parent representative on staff. As discussed in the Family/Consumer Partnership section, family engagement remains a priority and will be a focus in FY18.

   MCH Unit staff tenure varies from 35 years to 4 months. It is expected that a couple staff may retire in the next five years. Staff are encouraged to maintain updated desk manuals to plan for expected and unexpected staff turnover.

4. **Partnership, Collaboration, and Coordination Updates**

   a. **Other MCHB investments**

   Wyoming was not selected to receive Early Childhood Comprehensive Systems (ECCS) funding in 2016. However, carry-over funds continue to support the work of Help Me Grow (HMG).

   MCH continues to partner with Parents as Teachers, the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) grantee in Wyoming to build a network of home visiting organizations.

The State Systems Development Initiative (SSDI) supports the data work of Title V by partially funding an MCH Epidemiologist. SSDI also supports data collection and quality efforts; including partially funding Wyoming Vital Records participation in the State and Territorial Exchange of Vital Events program, improving quality control in the Vital Records data collection system, and gaining access to necessary WIC data.

b. Other Federal investments

MCH continues to partner with Wyoming's Title X grantee, WHC, to ensure optimal coordination of activities related to family planning. Quarterly meetings are ongoing. Since the last annual report was submitted, we have begun collaborative efforts to increase access to long-acting reversible contraception (LARC).

c. Other HRSA programs

The Wyoming Primary Care Association (WYPCA) is a key partner in MCH's infant mortality reduction and family planning promotion efforts. The Child Health Program (CHP) is partnering with WYPCA to provide training on the new National Committee for Quality Assurance Patient Centered Medical Home (PCMH) standards released in early 2017.

d. State and Local MCH programs

MCH continues to have a direct presence in 22 of 23 counties through an MCH MOU which provides funding to counties to provide home visiting and other MCH services related to Wyoming MCH priorities. Services are provided by PHNs.

e. Other programs within the Department of Health

In order to improve communication and collaboration between MCH and MCH Epidemiology and ensure that the MCH needs assessment is an ongoing process, the MCH Unit Manager and MCH Epidemiology Program Manager re-instituted monthly staff meetings in 2017.

In late 2016, the MCH Unit Manager and Unit Manager of the Rural and Frontier Health (RFH) Unit began discussions about possible collaboration. Two key areas of collaboration arose: (1) collaborating to incorporate telehealth into the provision of regional genetics clinics, and (2) identifying common goals between the MCH supported HBHV Program and the RFH Unit administered Community Service Block Grant.

f. Tribes

MCH and MCH Epidemiology continues to provide support to members of the Fremont County Fetal and Infant Mortality Review (FIMR) Advisory Committee (formerly the planning committee) to implement FIMR in Fremont County, the county where the WRIR is located.

The Wyoming PRAMS project continues to sample all births to Native American women. In September 2016, MCH Epidemiology staff and the Director of the Northern Arapaho Recovery program presented the use of PRAMS data to inform efforts of the Tribal Tobacco Prevention and Control Program.

g. Public Health and Health professional educational programs and universities

Several MCH and MCH Epidemiology staff participated in graduate level MCH courses at the Colorado School of Public Health through the MCH-Link Scholarship Program.

MCH Epidemiology participated in the CDC-University of Illinois, Chicago (UIC) analytic Capacity Building course. The Wyoming team chose to focus their project for the course on analysis of hospital discharge data an unintentional injuries in children.

FY 2017 Application/FY 2015 Annual Report Update

Following the identification of Wyoming MCH Priorities, each population group (Women and Infants, Child, and Adolescent) met with their specific stakeholders to present the final priorities. Programs began researching evidence-based strategies to address the Wyoming priorities. This research would later be used to determine evidence-based strategy measures (ESM).

Wyoming, like our sister Region VIII states, struggled with what evidence-based strategy measures should look like. A Region VIII conference call was devoted to this topic as states shared their progress and their frustrations. The Maternal and Child Health Bureau (MCHB) offered a Technical Assistance (TA) meeting in April. This provided much needed assistance from the experts. It also offered an opportunity for states to share.

A Request for Proposals (RFP) was created and disseminated in search of a consultant to guide MCH through the strategic planning process and into implementation. Lolina, Inc. was awarded the contract and designed the strategic planning process into the following steps:

- Baseline Leadership Team Assessment
- Vision and Mission Work
- Strategic Planning Retreat
- Initial Population Team Meetings
- Community Stakeholder Meeting

Baseline Leadership Team Assessment

StrengthsFinder 2.0 is a leadership development and team building tool. It is an online assessment to help individuals identify, understand, and maximize their unique combination of strengths. Rather than focusing on weaknesses, the tool helps one to understand, apply, and integrate their individual strengths leading to better performance, increased work engagement, and improved team identity. StrengthsFinder 2.0 identifies four domains of leadership strength (executing, influencing, relationship building, and strategic thinking) and 34 themes which are all critical to the overall effective functioning of a leadership group.

Lolina, Inc. developed an “MCH Baseline Leadership Survey”. The purpose of this survey was to provide Lolina, Inc. with broader understanding in the following areas:

- Makeup of the MCH leadership team
- Assess the current MCH mission and vision
- Understand to what degree the MCH leadership team believed they have been successful in the 2010-15 Title V Goals and Objectives
- SWOT analysis
- Understand to what degree the MCH leadership team believed they have the resources and support to be successful at achieving the selected 2016-2020 Title V Priorities and Goals
- Assess how individuals on the MCH leadership team felt about how the team worked together, based on the Team Emotional and Social Intelligence inventory (http://theemotionallyintelligentteam.com/tesi.asp, 2016)
- Assess the degree to which individuals on the MCH leadership team felt they possessed individual leadership qualities, based on “The Five Practices of Exemplary Leadership Model” by Kouzes & Posner (http://www.leadershipchallenge.com/About-section-Our-Approach.aspx, 2016)

The survey responses provided Lolina, Inc. with a foundational understanding of the MCH leadership team’s assets and challenges in order to combine the leadership teams’ individual and collective perception of leadership strengths and gaps in leadership skills and knowledge.

Lolina, Inc. facilitated an interactive three-hour StrengthsFinder session. An overview of StrengthsFinder theory and structure were presented to the MCH leadership team. In addition, the Team Talent Map was distributed, analyzed,

and discussed, followed by interactive activities to develop a greater understanding of how the unique personal strengths profile of each individual translates to team strengths and a high level of performance. Strengths-based development is an approach that helps individual team members identify how they can purposefully aim their unique talents so that the team is better equipped to accomplish its goals and performance objectives and respond to barriers.

Looking at the team as a whole, we learned that MCH is stronger together. Half of the team have strengths in executing (know how to make things happen) and influencing (can sell the team's ideas inside and outside the organization). Almost every team member has some strength in relationship building (the glue that holds the team together) and in strategic thinking, which keeps the team focused. One essential piece of information from this experience demonstrates that every person is essential to accomplishing our goals over the next five years.

In consideration of the "Maternal and Child Health Pyramid of Health Services" and a shifting focus toward more population-based and infrastructure-building services, MCH requested a presentation to refresh the team's knowledge and understanding of the meaning of "population health". Lolina, Inc. prepared and presented "MCH & Population Health" on April 26, 2016, the first day of the strategic planning retreat. Key elements of this presentation included:

- Defining "public health" and the public health system
- Defining "population health"
- Reviewing 10 Essential Public Health Services
- Defining CDC's "Factors that Affect Health"
- Reviewing the "Socio-Ecological Model: A Framework for Prevention"
- Discussing the "Maternal and Child Health Pyramid of Health Services"
- Explaining rationale for a shift in focus toward the pyramid foundation

The purpose of revising the vision and mission statements was to develop a common foundation for the work that will be implemented in the strategic plan. A vision is intended to be an articulated hope for the future. A mission statement is an extension of a vision statement that describes what will be done and how it will be done. In concise terms, a vision inspires a common dream and a mission statement inspires common action and purpose.

Lolina, Inc. facilitated two leadership team discussions to assess the strengths and gaps in what was the current MCH vision and mission. The MCH Baseline Leadership Assessment identified the current vision and mission of the MCH Unit needed to be revised in order to be more reflective of the current and future work of the unit. Lolina, Inc. facilitated a group process to revise the current vision and mission in consideration of the current context of the Wyoming Department of Health and Title V, as well as the future direction of MCH. In addition, MCH identified the primary target audience as MCH partner and stakeholders, MCH staff, and the end users and beneficiaries of MCH services, Wyoming families and communities.

In the MCH vision and mission work session on April 18, 2016 and April 26, 2016, the definition and purpose of a programmatic vision and mission were reviewed. Through this work, the MCH vision and mission were revised and core principles were added:

Vision: Wyoming MCH envisions a Wyoming where all families and communities are healthy and thriving.

Mission: The mission of Wyoming MCH is to improve the health and well-being of Wyoming families and communities by supporting and collaborating on public health activities that will benefit the health of mothers, infants, children, youth, and young adults.

Core Principles:
Data Driven: MCH strives to utilize data, best evidence and continuous quality improvement to identify areas of MCH health inequity and guide MCH interventions for Wyoming.
Engagement: MCH strives to address health priorities by empowering, leading, investing in and advocating for community-engaged systems with diverse partnerships.
Population Health Focus: MCH strives to achieve optimal health with targeted interventions and policies that link health outcomes with social determinants of health.
Healthy Equity: MCH strives to eliminate health disparities in order to achieve health equity.
Life Course Perspective: MCH strives to improve MCH services, policy & practice utilizing a life course perspective.
Sustainability: MCH strives for sustainability by investing limited resources strategically in public health interventions that are community-engaged & data driven.

The Needs Assessment aligned priorities with either a national or state performance measure. For each performance measure, MCH staff researched evidence-based strategies. Staff attended a special Maternal Child Health Bureau (MCHB) Technical Assistance (TA) training focused on evidence-based/informed strategy measures (ESMs).

Three full days were set aside for the MCH Leadership Team to work together with Lolina, Inc. and begin creating the Plan. Within the three days, each population group (Women and Infant, Child, Adolescent) met separately with Lolina, Inc. to review identified strategies. It was agreed that each priority required a strategy that was evidence-based, had potential for Wyoming, and was achievable within the MCH resources. The result, after assessing Strengths, Weaknesses, Opportunities and Threats, is as follows:

- **Priority**: Prevent Infant Mortality
    - **NPM**: % of cesarean deliveries among low-risk first births
        - **Strategy**: Support quality improvement efforts (e.g. patient safety bundles) to identify and address areas of improvement for hospitals to decrease % low risk cesarean deliveries.
            - **ESM**: Development of facility-specific prevalence data
            - **ESM**: # hospitals implementing data-driven quality improvement efforts
        - **Strategy**: Provide payment disincentives for early elective, non-medically indicated and low-risk cesarean deliveries (e.g. equalize payment for low-risk vaginal and cesarean births)
            - **ESM**: # hard stop policies developed and distributed by insurers
    - **NPM**: % VLBW infants born in a hospital with a NICU
        - **Strategy:** Use LOCATe results to inform quality of improvement for identified hospitals, focusing on all levels
            - **ESM: #** hospitals initiating action steps to improve level of care based on receipt of survey results
        - **Strategy:** Build capacity for development of a perinatal quality collaborative
            - **ESM:** To Be Determined
    - **NPM**: % women who smoke during pregnancy
        - **Strategy:** Work with Tobacco Program and WY Quitline to inform development of pregnancy and American Indian focused Quitline media materials
            - **ESM: #** maternal smoking'-focused workgroup meetings
            - **ESM: #** pregnant women enrolled in the WY Quitline

- **Priority:** Improve access to and promote use of effective family planning
  - **SPM: #** hospitals equipped to provide immediate postpartum long acting reversible contraception (LARC)
    - **Strategy:** Apply to participate in learning collaborative on LARC
      - **ESM:** Convene stakeholder workgroup
      - **ESM:** Completed application
    - **Strategy:** Work with Medicaid and private payers to increase education on coverage and reimbursement for immediate postpartum LARCs
      - **ESM:** Bulletin describing coverage and reimbursement created
    - **Strategy:** Develop LARC toolkit and work with the Wyoming Hospital Association (WHA) for distribution
      - **ESM:** Toolkit created
      - **ESM: #** toolkits distributed

- **Priority:** Improve breastfeeding duration
  - **NPM:** % of infants who are ever breastfed
    - **Strategy:** Complete environmental scan of available breastfeeding support resources
      - **ESM:** Scan completed
    - **Strategy:** Develop and disseminate a resource directory of local lactation support services available to new mothers
      - **ESM:** Breastfeeding support resource map and web page with county level data developed
  - **NPM:** % of infants breastfed exclusively through six months of age
    - **Strategy:** Award mini-grants and provide technical assistance to hospitals for participation in Baby Friendly Hospital Initiative, or a scaled back version like Can Do Five or Baby Steps
      - **ESM:** Mini-grant program structure developed
      - **ESM:** Mini-grant application finalized and approved
      - **ESM**: # applications received
      - **ESM: #** mini-grants awarded
      - **ESM: #** TA meetings
      - **ESM: #** hospitals demonstrating improvement in delivery of a maternity-care practice supportive of breastfeeding
    - **Strategy:** Work with WHA to develop hospital recognition program
      - **ESM:** To be determined

- **Priority:** Promote Preventive and Quality Care for Children and Adolescents
  - **NPM: #** children (10-71months) receiving developmental screen using a parent-completed tool
    - **Strategy:** Support Help Me Grow (HMG) activities to make developmental screens available to families
      - **ESM:** Contract with 2-1-1 Inc. for HMG services completed
  - **NPM:** % children with and without special health care needs having a medical home
    - **Strategy:** Support practices with TA to develop and implement Family Engagement policies
      - **ESM:** Environmental scan of medical home in Wyoming completed
    - **Strategy:** Conduct outreach to PLTI families about availability and benefits of the medical home.

- **ESM:** Medical Home module created and implemented into PLTI curriculum
    - **NPM:** % adolescents (12-17 years) with preventive medical visit in past year
        - **Strategy:** Promote Adolescent Champion Model through mini-grants to health care providers
            - **ESM:** Partnership with University of Michigan developed
            - **ESM:** Mini-grant process developed
            - **ESM:** Request for Applications developed
    - **NPM:** % adolescents with and without special health care needs who received services necessary to make transitions to adult health care
        - **Strategy:** Develop state level Adolescent Provider Team
            - **ESM:** # meetings of the state level Adolescent Provider Team in the last year (with Transition sub-committee meeting)
            - **ESM:** # provider champions participating on team
            - **ESM:** # adolescents participating on team

- **Priority:** Prevent Injury in Children
    - **SPM:** Rate of hospitalization for non-fatal injury per 100,000 children (1-11 years)
        - **Strategy:** Support Safe Kids with targeted best practice interventions to address the three major causes of injury/hospitalizations in Wyoming
            - **ESM:** # best practice interventions implemented by Safe Kids across the state

- **Priority:** Reduce and Prevent Obesity
    - **NPM:** % children (6-11 years) physically active at least 60 minutes a day
        - **Strategy:** Support development of a healthy schools coalition with a focus on improving nutrition, physical activity, and over-all child health
            - **ESM:** # meetings of the Wyoming School Health Coalition
        - **Strategy:** District level school health profile data analyzed to determine current policies and practices and determine districts for targeted outreach
            - **ESM:** Focus of targeted outreach is identified

- **Priority:** Promote Healthy and Safe Relationships with Adolescents
    - **SPM:** % of teens reporting 0 occasions of alcohol use in the past 30 days
        - **Strategy:** Implement Communities That Care Program in select Wyoming Communities
            - **ESM:** Implementation plan developed
            - **ESM:** RFA for Communities That Care developed

The above information was presented to each population advisory group. The expectation of the group was to provide feedback out of their expertise. MCH received support from each group and agreement to participate in next steps. The next step is to further define the actions entailed within each strategy. This step will also incorporate other MCH activities which are not within the priorities. Some are legislated. Some have a long history and need to be re-examined as to their place within MCH.

Five-Year Needs Assessment Summary
(as submitted with the FY 2016 Application/FY 2014 Annual Report)

II.B.1. Process

1. Needs Assessment Process

A. Goals, Framework, Methodology

Goal: The goal of Wyoming (WY)'s Five-Year Needs Assessment is to determine MCH priorities that reflect stakeholder input, are supported by evidence, and for which the program has capacity to address.

Framework: The WY MCH Unit based their needs assessment on the six-step Peterson and Alexander Needs Assessment Process. The stages are: start-up planning, operational planning, data, needs analysis, program and policy development, and resource allocation.

The Start-up Planning Stage began in October 2013 with the establishment of the 'Planning Group' which consists of internal MCH staff (Title V director, program managers, and MCH Epidemiology (MCH Epi) staff). This group decided the goals of the needs assessment, participants, target populations, and a timeline. These initial decisions included the development of a steering committee comprised of leaders within WDH, state government, and the community.

In the Operational Planning Stage the planning group developed a funnel diagram (see attachment one) to represent the process of gathering data, review by several individuals/groups, and techniques to narrow the pool of indicators into the final priorities. The tenants of project management were expanded upon during this stage to identify strategies for achieving the goals set during the Planning stage.

MCH Epi staff worked concurrently on the Data Stage. They developed a survey of state partners, collected qualitative data during community meetings, and compiled data from existing state and national sources.

The Needs Analysis Stage occurred in several iterations; in each the depth of data presented to decision makers increased and the potential priorities decreased through consolidation or deletion.

The process is now in the Program and Policy Development Stage. Advisory groups were reconvened in May 2015 to learn the final priorities and begin the discussion on strategic planning; planned for fall of 2015.The final stage, Resource Allocation, will begin in early 2016.

Methodology: MCH cast a wide net to determine priorities to avoid biases in the selection process. Information on potential priorities was collected in three ways: community meetings across the state, a survey of state partners, and a review of national and state health indicators of the MCH population. Indicators were divided into three population areas: Women and Infants (women 15-44 and infants 0-1), Child (1-11), and Adolescent Health (12-24).

Members of the MCH Needs Assessment planning group conducted an initial assessment of each indicator on their perception of its MCH relatedness, political will, capacity, and potential partnership for each indicator through an online survey. MCH epidemiologists evaluated each indicator for data availability, comparability, its status as a PHD priority, and as a topic of discussion during the community meetings.

Indicators were grouped using a modified version of concept mapping. Using cluster analysis, six clusters were identified for the women and infant group, six for the child group, and seven for the adolescent group. The clusters became potential priorities.

In each in-person population advisory group the data and strategies were presented by the program manager and the epidemiologist on the items below. The participants of the advisory group used a scoring matrix to evaluate topic areas on a scale of 1-3 in the following areas:

- Magnitude/Extent
- Public health strategies available/MCH responsibility
- Health equity
- Life course effect
- Leverage, political will, capacity

For additional details on the scoring process, please refer to the MCH Issues Criteria Definitions (see attached). Priorities with higher scores were those which the advisory group recommended as future MCH priorities.

Following the advisory group meeting, the planning group reviewed the results. The planning group discussed the following about the advisory group meetings: groupings of topics, topic areas' names to more accurately reflect the meaning and discarding of low scoring topic areas.Each member of the population specific planning group scored the updated priorities. The three members of each population group (program manager, epidemiologist, and CSH staff) ranked each topic within each priority with the same methods as the advisory group scoring. Results can be found in attachment.

The planning group agreed to choose the top two priorities in each population area. Family Planning and Infant Mortality Prevention were tied in the second spot; three priorities were chosen for the Women and Infant group. There was concern about not including injury prevention in the child group as this had been a higher scoring topic among the advisory group. It was decided that injury prevention would be presented to the Steering Committee and they would make the final decision on whether to include it.

The steering committee met to review the process for selecting the final priorities. Comments, suggestions, and decisions made by the steering committee were incorporated into the final priorities.

B. Stakeholder Involvement

Community meetings: Community meetings created a space for the MCH program to perspective on pertinent health issues across the state. The program used a stratified random sampling method to chose nine counties across the state based on location, (Northwest, Southwest, Northeast, Southeast, and Central) density (rural, urban, frontier), and health status (county health rankings). Twelve community meetings, including two on the WRIR were held; a total of 146 community members participated in the process.

Partner survey: The partner survey solicited feedback from state level stakeholders on four components: barriers and enabling factors to health in WY, current Title V priorities, proposed Maternal Child Health Bureau (MCHB) straw measures, and interest in participating in the needs assessment process. The survey was sent to 142 WDH, state, and community partners with a 60.0% response rate. Qualitative data analysis was conducted to define themes.

Steering committee: The goal of the steering committee was to involve decision makers to guide the needs assessment development, approve priorities, and hold MCH accountable to the plan. The steering committee is comprised of PHD leadership, leaders from WDH, and stakeholders from other state departments. The steering committee has approved the needs assessment process, discussed the creation of the advisory groups, and finalizes the selected priorities. The steering committee will meet once per year to monitor progress and provide guidance to MCH.

Advisory committee: Each population subgroup developed an advisory committee to participate in the needs assessment process. Invitees were picked for their statewide perspective and broad focus to prevent region or topic specific preferences from biasing the choice of priorities. An advisory committee meeting was held in February 2015. At this meeting, MCH staff presented findings from the community meetings, partner survey, data collection, and a capacity analysis to the group. The members scored topics on a variety of criteria so the priorities could be ranked and used to inform the final priorities. The advisory committees were brought back together in May 2015 to receive an update and ask for their participation in the next steps of the process. Groups will develop strategies to address the selected priorities in preparation for strategic planning. The advisory group will participate in the strategic planning process and help implement the strategies.

C. Methods

The MCH team used a variety of methods to assess the strengths and needs of each of the six domains. The community meetings, partner survey and advisory group meeting all provided qualitative data on the strengths and needs of the WY MCH community. Qualitative analysis of phrase frequency and themes were conducted on the community meeting and partner survey data. These data were incorporated into further decisions.

Where possible, additional analysis was conducted (see attachment) and presented to the advisory and planning groups for consideration. The two groups each ranked and scored the topics on specific criteria to determine the final priorities.

D. Data sources

Data collection was an integral step in deciding which health topics to consider as potential priorities. The MCH

epidemiologists compiled data from a range of sources including Behavioral Risk Factor Surveillance System (BRFSS), Census, Vital Statistics, Medicaid, Pregnancy Risk Assessment Monitoring System (PRAMS), and the Youth Risk Behavior Surveillance System (YRBS). For a full list of sources and indicators please see attachment one.

E. Interface between collection of data, finalization of state's priority needs and development of state's Action Plan

The data collected for the needs assessment were used to inform staff, stakeholders, and decision makers of the needs of the MCH populations in WY. The process of refining the data gathered into final priorities included many iterations of review by various people and methods. The development of the state action plan will be conducted in the fall with the stakeholders that identified the priority needs and will include selection of strategies and methods to address the identified priority areas.

II.B.2. Findings

II.B.2.a. MCH Population Needs

2. Findings

A. MCH Population Needs

Women and maternal health

- 15.7% of new moms reported smoking during the last three months of pregnancy (PRAMS 2011);
- A significantly higher proportion of WY (24.3%) women aged 18-44 smoke compared with the US (18.7%) (BRFSS, 2009); (cross cutting)
- Among WY reproductive age women (18-44 years), less than half (42.2%) had a healthy BMI (BRFSS, 2012); (cross cutting)
- In 2011, only 29.7% of pregnant women gained adequate weight during pregnancy; 46.7% gained excessive and 23.6% gained insufficient weight (PRAMS);
- Lifetime prevalence of rape, physical violence and/or stalking by an intimate partner in WY was reported at 35.8% in WY, similar to the US rate (NISVS 2010);
- Between 2009-2013, the maternal mortality rate was 18.5 deaths per 100,000 live births (VSS).

Perinatal/infant health

- In 2012, WY (9.0%) met the preterm (<37 weeks) Healthy People (HP) 2020 goal of 11.4% (VSS);
- In 2013, 22.4% of WY births were low-risk Cesarean deliveries (VSS);
- PRAMS data from 2011 indicate that 23.5% of WY mothers report always or usually sharing their bed and 82.5% of women primarily put their children to sleep on his or her back;
- WY exceeds the HP 2020 goal for breastfeeding initiation (87.6%);
- In WY, 84.7% of infants are cared for in a medical home, significantly higher than the nation (61.3%) (NSCH, 2011-2012); and (cross cutting)
- Between 2006-2013, the WY infant mortality rate was 5.8 per 1,000 live births compared with 6.1 in the US (VSS)

Child health (1-11 year olds)

- 59.4% received care in a medical home (NSCH, 2011-2012); (cross cutting)
- 73% of WY children had a preventive dental visit in the previous year (NSCH, 2011-2012);
- Current insurance usually or always adequately met the needs of 23.4% of WY children (NSCH, 2011-2012);
- Among kids 10-11 years old in WY, 40.6% were reported to be overweight or obese; 73.8% of kids 6-11 were reported to have exercised at least 4 out of the last 7 days (NSCH, 2011-2012); (cross cutting)
- Of middle school students in WY 56.1% reported being bullied on school property, the highest of any participating state (YRBS -middle school, 2013); and
- Leading causes of death among this population: unintentional injury, malignant neoplasms, congenital anomalies, homicide, and suicide (WISQARS, 2004-2013).

Adolescent health (12-24 year olds)

- Teen birth rate in WY 34.6 per 1,000 teens girls aged 15-19 (VSS, 2012);
- 10.3% of WY high school students reported intimate partner violence compared the same as reported in the US (YRBS, 2013);
- 17.4% of high school students report current tobacco use; WY teens were significantly more likely to smoke consistently and heavily than teens nationally (YRBS, 2013); (cross cutting)
- Parents reported that 67.1% of WY adolescents aged 12-17 had adequate insurance (NSCH, 2011-2012);
- WY adolescents are significantly less likely than the U.S. to self-report being overweight or obese (23.5% v. 30.3%), and more likely to meet the physical activity recommendations of 60 minutes per day, 5 or more days per week (YRBS, 2013); (cross cutting)
- In WY 78.7% of adolescents reported they had a parent or other adult in their lives with whom they could talk about serious problems (YRBS, 2013); and
- Parents reported that 60% of adolescents 12-17 had experienced at least one adverse childhood experience in WY (NSCH, 2011-2012);
- WY's suicide rate among teens is double the national rate (21.1 compared to 8.0 per 100,000 teens) (WISQARS, 2009-2013); and
- WY's death rate due to motor vehicle crashes is double the national rate (32.2 v. 16.4 per 100,000) (WISQARS, 200-2013).

CSHCN

- Only 42.8% of CSHCN received care in a medical home compared with 63.5% of non-CSHCN (NSCH, 2011-2012); (cross cutting)
- CSHCN (11.6%) were more likely to report 0 days of exercise in the last week compared with non-CSHCN (3.8%) in WY (NSCH, 2011-2012);
- CSHCN were less likely to receive a well-child visit in the previous year compared with non-CSHCN (78.9% v. 87.7%) (NSCH, 2011-2012);
- 27.1% of CSHCN have a health condition that consistently and often greatly affect their daily activities (NS-CSHCN, 2009-2010); and
- Under half (47.4%) of all CSHCN aged 12-17 received the necessary services for transition to adulthood (NS-CSHCN, 2009-2010).

Cross-cutting

- Cross cutting measures are reported within individual populations

Summary of population specific strengths/needs

Pregnant women, mothers, and infants:

Nearly three quarters of pregnant women receive prenatal care in the first trimester. Alcohol, smoking and inadequate weight gain are risk factors for preterm and low birthweight babies.

WY met the HP 2020 goal for preterm birth. Infants born preterm often must go out of state to a tertiary facility for care which creates emotional and financial stress for families. Almost one quarter of mothers co-sleep with their infant. WY has met the HP 2020 goal for breastfeeding initiation. Focus is now on duration, while continuing to encourage initiation.

Children:

Over 80% of infants are reported to have a medical home, which decreases with age. Insurance is often not adequate for the child's needs. Almost half of 10-11 year olds were reported to be overweight or obese. WY has the highest percent of children reporting being bullied at school and the teen suicide rate is double the national rate. Death due to motor vehicle crashes is double the national rate. The teen birth rate is higher than the national rate. Over 10% of teens didn't use a contraceptive method at last sexual intercourse. Access to contraception may become more limited as Title X clinics are decreasing around the state.

CSHCN:

Less than half of WY children were reported to have a medical home and almost a quarter of CSHCN had an unmet need. Just over 25% of CSHCN have a health condition that affects their daily activities. Less than half received one of the necessary services for transition. The AHPM has been working with the WAHP and the WDE and has been invited to participate in groups regarding transition.

Cross-cutting:

Throughout the gathering of data from the community meetings, partner survey, and state/national data sources a common theme of access to services emerged for all MCH populations. This was related to types and quantity of providers, services available in a community, and the distance to travel for specialty services.

State's successes, challenges, gaps and areas of disparity

Women and maternal health - MCH leads a coordinated efforts team to reduce early elective inductions and low risk cesareans in WY. These efforts were selected as a strategy in the MCHB CoIIN to reduce infant mortality. Currently, 22.4% of deliveries to WY women are classified as low-risk cesareans.

Perinatal/infant health - Infant mortality in WY is similar to the infant mortality rate at the national level (5.8 per 1,000 live birth compared with 6.1). However, large disparities exist in the state based on geographic and racial differences. The lowest county infant mortality rate between 2006-2013 was 0.0 and the highest was 12.0 deaths per 1,000 live births. The rate of infant mortality among American Indian (AI) women in WY is significantly higher than the non-Hispanic white rate. Infant mortality was selected as a priority for WY. The MCH program is focusing on maternal smoking, preterm delivery, and risk-appropriate care to address infant mortality. WY is part of the IM CoIIN. MCH supports home visitation with PHN and MIECHV and has worked to provide a data system that can report on outcomes such as breastfeeding, safe sleep, and tobacco cessation.

Child health (1-11 year olds) -Three of the five leading causes of death in this age group are injury related which is a continued focus area for MCH. The program has many ties to local coalitions and the statewide SK campaign. Additionally, WDH has recently developed an injury prevention program which MCH will work closely with to develop strategies around injury prevention in children. A similar number of children aged 10 months to 5 years have had a developmental screen in the previous year in WY and nationally. A significantly lower proportion of WY Medicaid children received at least one screen in the last year compared with the nation. Working through the Early Childhood Comprehensive System (ECCS) grant, a strong system of referral and screening is being designed using the Help Me Grow (HMG) framework.

Adolescent health (12-24 year olds) - In this population the rates for death due to suicide and motor vehicle crashes (MVC) are double the national rates but disproportionate across counties. The rate of teen births is also higher in WY compared to the U.S. Native American and Hispanic teens are significantly more likely to be teen parents compared with white non-Hispanic teens in WY. The selected priorities of improving healthy and safe relationships and access to family planning are aimed at reducing risk behaviors in adolescent and promoting protective factors that reduce these negative outcomes. Additionally, the priority to promote preventive and quality care for children addresses the need to improve screening and access to services in this population. The need is apparent in the Medicaid population where only 30% received a preventive screen in the previous year.

CSHCN - Disparities in most measures exist when comparing children with and without special needs in WY. CSHCN are less likely to receive care from a medical home, more likely to be overweight/obese, more likely to experience adverse childhood experiences, and less likely to receive the care they need compared to children without a special health care need. A strength of the MCH program in WY is its incorporation of CSHCN into all priorities. CSHCN are disproportionately affected in most of the selected priorities; different strategies may be needed to address the needs of this population when addressing priorities.

Cross-cutting - In WY 15.7% of mothers smoke during the last trimester; no change in recent years. WY is far from the Healthy People 2020 goal of 1.4% during this time frame. Many disparities exist in the maternal smoking rates. Native American women, teens, Medicaid clients, and those without a high school education are at higher risk of smoking during pregnancy. Nearly one in four WY women (24.3%) of reproductive age smoke. Addressing smoking during pregnancy and for women of reproductive age was chosen as a strategy in the MCHB CoIIN to reduce infant mortality and selected as a

priority for MCH. MCH has strong working relationships with the WY Quit Tobacco program and Public Health Nursing (PHN) offices who will be allies in the development and implementation of strategies to address this issue.

Analysis of program: where current efforts work well and where new efforts are needed

The MCH program conducted a capacity assessment (SWOT - straw measures; CAST5 - potential priorities) during the needs assessment process. This assessment will be combined with current work on identifying evidence-based strategies to address the priority areas in the strategic planning process. Strategic planning will occur in fall 2015.

II.B.2.b Title V Program Capacity

II.B.2.b.i. Organizational Structure

B. Title V Program Capacity

Organizational Structure

The Wyoming Department of Health (WDH) is one of 47 WY state agencies. MCH frequently works with WDE, DFS, DWS, Transportation, State Parks, and the University of Wyoming. (Organizational charts for WDH and PHD are attached)

The WDH is located in Cheyenne, WY's capitol, in the southeastern corner of the state. WDH is divided into four divisions, Aging, Behavioral Health (BHD), Healthcare Financing (HCFD), and Public Health (PHD). The MCH Unit sits within the Community Health Section (CHS) of PHD. The other Units within the CHS include PHN, Immunizations, WIC, and Chronic Disease and Substance Abuse Prevention.

State health agency responsible for the administration of programs

The MCH program and MCH Epi staff are funded by federal and state funds which are included in the maintenance of effort (MOE) required by Title V. MCH receives the PRAMS, State Systems Development Initiative (SSDI), Rape Prevention and Education (RPE), PREP and ECCS grants which provide funding for staff and specific programs.

Women/Maternal Health:

Activities supporting Wyoming's Infant Mortality CoIIN project are covered by state and federal Title V funds. Activities are organized by the following Learning Networks: smoking cessation, pre and early term birth and risk appropriate perinatal care. The Coordinated Efforts to Reduce Preterm Birth group has morphed into the Pre and Early Term Birth Learning Network for the Infant Mortality CoIIN and its activities are covered by state and federal Title V funds.

The Maternal High Risk (MHR) program promotes access to care for high risk pregnant women who require care at a Level III facility and who meet eligibility criteria. Care coordination with the assistance of PHN and gap-filling resources (e.g. travel assistance) are offered to eligible clients. This program is funded with federal Title V funds.

Perinatal/Infant Health:

The Healthy Baby Home Visitation Program (known in statute as PHN Infant Home Visitation Services) is a primary service included in an MCH Services MOU with 22 of 23 counties and is funded by state general funds and TANF funds. Payment under the contract is made through a fee-for-service reimbursement system for home visits, classes that support home visitation and trainings.

The Newborn Intensive Care (NBIC) Program promotes access to care for high-risk families and infants who require care at a Level III nursery and who meet eligibility criteria. Care coordination with the assistance of PHN and gap-filling resources are offered to eligible clients. This program is funded with federal Title V funds.

The Fremont County Fetal Infant Mortality Review (FIMR) pilot project is funded with state and federal Title V funds. Funds support the development of the community-led project. Planning committee members representing Fremont County Public Health, Indian Health Service (IHS), Eastern Shoshone Tribal Health, Northern Arapaho Tribal Health, Northern Arapaho WIC, SageWest Healthcare, and Parents as Teachers Home Visitation program participate in monthly planning meetings. Title V Director, Women and Infant Health Program Manager (WIHPM) and Senior MCH Epi Advisor facilitate and support planning efforts. Lessons learned are valuable for implementing FIMR projects in other counties.

The WIHPM position, funded 100% by Title V dollars, directly supervises one staff member, a Benefits and Eligibility Specialist (BES) also referred to as the Newborn Screening and Genetics Coordinator. The WIHP BES is funded half by Title V funds and half Newborn Screening Trust and Agency account funds. This position works with the Genetics contractor and the Cleft Palate clinic.

The WIHPM manages the Healthy Baby Home Visitation Program, Newborn Screening, Genetics Clinics, Coordinated Efforts to Reduce Preterm Birth, Breastfeeding promotion activities, and is a state trainer for Ages and Stages Questionnaire (ASQ). She works closely with the other MCH program managers, while also active with the EIC and the MIECHV grantee work on early childhood systems within WY.

MCH partnered with Prevent Child Abuse Wyoming (PCAWY) to purchase sleep sacks. PCAWY distributed the sleep sacks to PHN offices to support safe sleep promotion activities.

Child Health:

Injury prevention is a priority of Child Health. MCH uses Title V dollars to contract with SafeKids Wyoming (SKW) to provide injury prevention statewide. This group provides car seats, training for car seat technicians, and promotes other safety messages through billboards and fairs, and provides leadership for local level programs. Data is provided to MCH quarterly and the CHPM sits on the SKW board. MCH staff is active with the Emergency Medical Services for Children program and provided assistance to Emergency Medical Services (EMS) by purchasing infant and child restraints for EMS transport. Title V dollars are braided with other WDH funds to support an Injury Prevention Program (IPP) Manager within PHD and a half-time injury epidemiologist.

The Wyoming Vision Collaborative provides leadership and training, facilitates discussion, and implements the WY plan to increase vision screening and improve referral processes for early detection of childhood vision problems.

The CHPM position is funded 75% by Title V and 25% from the ECCS grant managed by this position. The ECCS grant is focused on expanding developmental screening and establishing HMG within WY. This work is closely aligned with Title V and is applicable to the new MCH priorities. Work on developmental screening through ECCS is supported by the WIHPM who is a state ASQ trainer and active in the development of HMG in WY.

The dental sealant program utilizes Title V dollars to provide sealants through dental offices for low income children who are not on Medicaid.

Adolescent Health:

Half of the AHPM position is supported by Title V. The other half is split between the RPE and PREP grants. The AH program developed a WY Adolescent Health Partnership (WAHP). Title V funds support meetings and trainings for this partnership which currently includes an adolescent advisor and will support a youth advisory council soon. The AHPM manages the RPE grant which focuses on primary prevention of interpersonal violence.

Title V dollars purchased contraceptives for counties with little or no access to Title X clinics. Contraceptives are distributed through PHN clinics. Approximately half of the clients accessing contraceptives are adolescents. The AHPM is a registered nurse and works with a state pharmacist for this project.

CSHCN:

Title V dollars fund three BESs who assist with coordination of care in the CSH program. State general funds assist families of children that qualify financially and medically for the program. The three CSH staff assists PHN and families with coordination of care.

MCH contracts, using Title V funds, with the University of Utah to provide 25 regional Genetics Clinics annually and genetics consultation to WY physicians. The university is considering the use of telehealth and how that can be supported for the clinics.

The Cleft Palate Clinics are funded with state general funds to provide a one-stop-shop for infants, children and young adults to receive coordinated care in one place from a variety of specialists. CSH staff assists the Oral Health Program Manager (OHPM) with the planning and implementation of the twice-a-year clinic.

Cross Cutting:

Access to Family Planning is limited; Title X provides services with limited locations and availability. Some PHN clinics offer contraception, but require MCH funds to maintain the service. Beginning in FY14, MCH, in conjunction with PHN, determined basic types of contraception needed. The AHPM, with the help of the Medicaid pharmacist, orders and distributes to seven PHN offices. AH program also supplies 14 counties with pregnancy tests.

Title V dollars support the implementation of PLTI. The goal is to assist parents to become advocates for children and active members in their community. Training includes communication skills, civic advocacy, and assistance with the development and implementation of a community project.

WY is carrying forward its Tobacco Cessation priority. The current focus on pregnant women and infants will change to a life course approach under the new structure. The focus will be on prevention among women of reproductive age requiring work to begin before pregnancy. In FY14, a new MCH policy ensured that women receiving home visitation services were asked about smoking status at every visit. Next steps include promotion of the Quitline fax referral.

The MCH epidemiologists work within all population groups. Title V will fund 80% of the MCH CDC Assignee in FY16. The Epidemiology Program Manager is funded 45% by two federal grants (SSDI and PRAMS) and 55% SGF. A second MCH epidemiologist is funded 100% SGF. The IPP/PRAMS epidemiologist is funded with 25% Title V and 50% PRAMS with the remainder through additional injury prevention sources.

II.B.2.b.ii. Agency Capacity

Agency Capacity

Capacity was assessed prior to February 2015 and focused on three areas: Structural Resources, Organizational Resources and Skills/Competencies. The MCH capacity is presented below by the priorities selected.

Women/Maternal Health

Prevent Infant Mortality:

- **Structural resources**: MCH needs more support from PHD programs around tobacco prevention. More formal processes/protocols should be created in order to assess improvement toward goals. MCH is active on efforts around infant mortality prevention and the reduction of adverse birth outcomes through efforts in CoIIN, FIMR (at the local level) and Coordinated Efforts to Reduce Preterm Birth. Formalized processes for this work will be built as the State Infant Mortality Reduction Team follows guidance outlined by CoIIN. Legislation for death review is missing, which could help move this work even further. MCH partnership with the new Injury Program, within PHD, will advance work around safe sleep.
- **Organizational relationships**: MCH has established good organizational relationships within PHD but has not expanded to include OB/GYN providers. Many relevant partners are currently engaged through both CoIIN and Coordinated Efforts. All are equal contributors to the process and motivation is high. Need to identify ways to engage the provider community.
- **Skills/competencies:** MCH benefits from a generous mixture of subject matter expertise, public health experience, and epidemiological skills. The workforce is also well-trained in evidence-based tools such as SBIRT and has access to a pregnant-specific Quitline curriculum. The MCH team focused on infant mortality include MCH Doctoral level Epidemiologist, MCH Unit Manager with MCH experience, particularly in clinical nursing and home visiting, and WIH Program Manager with public health and social work background.

Improve Access to and Promote Use of Effective Family Planning:

- **Structural resources:** The WIHPM and AHPM are working together to refine/improve the Reproductive Health program which provides contraceptives/multivitamins. AHPM is exploring Long Acting Reversible Contraceptives (LARC) training options for providers across the state. AHPM also manages the PREP grant.
- **Organizational relationships**: MCH will continue to work to improve relationship with the Wyoming Health Council (WHC) and will look to also build relationship with Medicaid to explore LARC coverage.
- **Skills/competencies**: In addition to MCH having a full staff with varying expertise, the AHPM has experience

ordering/supplying contraceptives.

Perinatal/Infant Health Domain:

Breastfeeding:

- **Structural resources:** MCH has high capacity to further breastfeeding support activities beyond promotion of breastfeeding during home visits. Engaging providers and hospitals is the next step.
- **Organizational relationships:** MCH must expand relationships beyond PHN, while continuing to ensure PHN workforce is trained to adequately promote/support breastfeeding.
- **Skills/competencies:** MCH is at full staff capacity and benefits from a generous mixture of subject matter expertise, public health experience, and epidemiological skills PHNs are well-trained in professional breastfeeding support strategies.

Child Health Domain:

Promote Preventive and Quality Care for Children and Adolescents

- **Structural resources**: Federal legislation mandates Title V and Title XIX Early Periodic Screening, Diagnosis and Treatment (EPSDT) programs to collaborate. An MOU exists between WY Title V and Title XIX. Funding through the ECCS grant is dedicated to increasing developmental screenings throughout the state. MCH has access to up-to-date information for improving outcomes. MCH has mechanisms for accountability/quality improvement.
- **Organizational relationships:** MCH has strong relationships with PHN, MIECHV, and the Home Visiting Committee of the Wyoming Early Childhood State Advisory Council (WECSAC). A developing relationship exists between MCH and Medicaid, including Oral Health. More partnerships need to be forged in the area of EPSDT with Medicaid/CHIP. Gaps exist in services and coverage for needed services. MCH works with PHN, Medicaid, KidCare, families and healthcare professionals to provide care coordination.
- **Skills/competencies**: MCH is able to provide ASQ training and continued organizational development is occurring at the program, unit and division levels. MCH program has staff with expertise with the CSHCN population. MCH is seeking ways to improve care coordination.

Reduce Childhood Obesity:

- **Structural resources**: MCH has funding to address obesity, as does the PHD Chronic Disease Prevention Unit . Gaps exist in partnership mechanisms with schools, local food source agencies and community organizations.
- **Organizational relationships**: MCH has strong relationships with other state agencies and other programs in WDH. Stronger relationships with WDE and local health care providers to effect change are necessary.
- **Skills/competencies**: MCH has the ability to work effectively with public and private agencies that can effect change within this priority.

Prevent Injury in Children:

- **Structural resources:** MCH has minimal structural resources to address the leading causes of death in the child population. MCH funding is provided to SafeKids Wyoming (SK) and the CHPM is a member of the SK Leadership Team to help inform injury prevention activities in the state. PHD recently added an Injury Prevention Program which MCH assists with funding and is a member of the team.
- **Organizational relationships:** MCH is a member of the WY Child Death Review (CDR), SKW Board, and the PHD Injury Prevention Program.
- **Skills/competencies:** MCH Epi provides analysis of data necessary for determination of program focus. There is growing knowledge amongst Injury Prevention staff through conferences, trainings, and webinars.

Adolescent Health Domain:

Promote Healthy and Safe Relationships in Adolescents:

- **Structural resources:** Numerous partnerships exist within WDH and statewide within the medical community and youth organizations. Infrastructure for communication with youth and their parents is in development. Workforce capacity is strong due to numerous overlapping risk and protective factors. MCH has access to up-to-date research and programmatic information. MCH has the ability to measure program success and make improvements to the

program. Funding for substance abuse prevention is housed in another Unit of PHD.

- **Organizational relationships**: Strong organizational relationships exist with state government organizations and other statewide agencies. A potential for stronger relationships with WDE and adolescents exists. MCH has an ongoing relationship with the National RPE Directors Council. There is limited availability of youth friendly and accessible services and potential for stronger relationships with youth-serving organizations. Relationships specifically related to substance use are minimal.
- **Skills/competencies**: AHPM is trained as a trainer in the Making Proud Choices, Reducing the Risk, and Understanding Adolescence: Seeing Youth Through a Developmental Lens curricula. MCH provides focus to other programs and agencies on the intersection of common risk and protective factors with other adolescent issues. MCH has the ability to train providers and community organizations in strengths-based strategies and positive youth development. MCH Epi provides analysis of data, necessary for determination of program focus.

Improve Access to and Promote Use of Effective Family Planning (Focus on Teen Birth Prevention):

- **Structural resources**: Funding is available through MCH and other sources to address teen births. Infrastructure for communication with youth and their parents is in development.
- **Organizational relationships**: MCH has strong relationships with other state government agencies and organizations. There is limited availability of youth friendly and accessible services, but as information and trainings are disseminated there is growing interest. MCH continues to develop the relationship with WHC, the Title X grantee.
- **Skills/competencies:** AHPM is a train the trainer for several reproductive health curricula. MCH provides focus to other programs and agencies on the intersection of common risk and protective factors with other adolescent issues. The AHPM is a nurse and able to work with PHN regarding contraceptives.

CSHCN Domain:

Transition:

- **Structural resources**: MCH has funding and ability to address medical transition. Communication with policy makers and agencies is excellent, but significant gaps exist in communication channels with medical providers and provider organizations.
- **Organizational relationships:** There are strong organizational relationships specifically with statewide non-profit agencies, advocacy organizations, and agencies that link directly to families. There is potential for stronger relationships with medical providers and provider organizations.
- **Skills/competencies:** MCH has excellent communication skills and ability to work effectively with groups that can help to improve these measures. The AHPM has a clinical medical background improving access to and credibility with providers. MCH Epi provides analysis of data, necessary for determination of program focus.

Medical Home:

- **Structural resources:** MCH has minimal authority to address this issue, although Title V agencies are charged with linking CSHCN to needed personal health services and ensuring provision of care when otherwise unavailable. MCH does have access to up-to-date policy and programmatic information.
- **Organizational relationships:** MCH continues to develop relationships with Medicaid, WYHealth, Blue Cross/Blue Shield, and KidCare CHIP. PHNs assist the CSH families in establishing a medical home.

Cross-Cutting/Life Course:

Tobacco:

- **Structural resources**: MCH is working with the Tobacco program within the Prevention Unit in order to expand inclusion of non-pregnant women of reproductive age and their families. WY offers Quitline services to all residents including pharmacotherapy. The Quitline has a specific pregnancy module with additional incentives for participation.
- **Organizational relationships:** While MCH has good partners for this work, there is a need to develop consistent communication. Tobacco cessation is one of the learning networks in the IM CoIIN and the PHD Tobacco Program is involved with the CoIIN.
- **Skills/competencies:** MCH is at full staff capacity and benefits from a generous mixture of subject matter expertise, public health experience and epidemiological skills.

State Program Collaboration with Other State Agencies and Private Organizations

The MCH Unit, to ensure activities occur within a system and strives to include other entities from within WY in its program development. March of Dimes (MOD) approached MCH prior to FY 14 to assist with sharing the MOD 39-week toolkit with WY birthing hospitals. A meeting with MOD, the Wyoming Hospital Association (WHA), and MCH illuminated the fact that several entities were interested in early elective delivery (EED) and preterm birth. In response, the State Health Officer (SHO) established the Coordinated Efforts for Preterm Birth group which began monthly meetings in FY13. Members include PHD leadership, MCH, MOD, MCH CDC Assignee, Medicaid, WHA, WINhealth, Wyoming Medical Society (WMS)and the Wyoming Business Coalition on Health. The Coordinated Efforts group recently began working with the State Infant Mortality Reduction Team.

In 2014, the Collaborative Improvement and Innovation Network (CoIIN) for Infant Mortality expanded to include all states. Following the Infant Mortality CoIIN Summit in July 2014 (attended by a representative of MCH, Medicaid, Epidemiology and WinHealth), a state team was formed to address Infant Mortality and participate in the CoIIN. Additional members include a pediatrician, a neonatologist, MOD, a representative from Eastern Shoshone Tribal Health, and a representative from the Primary Care Association (PCA). WY team priorities are:

- Improve community capacity to protect and improve their own health and reduce disparities
- Empower families to protect and improve their health and wellness and use their voices
- Ensure quality of perinatal care

The three Learning Networks chosen by the state team are:

- Tobacco Cessation
- Pre- and Early-Term Birth
- Perinatal Regionalization

Representatives from MCH, Tobacco Prevention, Chronic Disease, Public Health Nursing, Eastern Shoshone Tribal Health, Medicaid, and Epidemiology, comprise a Tobacco Cessation workgroup. The goal of the workgroup is to encourage the use of the Quitline among women of reproductive age through work with the Title X family planning clinics. This workgroup will become the Infant Mortality CoIIN Smoking Cessation Learning Network.

The Pre- and Early Term Birth Learning Network group is currently the same as the Coordinated Efforts Group. The aim of the group will be split between EED and how best to address the use of progesterone with women who have previously had a preterm delivery.

The Risk Appropriate Perinatal Care Learning Network is also working with the Coordinated Efforts Group as membership of both groups is similar. The group is working toward piloting the Level of Care Assessment Tool (LOCATe) tool to help identify the appropriate hospitals for high risk pregnancies.

The WIHPM assumed the role of the MCH representative on the EIC in early 2014. In April 2015, the WIHPM was nominated to be the Vice Chair of the Council and will assume the Chair role in 2016. This council presents ample opportunities for collaborative efforts and systems work, particularly around the improvement of early referrals for pregnant women and infants to necessary services including but not limited to home visitation, Early Intervention Part C services, etc.

The WIHPM has participated in a handful of systems-building meetings focused on early childhood mental health. The initiative is ongoing and involves stakeholders from WDH and other state agencies such as WDE, DWS, and DFS. MCH involvement focuses on ensuring focus on mental health begins prenatally and considers the role of maternal depression and adverse childhood experiences.

The ECCS grant began a new focus in FY14. The State team, comprised of PHN, child developmental centers, WDE early childhood staff, DWS, WDH and DFS and co-led by the CHPM and a developmental pediatrician, chose to expand developmental screening activities in early care and education settings statewide. The group decided the use of the same screening tool would provide a common language between providers. The Ages and Stages Questionnaire (ASQ), including the social emotional tool, was selected as the common screener. Diane Edwards, MD, FAAP, co-lead of the state team, is assisting with engagement of the WY Chapter of the American Academy of Pediatrics. The WIHPM and Jen Davis, WYCRP, provide ASQ trainings around the state.

Incrsing developmental screening means families and providers need to be aware of the service. In searching for a strategy to link families with providers, the state ECCS team identified HMG. WY MCH received technical assistance through Title V, in FY15, to travel to Utah with several stakeholders (211, early intervention and WDE) to view Utah's HMG program, data collection and how it fits within their 211 system. Since that trip, the HMG team has created work groups to consider all aspects of the program including sustainability and provider outreach.

As part of the required MIECHV systems work, MCH, PATNC, and PAT (WY) met with a facilitator to determine how to move HV within the WY Early Childhood System. The consensus was that a common understanding and language around HV is necessary among all HV providers. The second meeting added PHN, Early Head Start, and Tribal MIECHV to the conversation. The goal is to create a unified definition and vision of HV in WY. Future activities will focus on workforce development, training and shared outcome measurement.

State Support for Communities

In FY13, several groups within Fremont county approached WDH about the county's high infant mortality. MCH sponsored an Infant Mortality Summit that summer. Staff shared the Fetal Infant Mortality Review (FIMR) strategy as one way of addressing the issue. Attendees from PHN, IHS, Tribal Health, Fremont County Coroner's office, and Tribal Health participated. The following November, MCH visited those who attended and offered to assist the community with development of a FIMR. Beginning in January 2014, the Fremont FIMR planning committee began meeting monthly to plan implementation. Training for the Case Review Team and the Community Action Team was provided by MCH and the National FIMR Program in June 2015.

MCH has a Memorandum of Understanding (MOU) with 22 of the 23 counties to provide MCH services. The funding for the MOU is a combination of State General Funds (SGF) and Temporary Assistance to Needy Families (TANF). The MOU reimburses for HV of clients/families enrolled in the Healthy Baby HV program. It also assists with CSHCN HV, as well as classes offered by nurses. The WIHPM and PHN MCH Consultant meet weekly and this past year have focused on the roll-out of a revised data system which more accurately captures the services provided by PHNs.

Over the past few years, MCH gradually assumed responsibilities of the Oral Health Section. During FY14, the CHPM oversaw the Community Oral Health Coordinators (COHCs). COHCs provide dental screenings, referral to treatment, fluoride varnish and fluoride rinse programs, and educational programming for preschools, Head Starts, Cleft Palate Clinic and school districts in 13 counties. At the end of FY14, an MCH MPH intern reviewed the COHC program. In spring of FY15 she was hired as the Oral Health Program Manager (OHPM) and is revising the program to assure standardization of activities.

MCH hired a part-time dentist with an MPH. He resides in Billings, MT and provides oversight of the dental hygienists as per their scope of work. The dentist and OHPM have begun strategically planning an oral health program to meet the public health needs of WY.

II.B.2.b.iii. MCH Workforce Development and Capacity

MCH Workforce Development and Capacity

The PHD of the WDH is comprised of four sections. Dr. Wendy Braund is the State Health Officer and Senior Administrator of PHD. The MCH Unit is within the Community Health Section. The Section Chief and supervisor to the MCH Unit Manager is Stephanie Pyle.

At the beginning of FY14, MCH had two vacant positions--WIHPM and AHPM. In FY14, MCH replaced the CSHCN Director position with an Adolescent Health Program Manager. Adolescent health had only been addressed through specific activities such as with the RPE grant's focus on 12 to 24 year olds. MCH made this change understanding CSHCN are within all MCH populations. To help each population group (Women and Infants, Child and Adolescent) remember CYSHCN in different discussions, a Benefits and Eligibility Specialist (BES) was placed in each program and one is directly supervised by the Unit Manager.

MCH hired the AHPM in September 2013 and the WIHPM in January 2014. The administrative assistant position was vacant

for only a short time during the summer of 2014. The administrative assistant position is currently vacant again, but will be refilled soon.

The MCH Unit grew to eleven staff with the addition of the Oral Health program in FY14. Full time staff include Linda McElwain, MCH Unit Manager and Title V/CYSHCN director, Vicky Garcia, BES, and a vacant administrative assistant. The Unit is divided into three population groups and the Oral Health Program. CYSHCN are included within each of the population groups.

The Women and Infant Health Program is managed by Danielle Marks. Danielle works closely with the PHN MCH Consultant on the Healthy Baby Home Visitation Program, a joint effort of MCH and PHN. Carleigh Soule, BES, is the liaison between MCH and the Colorado Lab for NBS and the University of Utah for Genetics Clinics.

Charla Ricciardi is the Child Health Program Manager. Sheli Gonzales, BES, works with the CHPM, provides care coordination for CYSHCN, and assists with PRAMS.

The Adolescent Health Program Manager is Shelly Barth. Paula Ray, BES, works with the AHPM and provides care coordination for CYSHCN.

Cassandra Walkama is the Oral Health Program Manager. She is working with the part-time dentist and four COHCs to standardize the COHC program and refine the gap-filling marginal and severe malocclusion services.

MCH staff extend beyond the MCH Unit. MCH epidemiologists include Amy Spieker, Kerry Olmsted, Pedro Martinez, and, Ashley Busacker, a CDC MCH assignee to WY. All staff, but one, is located in Cheyenne. The part-time state dentist is located in Billings, Montana.

In FY14, as part of the PHD strategic planning priority to “Foster a competent, flexible workforce,” PHD employees participated in a survey to determine training needs across the division. The assessment included public health (PH) competencies, knowledge of WDH/state processes (fiscal, HIPAA, human resources, IT, contracts, HealthStat), and interest in training on various computer programs. This information was utilized by the PHD to determine training offerings.

Provide examples of mechanisms that the state has developed and utilized to promote and provide culturally competent approaches in its services delivery.

Since 2011, MCH Epi has worked with both tribes on Tribal PRAMS when PRAMS began to oversample all AI births. Through the process a Tribal PRAMS logo and an AI specific PRAMS survey cover were developed. During the Tribal PRAMS program response rates have improved among the AI mothers by 20%.

PHNs in a county with a population of undocumented Hispanic women are creating a group prenatal class to complement home visits. These women are not eligible for Medicaid until delivery. To provide support and prenatal education, the PHNs developed a class schedule to support the women and provide information regarding their pregnancy. This class will be piloted and could guide other PHN offices seeking to support pregnant women in similar ways.

MCH and DFS created an eligibility form to assist PHNs in accurately determining client eligibility. Prior to the new form, which is being piloted in several PHN offices, if a woman was undocumented the family would not qualify for services. With DFS assistance, the new form considers all members within the family and their income. Initial information from pilot sites suggest success.

II.B.2.c. Partnerships, Collaboration, and Coordination

C. Partnerships, Collaboration, and Coordination

Other MCHB investments:

MCH Epi utilizes the SSDI grant to assist with the development of the FIMR pilot in Fremont County. The grant supported work with the vital records systems including data validation for birth certificates, a system for entering fetal death certificates, and a linked infant birth and death export feature.

MCH partners with MIECHV to assure home visiting services are included within the Early Childhood system. The first

systems meeting was held in May to work with a facilitator to define home visiting in WY. A second was held in June with a representative from each home visiting program within WY.

The ECCS grant is managed by the CHPM. The ECCS State Team, made up of child care program representatives, PHN, Early Intervention Services, staff from WDE, DWS, WDH, and DFS and other early childhood stakeholders, chose to expand developmental screening using the Ages and Stages Questionnaire (ASQ). ECCS has funded over 65 ASQ kits to child care centers and home visitors. Over 115 staff have attended nine regional ASQ trainings.

The AHPM has utilized National Adolescent and Young Adult Health Information Center (NAHIC) and the State Adolescent Health Resource Center (SAHRC) to develop a training for providers called “Adolescent Development and Communication For Health Care Providers”.

The Infant Mortality CoIIN which has provided additional framework to work already begun in WY. State partners include the State Health Officer, providers, Medicaid, epidemiologists, MCH, Primary Care Association, Eastern Shoshone Tribal Health, March of Dimes, WHA, WMS, and WinHealth. The three foci chosen by the state team are tobacco cessation, pre-and early-term birth, and risk-appropriate care.

MCH partnered with Emergency Medical Services for Children in the WY Responders Safe Transport Initiative (WYRESTRAIN). The goal is to assure that all children are transported in the safest manner by ambulance. MCH funded 30 Ambulance Child Restraints (ACR) and 35 Baby ACRs.

Other Federal investments:

The AHPM partners with the Communicable Disease Unit to carry out PREP in WY. For the first year PREP was provided in the Boy and Girls Clubs. A total of 90 youth ages 12-15 completed the program with fidelity in three counties. Since that time, over 30 new facilitators have been trained including PHN, school nurses, school health teachers, juvenile justice staff, and Boys and Girls Club staff. MCH is also working with community mental health centers to implement Making Proud Choices for youth in out of home care.

MCH meets at least quarterly with WHC, the WY Title X grantee, to discuss current activities within both programs. Topics have included a Reproductive Life Plan, Long Acting Reversible Contraceptives (LARC), and discuss how the two programs can work together to improve family planning access throughout the state.

MCH is a member CDR. It is currently led by the WYCRP to review child maltreatment deaths and major injuries. The MCH CDC Assignee is also active with the leadership council.

The WIHPM is the Office of Women’s Health representative and attends quarterly meetings which include state updates, resource sharing and presentations which respond to member inquiry and interest.

Other HRSA programs:

The Primary Care Association (PCA) is a member of the IM CoIIN. The PCA is kept informed of activities occurring within the CoIIN.

State and local MCH programs:

MCH contracts with 22 of the 23 county PHN offices with combined funding of TANF and SGF provided for reimbursement of MCH services, such as home visitation and care coordination for CYSCHN. The WIHPM partners with the MCH Nurse Consultant (PHN) to enhance the home visiting services and increase communication.

Other programs within WDH:

Currently MCH is partnering with Chronic Disease and WIC on an ASTHO project to increase access to professional and peer support for breastfeeding. The first step is an environmental scan to obtain a baseline of current support services.

The IM CoIIN includes MCH, Medicaid, MCH Epi, and the Tobacco program.

The WIHPM works with the Behavioral Health Division’s Part C (Early Intervention) Program Manager and the Governor’s Early Intervention Council (EIC) to increase early referrals to services. The Part C Coordinator has also been involved in planning meetings for visits to tertiary care facilities. Other partners for tertiary facility visits include WIC, Medicaid, CSH, Vital Statistics, and PHN.

Other governmental agencies:

The MCH Needs Assessment advisory committee included representatives from DFS, DWS, the governor's office and WDE. MCH would like to partner with the Department of Corrections, specifically on their newly created mother/baby unit at one of the correction facilities in WY.

Tribes:

The FIMR planning committee involves county personnel, IHS, hospital, and the Eastern Shoshone and Northern Arapaho tribes. Both tribes are involved in the Tribal PRAMS project. Eastern Shoshone Tribal Health participates in WY's IM CoIIN state team and the WAHP. The AHPM is an active member of the Wind River Wellness Coalition.

Public Health and Health professional educational programs and universities:

The AHPM confers monthly with the Society for Adolescent Health and Medicine (SAHM) to keep up with evidence-based and best practices for adolescent health.

The MCH Epi staff completed the University of Illinois Chicago and CDC course on administrative data sets and public health. The team used hospital discharge data to calculate severe maternal morbidity in WY.

Family/consumer partnership and leadership programs:

MCH provides funding and support for the expansion of the Parent Leadership Training Institute (PLTI), a strategy to increase parent engagement in communities. Current sites include the counties of Hot Springs, Natrona, Albany, and Laramie, and the Wind River Indian Reservation. Equipping parents with a "tool kit" of leadership skills through PLTI, especially those with CYSHCN, creates effective leaders at the family, community, and state level who can ensure positive health and safety outcomes for all WY children.

In spring 2014, the Kellogg Foundation awarded a grant to PLTI National Center which included funding to build a native literature piece into the Children's Leadership Training Institute (CLTI).

The Kellogg grant also included funding to evaluate and modify the PLTI curriculum to create a Rural PLTI curriculum to be conducive to rural and frontier states. The CHPM will participate with the PLTI Director from Colorado to develop the curriculum modifications based on experiences from WY PLTI sites. Meetings are scheduled throughout 2015 and 2016 to pilot the Rural PLTI curriculum in fall 2016.

The AHPM is partnering with F2F to develop a position for adolescents selected for the WAHP.

Other state and local public and private organizations that serve the state's MCH population:

The CHPM represents MCH on the Governor's Early Childhood State Advisory Council (WECSAC). The goal of the council is to ensure children are ready for school and beyond.

The CHPM serves on the WY Afterschool Alliance. The Alliance is represented on the MCH advisory committee for the Needs Assessment. Both the CHPM and the AHPM will present at the WAA 2015 annual conference on increasing parent engagement and positive youth development.

The CHPM sits on the Wyoming Early Childhood Partnership (WECP) Advisory Committee. Within WECP is WY Kids First, an early childhood systems building initiative. MCH partners with the WECP and the WY Kids First Initiative on developing an early childhood system of quality-based early care and education, integrated family support services, and accessible and affordable healthcare.

The MCH Unit Manager represents MCH on the Governor's Developmental Disabilities (DD) Council. In FY14, the council began to look at objectives and the need to be measureable and attainable.

III.D. Financial Narrative

	2015		2016	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$1,117,686	$1,122,915	$1,100,000	$1,105,862
State Funds	$1,869,786	$1,995,605	$1,951,264	$1,815,114
Local Funds	$0	$0	$0	$0
Other Funds	$505,805	$514,865	$599,192	$560,477
Program Funds	$0	$0	$0	$0
SubTotal	$3,493,277	$3,633,385	$3,650,456	$3,481,453
Other Federal Funds	$1,484,162	$1,511,035	$2,192,704	$1,447,303
Total	$4,977,439	$5,144,420	$5,843,160	$4,928,756

	2017		2018	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$1,125,000	$1,085,502	$1,125,000	
State Funds	$1,775,473	$1,867,148	$1,825,591	
Local Funds	$0	$0	$0	
Other Funds	$600,119	$508,443	$550,000	
Program Funds	$0	$0	$0	
SubTotal	$3,500,592	$3,461,093	$3,500,591	
Other Federal Funds	$2,179,510	$1,534,364	$1,600,234	
Total	$5,680,102	$4,995,457	$5,100,825	

	2019	
	Budgeted	Expended
Federal Allocation	$1,100,000	
State Funds	$1,736,286	
Local Funds	$0	
Other Funds	$639,305	
Program Funds	$0	
SubTotal	$3,475,591	
Other Federal Funds	$1,578,412	
Total	$5,054,003	

III.D.1. Expenditures

Expenditures

In Fiscal Year (FY17), Wyoming received $1,105,862 in Title V federal funding. The funding will be fully spent before the end of the grant year on September 30, 2018.

As of June 15, 2018, the MCH Block Grant expenditures for FY17 were categorized into the following categories:

- Prevention and Primary Care for Children (39%);
- Children with Special Health Care Needs (38%);
- Administrative (4%); and
- Other (Family) (19%).

MCH met the 30% requirement for both Prevention and Primary Care for Children and Children with Special Health Care Needs and spent less than the maximum 10% of funds on administrative costs. The Other, or Family category, supports salary/benefits and key activities of the Women and Infant Health Program (WIHP) and the Youth and Young Adult Health Program (YAYAHP).

The majority of Title V funding supports state-level workforce and contracts with partner organizations to address Wyoming's seven state MCH priority needs. Specifically, Title V funding supports 2.5 program manager positions which are organized according to the population groups they serve and 3.5 Children's Special Health (CSH) Program staff. This funding structure aligns well with the Title V population domain framework and assures dedicated resources within each domain. Title V funding also supports approximately 1.5 MCH epidemiology staff positions. The partnership between MCH and MCH Epidemiology is essential to ensure the Unit is continually assessing and monitoring the needs of Wyoming communities as well as the success of programming. State matching funds and other federal funds are leveraged to fund the remaining MCH Unit and MCH Epidemiology Program staff. Title V funding also supports a portion of two staff positions in the Injury Prevention Program.

In FY17, Title V funds supported the following programs/projects, each aligned with the state priority need they address:

- Help Me Grow Wyoming (Promote preventive and quality care for children)
- Safe Kids Wyoming (Prevent injury in children)
- Parent Partner Project (Promote preventive and quality care for children/adolescents)
- Fremont County Fetal and Infant Mortality Review (FIMR) Project (Prevent infant mortality)
- Wyoming 5 Steps to Breastfeeding Success mini-grant program (Improve breastfeeding duration)
- Wyoming Genetics Program (Promote preventive and quality care for children/adolescents)

The MCH Unit also funded the Parent Leadership Training Institute in order to improve family engagement.

The MCH Unit provides funding to support initiatives of partner organizations such as the Wyoming Department of Family Services and Wyoming Medicaid. Examples include funding to support a Wyoming Adverse Childhood Experiences (ACE) Interface training, funding to support a Medicaid-funded phone application which tracks family health milestones across the life course and funding for community baby showers.

MCH staff dedicate considerable staff time building infrastructure to address the new state priority needs identified in the 2015 MCH Needs Assessment. For example, the Women and Infant Health Program Manager participated in

the Association of State and Territorial Health Officials (ASTHO) Improving Access to Contraception Learning Community, an activity which supports the state priority need “Improve Access to and Promote Use of Effective Family Planning.” In addition, the Child Health Program Manager convened meetings of a cross-agency physical activity workgroup and financially supported the Chronic Disease Prevention Program’s Comprehensive School Physical Activity Programs (CSPAP) training to address the state priority need “Reduce and Prevent Childhood Obesity”.

Using state matching funds, MCH continues to provide limited gap-filling financial assistance to eligible families served by our CSH program including high risk pregnant women and infants cared for by Level III providers. CSH is a payer of last resort for enrolled clients who meet medical and financial eligibility criteria. In order to be eligible for assistance, families must first apply for Medicaid, KidCare Child Health Insurance Program (CHIP) and the Federal Marketplace. Other state matching funds support implementation of a statewide home visiting program called Healthy Baby Home Visitation Program and immunization expenditures for the MCH population.

The MCH Unit leverages partnerships and both federal and non-federal funding to address Wyoming state priority needs. Although the MCH Unit receives a small Title V award, matching state and other funds, as well as the work and resources of our partners, increases our capacity to achieve outcomes related to state priority needs.

Through statute requirement, the MCH Unit and Public Health Nursing (PHN) jointly receive Temporary Assistance for Needy Families (TANF) funding from a partner agency, the Department of Family Services, to support the implementation of home visiting and breastfeeding support activities. The MCH Unit also benefits from $2,375,591 in state funds required to meet 1989 maintenance of effort (MOE). These state funds primarily support delivery of home visitation and care coordination services by PHN in all 23 Wyoming counties.

State General Funds used for the infant immunization, Prevnar, assist with meeting the required MOE.

The MCH Unit continues to brainstorm ways to build partnerships and implement programming which align with the MCH Unit’s core principles of population health, sustainability, life course perspective, health equity, engagement and data-driven.

Wyoming MCH receives direct assistance to support a CDC-assigned MCH Epidemiologist who provides technical assistance and scientific guidance supportive of all MCH programs with a specific emphasis on support for the WIHP.

See Form 3a for a breakdown of MCH expenditures by population type (pregnant women, infants <1 year, children 1-22 years (including adolescents), children with special health care needs, and other).

See Form 3b for a breakdown of MCH expenditures by service type (direct, enabling, and public health services and systems).

III.D.2. Budget

Budget

MCH 3.0, the required Maternal and Child Health (MCH) needs assessment, and subsequent strategic planning processes provided MCH with direction for leveraging scarce resources to impact the health and wellness of Wyoming's families. Title V funding, combined with other federal dollars (e.g. Personal Responsibility Education Program and Rape Prevention Education Program) support most MCH Unit positions, including a Centers for Disease Control and Prevention (CDC) assigned MCH Epidemiologist. Three positions, the MCH administrative assistant, MCH unit manager and one epidemiologist, are funded with state dollars.

Wyoming's required maintenance of effort is greater than the legislatively-required match. Several programs assist in maintaining this effort. The NBS program is managed within MCH. Hospitals are charged a fee set by the NBS advisory committee. From this fee, MCH contracts with the Colorado Department of Public Health and Environment (CDPHE) to analyze the laboratory specimens and with various providers to provide confirmatory testing and follow-up care, as needed, to diagnosis. The fees also fund a courier to pick up screens from hospitals around the state and deliver them to CDPHE.

State funds are utilized for direct services for children with special health care needs (CSHCN) and their families. While Title V dollars fund three CSH benefits and eligibility specialist positions for the provision of care coordination from the state level for children and youth with special health care needs, state matching funds provide gap filling services for those children who qualify financially and medically.

Currently, Wyoming is facing an economic downturn and WDH has had to make difficult decisions to address decreasing state revenues. The MCH Unit experienced significant cuts during the last biennium. The MCH Unit remains able to meet the required MOE.

Wyoming's proposed budget for FY 2019, as reflected on Form 2, includes the following budget items:

- Prevention and Primary Care for Children: $390,000 (35%)
- Children with Special Health Care Needs: $345,000 (31%)
- Administrative Costs: $45,000 (4%)
- State MCH Funds: $1,736,286
- Other Funds (NBS): $639,305
- State MOE: $2,375,591

The MCH Unit hired two new program managers in Spring 2018. Each program manager will review current programmatic efforts to assure use of evidence-based strategies and alignment with MCH Unit core values.

III.E. Five-Year State Action Plan

III.E.1. Five-Year State Action Plan Table

State: Wyoming

Please click the links below to download a PDF of the Entry View or Legal Size Paper View of the State Action Plan Table.

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

III.E.2. State Action Plan Narrative Overview

III.E.2.a. State Title V Program Purpose and Design

The Wyoming Title V Program, known as the Wyoming Maternal and Child Health (MCH) Unit, is organized within the Community Health Section (CHS) of the Public Health Division (PHD). The Wyoming Department of Health (WDH) has four operating divisions. They include PHD, Aging, Behavioral Health, and Healthcare Financing (e.g. Wyoming Medicaid).

Structurally, the MCH Unit's programs are divided according to the population groups they serve: women (ages 15-44) and infants (ages 0-1), children (ages 2-11), youth and young adults (ages 12-24), and children and youth with special health care needs (CYSHCN). This structure aligns well with the Title V population domain framework and assures dedicated resources within each domain.

The Wyoming Title V Program receives approximately $1,200,000 in federal Title V funding annually. This funding supports programming for an estimated population of 579,315 (2017 estimate, American FactFinder, U.S. Census) spanning 97,813 square miles. Wyoming is the least populous state and the tenth largest state.

Due to a small budget, small staff capacity, and the rural/frontier nature of Wyoming, the MCH Unit relies heavily on partnerships to develop and achieve State Action Plan objectives. The MCH Unit strives to partner with all PHD programs with particular emphasis on fellow CHS Units which include Immunization, Public Health Nursing (PHN), Prevention and Health Promotion (including Tobacco Prevention, Substance Abuse Prevention, Injury Prevention, Chronic Disease Prevention, and Cancer Prevention), and Women, Infants and Children. In addition, the WDH organizational structure and a current TItle V-Title XIX interagency agreement encourages a close working relationship between MCH and Wyoming Medicaid which is evident in program strategies.

Partnerships external to WDH are building as the Unit prioritizes stakeholder engagement. Unit partners completed a collaboration survey in early 2018 and found the majority of partners were interested in increasing their level of partnership with MCH and that MCH is a committed and willing partner. Areas for improvement in partnership were found around understanding roles and responsibilities of participating partners, establishing a clear vision and ensuring strong communication between partners.

The MCH Unit is committed to partnerships that assure access to the delivery of quality health care services for mothers, infants and children and youth, including CYSHCN. Specifically, the MCH Unit supports statewide delivery of home visiting and care coordination services for families by PHN in all 23 Wyoming counties. Beyond providing support to PHN, each MCH program has increased its engagement of providers and hospitals in order to improve access to preventive and quality care for children and adolescents and risk appropriate perinatal care for mothers and babies. Examples of ways the MCH Unit supports a foundation for family and community health include our work towards improving Early and Periodic, Screening, Diagnostic and Treatment (EPSDT) rates and our assessment of levels of maternal and neonatal care.

The MCH Unit's 2016-2020 state priority needs as well as the Unit's vision, mission and core principles also drive the work of the State Action Plan. The MCH priority needs for 2016-2020 include:

- Prevent infant mortality
- Improve breastfeeding duration
- Improve access to and promote use of effective family planning
- Reduce and prevent childhood obesity
- Promote preventive and quality care for children and adolescents

- Promote healthy and safe relationships in adolescents
- Prevent injury in children

The Wyoming MCH Unit core principles include:

- Data Driven: MCH Strives to use data, best available evidence, and continuous quality improvement to guide programs and policies.
- Engagement: MCH strives to address health priorities by empowering, leading, investing in, and advocating for community-engaged systems with diverse partnership.
- Population Health: MCH strives to achieve optimal health with targeted interventions and policies that link health outcomes with social determinants of health.
- Health Equity: MCH strives to eliminate health disparities in order to achieve health equity.
- Life Course Perspective: MCH strives to improve MCH services, policies, and practices through a life course lens.
- Sustainability: MCH strives for sustainability by investing limited resources strategically in public health interventions that are community-engaged and data driven.

Before the core principles were officially developed in 2016, many of the principles' concepts (e.g. health equity, life course impact) were used to drive prioritization of needs during 2016-2020 needs assessment. Currently, the six core principles help Unit leadership and staff to make decisions about programming, funding, partnerships and evaluation. Specifically, this framework along with realistic assessments of staff capacity allows MCH to determine the most appropriate role in priority-related work. For example, the MCH Unit *leads* efforts to reduce infant mortality, *convenes* others to improve EPSDT, and *supports* others' work towards improving physical activity in children. This framework for decision-making is particularly useful because limited staff and resource capacity.

The MCH Unit also partners closely with the MCH Epidemiology Program to conduct required needs assessments, identify and respond to emerging needs in between needs assessment cycles, and plan and evaluate programs. The State Action Plan is reviewed quarterly with program and epidemiology staff in order to continually assess progress and alignment with state priority needs as well as emerging needs.

III.E.2.b. Supportive Administrative Systems and Processes

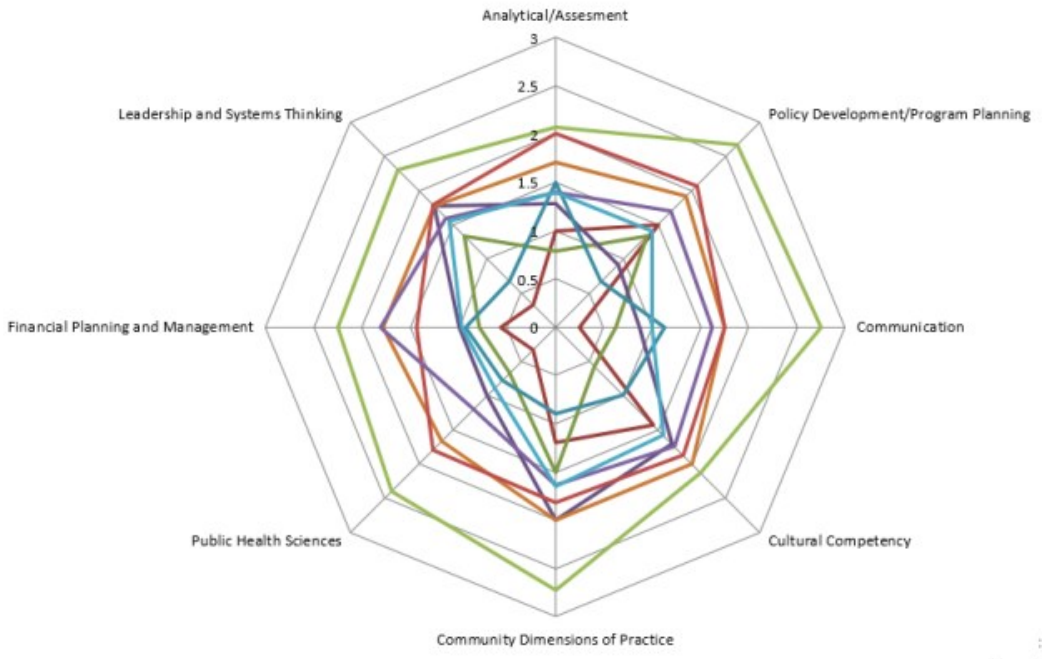
III.E.2.b.i. MCH Workforce Development

The Maternal and Child Health (MCH) Unit has a current staff of nine. As of June 18, 2018, the Unit is operating at full staff capacity with zero vacant positions. Recent hires include a Child Health Program Manager, Youth and Young Adult Health Program Manager, and an MCH Administrative Assistant.

While a small staff size presents capacity and resource challenges, it also allows for increased collaboration across population areas and increased cohesion as it relates to advancing a shared vision. Often, decisions about future programming are made as a team instead of by an individual program manager.

The MCH Unit works very closely with the MCH Epidemiology Program, a program organized within the Public Health Sciences Section of the Wyoming Department of Health (WDH) Public Health Division (PHD). The program includes an MCH Epidemiology Manager, an MCH Epidemiologist/PRAMS Coordinator, and an MCH/Injury Epidemiologist. Though organizationally a part of the MCH Unit, one Children's Special Health (CSH) Benefits and Eligibility Specialist provides half-time support to the Pregnancy Risk Assessment Monitoring System (PRAMS) program. A Centers for Disease Control and Prevention (CDC) assigned MCH Epidemiologist and Senior Epidemiology Advisor works closely with both MCH and MCH Epidemiology and is fully funded by Title V.

The WDH PHD uses the Core Competencies for Public Health Professionals to help employees and their supervisors identify areas for improvement to guide performance and professional development goals. The assessment is completed every two years. 2018 assessment results are not yet available; however, results from 2016 are included below, demonstrating individual and Unit strengths and opportunities:



All MCH Unit program managers participate in the WDH HealthStat Initiative which provides at least annual opportunities at the PHD and/or WDH level to discuss program performance successes and challenges with leadership. In 2017, the MCH Unit brainstormed ways to streamline Title V performance reporting and required

Healthstat reporting. Each program manager now maintains just one performance reporting dashboard which combines Title V reporting requirements (performance measures, strategies and evidence-based strategy measures) with WDH required performance measures instead of completing two similar, duplicative dashboards.

MCH Staff participate on both the PHD Quality Improvement (QI) Council and the Performance Management Council. Technical assistance and QI tools are provided to programs to help increase program effectiveness and efficiency.

MCH staff are encouraged to participate in training programs and professional development opportunities such as the Association of Maternal and Child Health Programs (AMCHP) Leadership Lab or CityMatCH leadership. The Women and Infant Health Program Manager participates in the Next Generation MCH Leaders cohort of the AMCHP Leadership Lab. This is a ten-month program geared toward next generation professionals (age 45 or less) that want to develop their leadership skills at the state and/or national level. It is designed to help expand their Title V network, MCH knowledge, and skills. The MCH Unit Manager also participates in an AMCHP Leadership Lab for new directors.

The MCH Unit continues to support employee development through the use of StrengthsFinder 2.0, an online assessment to assist individuals to identify, understand, and maximize their unique combination of strengths. StrengthsFinder assess four domains of leadership strength (executing, influencing, relationship building, and strategic thinking) and 34 themes which are all critical to the overall effective functioning of a leadership group. All staff completed the Strengthsfinder assessment and strengths coaching with a certified coach is available for all. This offering is especially important in order to support a small staff tasked with expansive priorities.

In 2017, the MCH Unit submitted a Public Health Associate Program (PHAP) application, a first for Wyoming's MCH Unit. Although the original application was not accepted, the MCH Unit continues to seek out opportunities to increase workforce capacity through internships including resubmission of a PHAP application in 2018. The 2018 application was accepted and placement of an associate is pending.

In 2018, Wyoming was also accepted as a site for the Title V MCH Internship Program, a program offered through the MCH National Workforce Development Center. During Summer 2018, two graduate level public health interns will support a collaborative project between MCH and Medicaid to improve Early and Periodic Screening, Diagnostic and Treatment (EPSDT) rates and promote Bright Futures, 4th Edition.

III.E.2.b.ii. Family Partnership

Family Partnership

As part of the Maternal and Child Health (MCH) Unit's core principle of engagement, activities that improve meaningful engagement of families, communities, and stakeholders are a priority. Meaningful family partnership requires dedicated staff and resources. The MCH Unit hopes to leverage resources to meet this priority through the Public Health Associate Program (PHAP). The submitted application focuses on increasing family, youth, and community engagement.

New MCH leadership met with UPLIFT, Wyoming's Family to Family (F2F) Information Network and Family Voices affiliate in 2017 and 2018 to discuss opportunities for improving partnership. UPLIFT and MCH staff also attended similar sessions at AMCHP 2018 in hopes of generating ideas for future collaboration.

MCH staff participate on a variety of councils and advisory groups including those that require parent and/or consumer representation. This provides the opportunity to receive input from individuals most affected by the programs developed and supported by the councils.

MCH staff participate in University of Wyoming sponsored Project Extension for Community Healthcare Outcomes (ECHOs) for families such as one related to the topic of autism.

In 2015 and 2016, MCH included parent and parent organization representatives in the needs assessment and strategic planning advisory groups for all three programs. The goal is to maintain this level of parent/consumer engagement for the next needs assessment and strategic planning cycles which will begin within the next year.

A new Youth and Young Adult Health Program Manager began in May 2018 and will continue forward with a vision to develop a statewide youth advisory council pending approval by WDH leadership. The council will provide opportunities for youth and young adults to share their expertise and experiences to help inform and guide WDH programs that target youth and young adults including those focused on suicide prevention, substance use, communicable disease, behavioral health, etc. The council members will also learn how to advocate for themselves and their peers in State Government. Lastly, the council's presence and activities will help adults better understand youth and young adult culture and needs. Membership of the council will represent the diversity of the State related to age, gender, geographic location, and race/ethnicity.

In 2017, Wyoming Adolescent and Young Adult Health Collaborative Improvement and Innovation Network (AYAH CoIIN) team included a youth and young adult representative who led efforts to develop a survey of their peers regarding health care which was distributed during a community event. Feedback will be used to guide future activities to support youth and their families in receiving recommended well-visits and to support providers and systems to provide care that is responsive to youth and young adult needs.

MCH assisted several communities to sponsor the Parent Leadership Training Institute (PLTI) model, which is a strate identified to increase parent engagement. PLTI Training attendees, which include families of children and youth with special health care needs, are equipped with a 'tool kit' of leadership skills and provided opportunities to put those sk into practice through a community project during the 20-week course. Wyoming PLTI graduates are encouraged to participate in training opportunities with PLTI graduates across the nation. In 2017, the Child Health Program Manag and representatives from the Wyoming Department of Education discussed potential partnership to offer future PLTI classes to school districts. Currently, the MCH Unit is internally reviewing opportunities to evaluate and build sustainability for the PLTI project before any new classes are offered.

A recently submitted PHAP application describes an opportunity for the MCH Unit to more intentionally engage PLTI graduates. If a PHAP is matched with the MCH Unit, they will develop a searchable inventory of trained parent leader featuring their skills, experience, and interests. The goal will be to match parent leaders with parent engagement opportunities such as joining an advisory council or reviewing consumer materials related to a state priority need. Th goal is to match parents with both MCH opportunities as well as opportunities to lend expertise to other Wyoming agencies and organizations.

The Child Health Program administers the Wyoming Parent Partner Program (PPP) through a contract with the Hali Project. This evidence-informed program helps medical homes identify/hire a parent within their practice who has a child with a special health care need. Between July 2017 and January 2018, the PPP served 150 families and 180 children. The PPP expanded to the clinic on Warren Air Force Base in Cheyenne but lost their Parent Partner due to the movement of military families. The process for identifying a new Parent Partner is ongoing.

In June 2016, WDH released a new website. MCH staff received website design training and continue to work within their individual program sites to improve content and design. In order to ease navigation for website users, most programs separated content by the type of audience. For example, the Children's Special Health (CSH) Program page has separate sections based on topic and target audience including CSH parent resources, CSH provider resources, and CSH data. In 2018, there will be renewed focus on assuring the MCH website is user-friendly to consumers and families.

In 2017, Lolina, Inc. facilitated strategic planning sessions with MCH and MCH Epi staff related to improving community and stakeholder. The meetings resulted from the Unit's vision of improving MCH visibility with internal and external stakeholders and building Unit capacity to engage routinely with communities including parents, families, youth, and direct recipients of program services. The meetings included the following:

- Strengthsfinder 2.0 team building exercises;
- Review of Wyoming MCH Vision, Mission, and Core Principles and their application since development in 2016;
- Communication brainstorming session including discussions about the 'why' behind MCH and target audiences for communication;
- Group completion of a Single Overriding Communication Objective (SOCO) worksheet related to what we want stakeholders to know about MCH;
- Development of common definitions of community engagement; and
- Development of an example draft action plan for achieving community engagement.

III.E.2.b.iii. States Systems Development Initiative and Other MCH Data Capacity Efforts

The SSDI grant is a key resource for ensuring access to quality MCH data for the Wyoming Title V Program. SSDI supports the work of Title V in three main ways: (1) support for needs assessment and block grant reporting, (2) providing access to timely and accurate MCH data, including linked data sets, and (3) supporting ongoing MCH surveillance to identify emerging issues.

Block Grant Reporting and Needs Assessment

The SSDI grant supports funding for Epidemiology staff who gather and analyze the necessary data to complete the Block Grant. This support includes development of ESMs and data gathering efforts for Evidence-Based Strategy Measure (ESM) monitoring. MCH Epidemiology will participate in the leadership team for the 2020 Needs Assessment.

Access to Timely Accurate MCH Data

SSDI continues to support the work of the Wyoming Vital Statistics Services (VSS) office as they work to improve timeliness and accuracy of their data. These efforts include:

- Creation of electronic fetal death reporting - enhancing quality and timeliness for MCH projects including Fetal and Infant Mortality Review (FIMR).
- Inclusion of maternal email and phone number on the birth certificate - enhancing the ability of Pregnancy Risk Assessment Monitoring System (PRAMS) to contact mothers for improved response rates
- Development of a test environment for VSS linkage to the Wyoming Health Information Exchange for automatic completion of portions of the death (and eventually birth certificates) - increasing accuracy and decreasing burden and time for providers to compete certificates.
- Creation of data linkage between Wyoming birth and death certificates - enhancing our ability to monitor infant mortality

In addition to the work with Wyoming VSS, SSDI supports:

- Access to and training on data visualization software (Tableau) for MCH Epidemiologists to enhance the ability to share data in a timely manner with internal and external partners.
- Continued participation in PRAMS, specifically the phone data collection protocol of PRAMS which is contracted to the University of Alabama at Birmingham.
- Epidemiology staff time to conduct data linkages. Current work is focused on linking VSS birth certificates and Hospital Discharge delivery hospitalizations.

MCH Surveillance

- Ongoing surveillance is being developed for key MCH indicators. Using Tableau software we have a dashboard for tracking injuries (including childhood injuries) that we will use to model MCH surveillance efforts.

III.E.2.b.iv. Health Care Delivery System

The Maternal and Child Health (MCH) Unit partners with Public Health Nursing (PHN) to offer home visiting services in every Wyoming county. Assuring access to these services is especially important in rural and frontier communities with limited providers. Ten counties have no obstetricians/gynecologists and twelve counties have no pediatrician. Both MCH and PHN participate in the Wyoming Home Visiting Network (WYHVN). This network of committed stakeholders promote quality home visiting from pregnancy through age three as a core early childhood service available to all Wyoming families. Key stakeholders include Early Headstart, Early Intervention Services (Part C and Part B), Parents as Teachers (i.e. Wyoming Maternal, Infant, Early Childhood Home Visiting (MIECHV) grantee), and Family Spirit, a tribal home visiting program.

Using primarily matching funds, the MCH Unit's Children's Special Health (CSH) program provides gap-filling financial assistance and care coordination services for eligible high risk pregnant women, high risk infants, and children with special health care needs. MCH is the payer of last resort; in order to be eligible for assistance, families must first apply for Medicaid, Kid Care CHIP (Child Health Insurance Program) and the Federal Marketplace. The program provides reimbursement to eligible providers for covered services provided to eligible clients. Program eligibility is determined based on financial and medical criteria.

Care coordination services are provided by state-level MCH/CSH Benefits and Eligibility Specialists and local-level PHNs. Examples of care coordination services provided include:

- Working with the client/family to identify needs, concerns, and priorities;
- Supporting families in following the client's plan of care and recommended preventive well-child visits (e.g. tracking and providing appointment reminders based on care plan and Bright Futures periodicity chart);
- Locating, accessing, and connecting families to needed community services and resources;
- Assuring services are coordinated among interdisciplinary team members and across programs and agencies;
- Assuring families have access to health care coverage (e.g. helping families sign up for Medicaid, Kid Care CHIP, Marketplace, etc.);
- Investigating billing problems;
- Providing support for transition to adult health care services;
- Providing support for interpretation and translation services; and
- Evaluating the effectiveness of service delivery in meeting client and family needs.

In 2016, the MCH Unit and MCH Epidemiology Program completed the Levels of Care Assessment Tool (LOCATe) in order to better understand the system of perinatal care in Wyoming. The act of completing the assessment has significantly increased hospital engagement with the Wyoming Hospital Association as well as with individual facilities. The LOCATe results also led to quality improvement projects including Wyoming facilities' participation in a Utah Project Extension for Community Healthcare Outcomes (ECHO) on the maternal hypertension safety bundle. In late 2017, a group of stakeholders committed to improving perinatal health voted to establish a Wyoming Perinatal Quality Collaborative (PQC). The MCH Unit will lead efforts to establish a solid infrastructure for the PQC, and to help the group move towards implementing quality improvement projects that focus on perinatal care. This is an example of MCH Unit's efforts to provide a systems-building approach to ensuring access to high-quality health care services for Wyoming pregnant women and infants.

Partnership with Medicaid

In Wyoming, Title V and Medicaid are housed within one agency which allows for frequent communication and partnership. Partnership is formalized by a 2013 interagency agreement and is strongly supported by WDH

leadership. Specifically, senior administrators for Public Health Division (PHD) and Healthcare Financing (Medicaid) meet monthly to discuss ongoing and new collaboration opportunities. The MCH Unit routinely provides updates to PHD senior administrator to discuss during these partnership meetings. MCH and Medicaid actively partner to address the following state priority needs:

- Reduce infant mortality
- Improve access to and promote use of effective family planning
- Promote preventive and quality care for children and adolescents

In 2017, the MCH Unit received technical assistance related to Early and Periodic Screening, Diagnostic and Treatment (EPSDT), a topic prioritized by both the MCH Unit and Wyoming Medicaid. Collaboration on this project is formalized in a required interagency agreement which states that both entities shall "coordinate and collaborate in planning and implementing services related to maternal and child health populations including well-child checkups" (e.g. EPSDT). Collaboration on EPSDT and implementation of Bright Futures is essential in order to improve Wyoming EPSDT rates which currently rank 44th in the Nation. Dr. Wendy Davis from the University of Vermont College of Medicine presented during Wyoming's 2017 Block Grant Review and during an October 2017 Wyoming Medicaid Medical Advisory Group (MAG) meeting. Following Dr. Davis' presentation on Bright Futures, 4th Edition and the promotion efforts in Vermont, the MAG voted to adopt the Bright Futures Guidelines, 4th Edition in Wyoming.

In order to maintain momentum on this important cross-division project, the MCH Unit submitted a successful application for the Title V MCH Internship Program. Two graduate-level interns will work with MCH, Medicaid and other key stakeholders to develop a plan to implement Bright Futures, 4th Edition. This joint project supports Wyoming's 2016-2020 Title V priority to improve preventive and quality care for children and adolescents, a priority which directly aligns with three (3) Title V National Performance Measures (NPM). They include NPM 6: Developmental Screening, NPM 10: Adolescent Well Visit, and NPM 12: Transition. The student-developed plan to implement Bright Futures will specifically include education of providers and families/consumers on these key topics of preventive care for children and adolescents as well as a plan to evaluate the impact of implementation on the measures themselves at the clinic and State level.

The MCH Unit promotes enrollment in Medicaid programs primarily through the Healthy Baby Home Visitation Program and CSH Program. Specifically, in order for families to be eligible for CSH financial assistance, they first must apply for Medicaid, as CSH is the payor of last resort. PHNs at the local level provide support to families in applying for Medicaid. State-level CSH care coordinators also provide support to families in applying for and navigating Medicaid benefits.

In 2018, the CSH program facilitated a discussion between Medicaid and PHNs on the availability of waivers for the MCH population, specifically those with special health care needs. The waivers include:

- Developmental Disabilities Waiver, including Supports and Comprehensive Waivers. These waivers are open to children, adults and those with acquired brain injuries.
- Children's Mental Health Waiver. This waiver is open to children 4 - 20.

A number of collaborative MCH/Medicaid projects have or have the potential to include joint policy level decision-making. For example, the Medicaid MAG's vote to adopt Bright Futures, 4th Edition, was informed by a MCH-facilitated presentation by national EPSDT/Bright Futures expert Dr. Wendy Davis. Another opportunity for joint policy level decision making relates to barriers to improving access to immediate postpartum long-acting reversible contraception (IPP LARC). MCH and Medicaid jointly participated in Association of State and Territorial Health Officials (ASTHO) Improving Access to Contraception learning community and learned that facilities and providers

may be disincentivized from stocking and offering IPP LARC due to bundled Medicaid payments. On April 8, 2016, the Department of Health and Human Services' Centers for Medicare & Medicaid Services released an informational bulletin detailing payment and policy approaches several state Medicaid agencies have used to optimize access and use of LARC methods. One such approach requires unbundling payment for LARC from other labor and delivery services.

The TItle V-Title XIX interagency agreement was last updated in 2013. In Fiscal Year 19, the MCH Unit plans to facilitate discussions regarding current language and proposed updates. The programs will reference the National Academy of State Health Policy (NASHP) report “Strengthening the Title V-Medicaid Partnership: Strategies to Support the Development of Robust Interagency Agreements between Title V and Medicaid.”

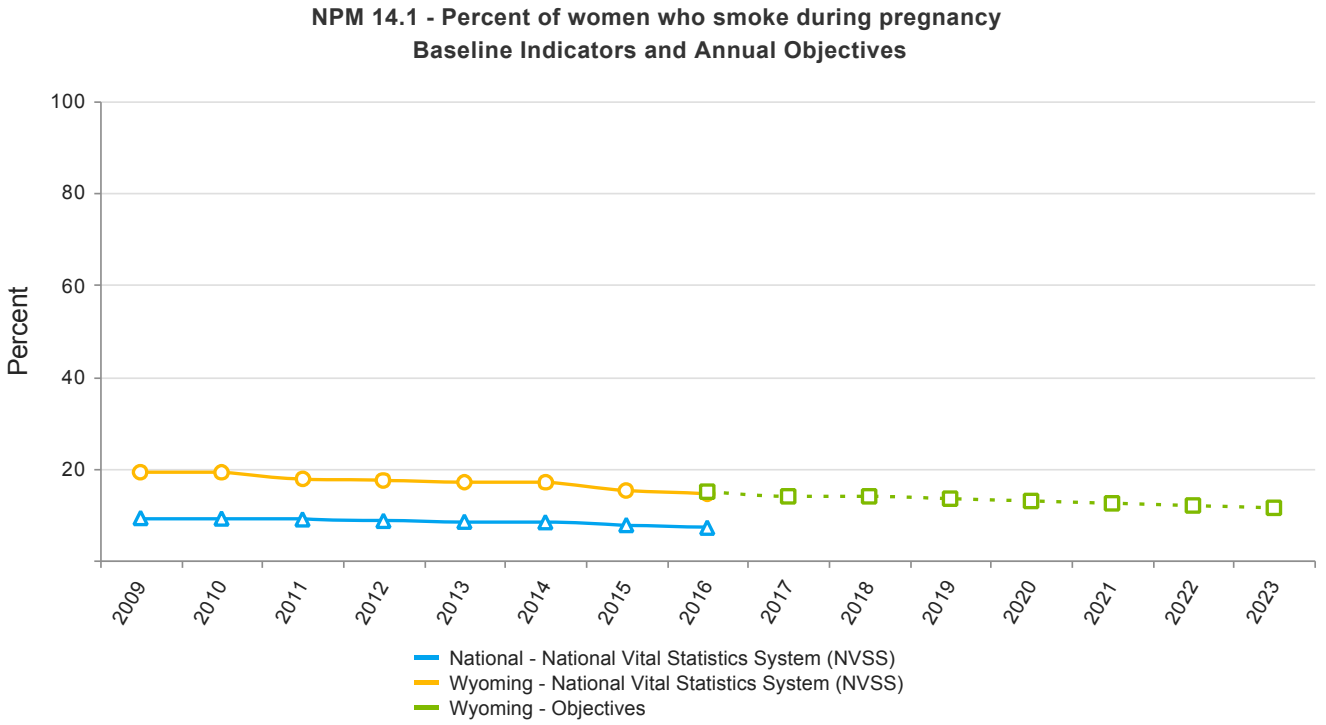
III.E.2.c State Action Plan Narrative by Domain

Women/Maternal Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID-2015	107.9	NPM 14.1
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS-2012_2016	26.3	NPM 14.1
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2016	8.5 %	NPM 14.1
NOM 5 - Percent of preterm births (<37 weeks)	NVSS-2016	9.5 %	NPM 14.1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2016	25.4 %	NPM 14.1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2015	5.5	NPM 14.1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2015	4.9	NPM 14.1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2015	3.1	NPM 14.1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2015	1.8	NPM 14.1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2015	167.4	NPM 14.1
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2015	Not Reportable	NPM 14.1
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2016	90.2 %	NPM 14.1

National Performance Measures



Federally Available Data		
Data Source: National Vital Statistics System (NVSS)		
	2016	**2017**
Annual Objective	15	14
Annual Indicator	15.2	14.6
Numerator	1,148	1,043
Denominator	7,540	7,152
Data Source	NVSS	NVSS
Data Source Year	2015	2016

State Provided Data		
	2016	2017
Annual Objective	15	14
Annual Indicator	13.5	11.2
Numerator		
Denominator		
Data Source	PRAMS	PRAMS
Data Source Year	2015	2016
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	14.0	13.5	13.0	12.5	12.0	11.5

Evidence-Based or –Informed Strategy Measures

ESM 14.1.1 - # of pregnant women referred to the WY Quitline services from Healthy Baby Home Visitation

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	25.0	30.0	30.0	35.0	35.0

ESM 14.1.2 - # of providers trained on SCRIPT implementation

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	7.0	7.0	8.0	10.0	10.0

State Performance Measures

SPM 3 - Number of Wyoming birthing hospitals billing Medicaid for immediate postpartum LARCs

Measure Status:	Inactive - Replaced

State Provided Data		
	2016	2017
Annual Objective		2
Annual Indicator	0	1
Numerator		
Denominator		
Data Source	Medicaid Billing Data	Medicaid Billing Data
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

SPM 6 - Use of most/moderately effective contraception by postpartum women

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	66.0	68.0	70.0	71.0	72.0

State Action Plan Table

State Action Plan Table (Wyoming) - Women/Maternal Health - Entry 1

Priority Need
Prevent Infant Mortality

NPM
NPM 14.1 - Percent of women who smoke during pregnancy

Objectives
Decrease the percent of Wyoming women who smoke during pregnancy.

Strategies
Train health care providers in SCRIPT smoking cessation protocol.
Promote the Quitline with pregnancy and postpartum protocol to pregnant and postpartum women, with a focus on women served through the Healthy Baby Home Visitation Program.

ESMs	Status
ESM 14.1.1 - # of pregnant women referred to the WY Quitline services from Healthy Baby Home Visitation	Active
ESM 14.1.2 - # of providers trained on SCRIPT implementation	Active

NOMs

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

NOM 3 - Maternal mortality rate per 100,000 live births

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

NOM 5 - Percent of preterm births (<37 weeks)

NOM 6 - Percent of early term births (37, 38 weeks)

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.2 - Neonatal mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

State Action Plan Table (Wyoming) - Women/Maternal Health - Entry 2

Priority Need

Improve access to and promote use of effective family planning

SPM

SPM 6 - Use of most/moderately effective contraception by postpartum women

Objectives

Increase the number of Wyoming hospitals that bill Medicaid for immediate postpartum LARC insertion.

Strategies

Provide to technical assistance to Wyoming hospitals implementing IPP LARC protocols.

Complete an environmental scan of LARC use in Federal Qualified Health Centers, Indian Health Service, Title X, and Rural Health Clinics.

Develop an IPP LARC toolkit

State Action Plan Table (Wyoming) - Women/Maternal Health - Entry 3

Priority Need

Prevent Infant Mortality

Objectives

Improve perinatal outcomes.

Strategies

Implement FIMR in pilot community.

Support hospitals in implementation of AIM safety bundles (e.g. VTE, hypertension, opioids/NAS, low-risk Cesarean delivery)

Annual Report Fiscal Year 2017: This section provides a summary of FY17 activities, accomplishments, and challenges related to priorities, NPMs, and SPMs for the Women/Maternal Health Domain.

Priority: Prevent Infant Mortality
NPM 2: Percent of cesarean deliveries among low-risk first births
(*This NPM will be discontinued starting in FY19)

The Wyoming 5-year Title V needs assessment helped the MCH Unit identify seven key priority needs for the 2016-2020 period. One such priority aims to reduce the percent of cesarean deliveries among low-risk first births. Women who have cesarean sections are at an increased risk for infections after birth (including uterine, bladder, and incision-site), increased pain, extended recovery periods, and face a great risk of re-hospitalization. A woman who has had a cesarean section is more likely to have a cesarean section in future pregnancies. As the number of cesareans increases for a woman, the risk of complications in future pregnancies, especially placental problems, also increases.

The WIHP, along with a key group of stakeholders, including the Wyoming Primary Care Association (WYPCA), Wyoming Business Coalition on Health, The Wyoming Hospital Association (WHA), American College of Obstetrics and Gynecology (ACOG), March of Dimes (MOD), Wyoming Medicaid, Blue Cross Blue Shield (BCBS) and others, voted in December of 2017 to establish a Wyoming Perinatal Quality Collaborative (PQC) in response to the need for more coordinated perinatal quality improvement work in the state, and to increase the capacity in our state to impact goals such as reducing cesarean deliveries among low-risk first births. PQCs are state or multi-state networks of teams working to improve health outcomes for mothers and babies by identifying health care processes that need to be improved and using the best available methods to make changes as quickly as possible.

The group of engaged stakeholders more than doubled in early 2018 with increased outreach, and in June of 2018, a WYPQC Strategic Planning Retreat was held in Cheyenne. The retreat, which was attended by more than 30 key stakeholders, and included representatives from out of state hospitals at which many of our high risk births take place, other state PQC's, and clinical and public health specialists from around the state, helped us to better establish the next steps for establishing ourselves as a nationally recognized PQC. Speakers from the CDC and the NNPQC presented on PQCs and key next steps, and this retreat helped the group to take the next steps to establish a shared vision and mission for the group. At the next statewide meeting, which will take place in September 2018, there are plans to elect a leadership team and begin to determine the priorities that will guide perinatal quality improvement efforts throughout the state. The MCH Unit has committed to contracting with a part-time coordinator for the PQC using Title V funding, in order to ensure momentum is not lost, and that continued work goes through a coordinated system for communication and planning. There is also a need going forward to establish a statewide advisory committee for the PQC.

It is expected that from this group, momentum will build for the creation of a Maternal Mortality Review Committee (MMRC). Several members of the newly formed PQC have expressed interested in participating in this effort, and the Wyoming ACOG chair has committed to championing the effort during her tenure. Representatives from the CDC's Division of Reproductive Health have provided ongoing information and TA in regard to this priority, and a representative from this group presented on MMRCs during a site visit conducted in early 2018 with Wyoming's CDC MCH Epidemiology assignee.

During 2017, the WIHP partnered with the Utah Department of Health and the University of Utah to offer an opportunity for Wyoming hospitals to participate a 7-month ECHO project focused on hypertension in pregnancy. All

Wyoming facilities were invited to participate, and six hospitals officially joined the ECHO in mid-2017. The ECHO project implemented pre/post assessments, and allowed participating Wyoming hospitals to register as Alliance for Innovation in Maternal Health (AIM) facilities and upload data into the AIM portal, thus contributing to data capacity on maternal safety in the hospital setting. Participation in this effort has helped Wyoming hospitals establish and/or revise their current hypertension protocols and improve overall maternity care practice. The current ECHO project is wrapping up in mid-2018. However, the partnership between Utah and Wyoming has remained strong, and there are plans to continue to offer ongoing maternal safety ECHO's to Wyoming facilities through Utah's ECHO project. Current discussions are centered around whether to offer a Venous Thromboembolism or Opioid bundle in the next cycle, and input is being sought from Wyoming and Utah hospitals on what is most needed from the perspective of providers in the field.

Another activity that has grown from Wyoming's implementation of the LOCATe assessment is the opportunity to participate in an ACOG project that piloted in person verification of the maternal levels of care. Wyoming, Georgia and Illinois participated. ACOG visited six Wyoming hospitals to conduct a more comprehensive assessment of maternal levels of care during August/September of 2017. These visits supplemented LOCATe results and helped ACOG understand the perspective of rural facilities in the context of maternal levels of care. This effort also helped the WIHP to learn more about maternal safety protocols in place at Wyoming facilities, and helped to increase collaboration and engagement amongst Wyoming facilities.

In FY17, the WIHP program partnered with the Wyoming Immunization Unit to provide information on 17 alpha-hydroxyprogesterone caproate (17P) to include in informational packets provided to expectant mothers at prenatal visits. Approximately 575 March of Dimes produced 17P pamphlets were provided with the hopes of reaching as many expectant mothers in the coming year. The materials educate moms on the risk of spontaneous preterm birth, and provide information on the benefits of 17-P for moms with a high risk of a recurrent preterm birth.

Priority: Reduce Infant Mortality
NPM 14: A) Percent of women who smoke during pregnancy

The Wyoming 5-year Title V needs assessment helped the MCH Unit identify seven key priority needs for the 2016-2020 period. One such priority aims to reduce to percentage of women who smoke during pregnancy. Smoking during pregnancy has been linked with numerous health problems for the unborn infant, including placental issues, low birth weight, increased risk of premature birth, birth defects, and spontaneous abortion.

The WIHP has committed to the ongoing promotion of evidence-based smoking cessation strategies targeted at pregnant and postpartum mothers. Through an MCH services contract held with all counties, MCH required PHNs to ask about smoking status at every home visit and refer smoking clients to the Wyoming Quitline. The WIHP continued to promote the WY Quitline through distribution of marketing materials in PHN home visiting and PHN offices.

As another strategy to promote smoking cessation among pregnant women, the WIHPM partnered with MOD in April of 2017, and attended a train-the-trainer session for Smoking Cessation and Reduction in Pregnancy Treatment (SCRIPT) at the Society for Public Health Education (SOPHE) conference in Denver, CO. The 8-hour training included the fundamentals of SCRIPT implementation, SCRIPT evaluation, and a certification to train others in SCRIPT implementation. The WIHPM plans to increase the use of this evidence-based smoking cessation intervention across the state. The SCRIPT program will also help to increase referrals to the Wyoming Quitline. This process will include providing training at the Wyoming Public Health Association annual conference in September of 2018, as well as working with program partners to offer training to the providers in the state.

In mid-2017, the WIHPM began to develop a plan to bring a licensed clinical psychologist to offer life-history training to healthcare and social service providers on the Wind River Reservation. The training will include qualitative interviewing and coding techniques. The goal of the training was originally to learn more about smoking status among pregnant and postpartum women, and to use that information to better target information and interventions related to smoking cessation in pregnancy. This training has since been modified so as to allow providers to use the training to impact other issues as well, including substance use in pregnancy. The trainings are expected to take place in summer of 2018, with up to 10 providers from the White Buffalo Recovery Center participating in the training.

Priority: Improve Access to and Promote Use of Effective Family Planning
SPM: # of hospitals billing Medicaid for IPP LARC

In spring 2015, the MCH Unit selected Improve Access to and Use of Effective Family Planning as one of its 2016-2020 priorities. There is no available NPM for this priority. The state performance measure is the number of hospitals billing Medicaid for IPP LARCs. This strategy was especially important to MCH given the unique challenges to accessing family planning services in a frontier state.

In October 2016, Wyoming was accepted into the ASTHO learning collaborative on IPP LARCs and work began in November of 2016. The ASTHO collaborative provided valuable TA to Wyoming on many topics relevant to IPP LARC use in the state, including administrative support and infrastructure, clinical leadership, billing management, and medicaid billing and policy. The collaborative also identified opportunities for improving access to most and moderately effective contraception beyond IPP LARC. In order to gather information on barriers to implementation around the state, the CDC-assigned MCH Epidemiologist piloted a hospital assessment of procedures/policies/practices related to IPP LARC based on the South Carolina Postpartum LARC Toolkit. Clinical, administrative, and pharmacy staff completed the assessment and opportunities for improvement were identified.

To date, Wyoming has been successful in identifying champions for this project in a local OB/GYN practice, and the labor and delivery staff and pharmacy staff at Cheyenne Regional Medical Center (CRMC). These individuals have committed to working through the processes required to implement IPP LARC, and to contribute to the development of an implementation guide that can be distributed to other facilities that are interested in exploring IPP LARC options in their community. Materials have been developed to begin this effort, including a “Why IPP LARC?” factsheet. The facility provided input and suggestions for improvement for the factsheet and will continue to provide feedback on materials created for the implementation guide.

Efforts to fully implement IPP LARCs in CRMC have encountered several barriers related to Medicaid policy and reimbursement for the placement of IPP LARCs. While the provider champion determined a workaround to attempt more regular implementation, the workaround demonstrated that hospitals will lose out on reimbursement for insertion in the facility. The WIHPM and partners are working with Medicaid to better demonstrate these barriers, with the hope that Medicaid policy change regarding reimbursement for IPP LARC insertion outside of the delivery bundle will be considered.

The continued work to reduce barriers to access in this pilot work will inform the development of a Wyoming-specific IPP LARC implementation guide as mentioned above, with the hope that this guide will be distributed to all Wyoming providers later in 2018 or early 2019. The guide will include information from Medicaid on billing for IPP LARC insertion outside of the labor and delivery bundle, information from the pilot facility on challenges and barriers, and content created by the South Carolina IPP LARC toolkit.

Women/Maternal Health - Application Year

Application Fiscal Year 2019: This section presents strategies/activities for 2016-2020 MCH priorities related to Women/Maternal Health. See Five-Year State Action Plan Table for more information.

Wyoming MCH priorities addressed in the Women/Maternal Domain include:

1. Improve Access to and Use of Effective Family Planning
2. Reduce Infant Mortality through Smoking Cessation
3. Emerging Priorities

Priority: Improve Access to and Use of Effective Family Planning
SPM: # of hospitals billing Medicaid for IPP LARC

Beginning in FY19, the Women and Infant Health Program (WIHP) will impact the SPM -- # of hospitals billing medicaid for immediate postpartum long-acting reversible contraception (IPP LARC) -- by implementing the following selected strategies paired with their associated evidence-based/informed strategy measures, where applicable:

1. Develop and release a comprehensive IPP LARC implementation guide for Wyoming hospitals
    a. # of TA requests from hospitals regarding IPP LARC implementation guide
2. Develop and disseminate consumer education on contraception options
    a. # of materials distributed through Public Health Nursing (PHN) and OB/GYN Offices
3. Develop and implement provider education on contraceptive counseling
    a. # of providers engaged in education opportunities
4. Develop and implement an environmental scan and needs assessment regarding general LARC implementation in federally qualified health centers (FQHC), Indian Health Services (IHS) clinics, Title X clinics and rural health center (RHC) settings.
    a. Completion of scan

Wyoming's participation in the Association of State and Territorial Health Officials (ASTHO) Increasing Access to Contraception learning collaborative will continue to inform the work surrounding IPP LARCs and has generated broad interest among program partners in increasing access to the range of methods as a way to improve maternal and infant outcomes. MCH will lead future work related to building capacity for LARC use and billing and will ensure a reproductive justice lens is applied to this work. Key partners will include Wyoming Medicaid, OB/GYN providers and hospitals.

The WIHP will continue to support the Fremont County Fetal and Infant Mortality Review (FIMR) pilot project. The WIHP is prepared to provide technical assistance and resources as the Community Action Team plans next steps, which will include training on contraceptive counseling, chronic disease management in pregnancy, and other preconception health topics.

Priority: Reduce Infant Mortality
NPM 14: A) Percent of women who smoke during pregnancy B) Percent of children who live in households where someone smokes

Beginning in FY19, we plan to impact NPM 14A--percent of women who smoke during pregnancy-- and 14B -- Percent of children who live in households where someone smokes -- by implementing the following selected strategies paired with their associated evidence-based/informed strategy measures, where applicable:

1. Provide Smoking Cessation and Reduction in Pregnancy (SCRIPT) training at the Wyoming Public Health Association Conference
    a. # of providers trained in SCRIPT
2. Work with tribal tobacco program to build capacity to implement strategies for smoking cessation during pregnancy
    a. # of life-history interviewing trainings held on reservation (Wind River/White Buffalo)
    b. # of people trained to conduct life-history interviews
3. Continue to work with the Healthy Baby Home Visitation Program to promote evidence-based smoking cessation programs
    a. # of pregnant women referred to the Wyoming Quitline services from Healthy Baby Home Visitation

Emerging Priorities

The following emerging priorities have been identified through ongoing data surveillance and community feedback, and will help guide program activities over the next few years.

Perinatal Quality Collaborative (PQC)

The WIHP will continue to provide support to the development and ongoing work of the WYPQC. Support will include funding for a PQC coordinator, meeting facilitation, and ongoing data support.

Opioids

MCH is working with the Substance Abuse Prevention Program (SAPP) to identify future partnership opportunities. During the 2016 legislative session several bills related to opioids were introduced and both programs were asked to respond. A few months later, in response to the current federal administration announcing state funding to combat the opioid epidemic, MCH reached out to the SAPP Program to offer MCH support and assistance. An MCH Epidemiologist will participate in an opioid-focused data workgroup and the WIHPM will participate in a training workgroup to keep MCH informed and involved. MCH Epidemiology is working to increase capacity to monitor opioid use in MCH populations. WDH does not have a dedicated Substance Abuse Epidemiologist; instead, Substance Abuse Epidemiology responsibility falls on the State Epidemiology Outcomes Workgroup (SEOW). MCH Epidemiology is an active member of this group. The SEOW created a workgroup to write the first State Opioid report, and MCH Epidemiology is a member of the workgroup to ensure that the MCH population is a focus of the analysis/report. Although this topic is not a current MCH priority, it is a topic that we will continue to monitor closely.

Through this ongoing collaboration, the WIHP is working with the SAPP to develop educational materials related to opioid use in pregnancy,. The materials developed will be targeted at three main groups: pregnant women, OB/GYN Providers, and hospital staff, and will provide education information on safe prescribing of opioids in pregnancy, the risks of use for pregnant mothers and their infants, and effective identification and coding of cases in the hospital setting. Strategies for distributing these materials will be developed in conjunction with key partners, including hospitals and provider partners, and the PQC.

A primary challenge with addressing opioid issues in Wyoming remains the lack of accurate data on the issue. We have heard from members of the community that neonatal abstinence syndrome (NAS) is on the rise, but hospital discharge data is not reflecting these concerns. It is our hope that the work in developing and disseminating educational information will lead both to an increase in the accurate identification and coding of cases, and therefore Wyoming's capacity to monitor the issue, and a reduction in the use of opioids in pregnancy.

Maternal Mortality Review

There is growing interest in Wyoming around establishing a Maternal Mortality Review Committee (MMRC). Several

key program partners have committed to seeing this work supported and moved forward, including the Wyoming ACOG Chair and members of the newly formed WYPQC. Ongoing TA and support have been offered by the Centers for Disease Control and Prevention's (CDC) Division of Reproductive Health. While the number of maternal deaths in Wyoming remains fairly low, there is a desire to learn more about the root cause(s) behind these deaths, to ensure that Wyoming is doing what is necessary to promote the health and safety of Wyoming mothers. It is important to note that there is currently no legislative authority, and therefore protection, in place for a MMRC in Wyoming.

Perinatal/Infant Health

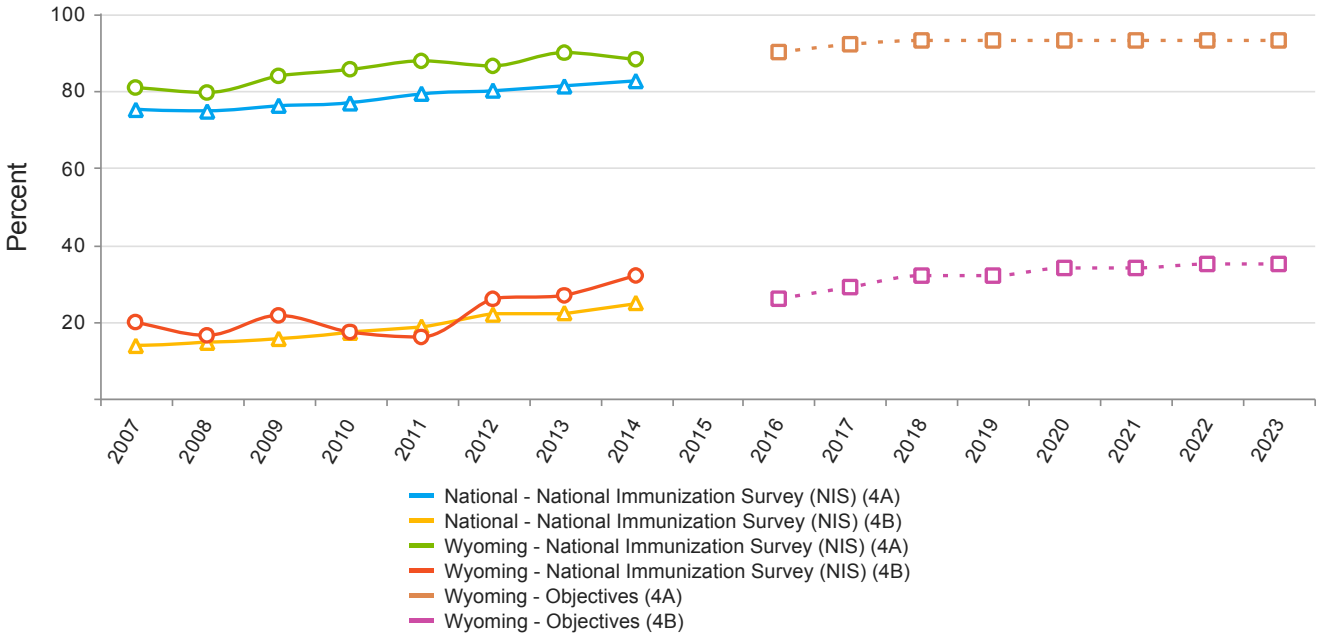
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2015	4.9	NPM 4
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2015	1.8	NPM 4
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2015	Not Reportable	NPM 4

National Performance Measures

NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Baseline Indicators and Annual Objectives



NPM 4A - Percent of infants who are ever breastfed

Federally Available Data		
Data Source: National Immunization Survey (NIS)		
	2016	**2017**
Annual Objective	90	92
Annual Indicator	89.7	88.3
Numerator	5,817	5,853
Denominator	6,486	6,628
Data Source	NIS	NIS
Data Source Year	2013	2014

State Provided Data		
	2016	2017
Annual Objective	90	92
Annual Indicator	91	90.7
Numerator		
Denominator		
Data Source	PRAMS	PRAMS
Data Source Year	2014	2016
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	93.0	93.0	93.0	93.0	93.0	93.0

NPM 4B - Percent of infants breastfed exclusively through 6 months

Federally Available Data		
Data Source: National Immunization Survey (NIS)		
	2016	**2017**
Annual Objective	26	29
Annual Indicator	27.0	32.0
Numerator	1,693	2,049
Denominator	6,263	6,412
Data Source	NIS	NIS
Data Source Year	2013	2014

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	32.0	32.0	34.0	34.0	35.0	35.0

Evidence-Based or –Informed Strategy Measures

ESM 4.1 - Mini-grant program structure developed

Measure Status:	Inactive - Completed

State Provided Data		
	2016	2017
Annual Objective		Yes
Annual Indicator	Yes	Yes
Numerator		
Denominator		
Data Source	Women and Infant Program	Women and Infant Program
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

ESM 4.4 - Implementation of Wyoming 5-Steps to Breastfeeding Success Program

Measure Status:	Active

State Provided Data	
	2017
Annual Objective	4
Annual Indicator	4
Numerator	
Denominator	
Data Source	Women and Infant Program
Data Source Year	2017
Provisional or Final ?	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	4.0	4.0	4.0	4.0	4.0	4.0

ESM 4.5 - Hospitals Recognized by Wyoming 5-Steps Program

Measure Status:	Inactive - Replaced

State Provided Data	
	2017
Annual Objective	2
Annual Indicator	0
Numerator	
Denominator	
Data Source	Women and Infant Program
Data Source Year	2017
Provisional or Final ?	Final

ESM 4.6 - Percent of hospitals demonstrating an increase in at least one step from baseline based on hospital self-reported assessment

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	100.0	100.0	100.0	100.0	100.0

ESM 4.7 - Percent of counties that have at least one public health nurse trained as a Certified Lactation Consultant (CLC)

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	90.0	90.0	95.0	95.0	95.0

State Performance Measures

SPM 1 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		54
Annual Indicator	51.9	68
Numerator	42	68
Denominator	81	100
Data Source	Wyoming Vital Statistics Services	Wyoming Vital Statistics Services
Data Source Year	2015	2016
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	70.0	71.0	72.0	73.0	74.0	75.0

State Action Plan Table

State Action Plan Table (Wyoming) - Perinatal/Infant Health - Entry 1

Priority Need

Improve breastfeeding duration

NPM

NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Objectives

Increase the percent of women who breastfeed their infants and increase the proportion who continue to breastfeed exclusively through 6 months.

Strategies

Ensure each county has one nurse who is a Certified Lactation Consultant.

Award mini-grants and provide ongoing technical assistance to hospitals to participate in the Wyoming 5-Steps to Breastfeeding Success Project and work with WHA to develop hospital recognition program.

Promote breastfeeding and track breastfeeding support within the Healthy Baby Home Visitation Program.

ESMs	Status
ESM 4.1 - Mini-grant program structure developed	Inactive
ESM 4.2 - Completion of environmental scan and incorporation of findings into strategic planning	Inactive
ESM 4.3 - Breastfeeding support resource map and web page with county level data developed	Inactive
ESM 4.4 - Implementation of Wyoming 5-Steps to Breastfeeding Success Program	Active
ESM 4.5 - Hospitals Recognized by Wyoming 5-Steps Program	Inactive
ESM 4.6 - Percent of hospitals demonstrating an increase in at least one step from baseline based on hospital self-reported assessment	Active
ESM 4.7 - Percent of counties that have at least one public health nurse trained as a Certified Lactation Consultant (CLC)	Active

NOMs
NOM 9.1 - Infant mortality rate per 1,000 live births
NOM 9.3 - Post neonatal mortality rate per 1,000 live births
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

State Action Plan Table (Wyoming) - Perinatal/Infant Health - Entry 2

Priority Need

Prevent Infant Mortality

SPM

SPM 1 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Objectives

Improve perinatal outcomes.

Strategies

Distribute facility specific reports on levels of care assessment tool (LOCATe).

Develop a Wyoming Perinatal Quality Collaborative.

Support hospitals in implementation of AIM safety bundles (e.g. VTE, hypertension, opioids/NAS, low-risk Cesarean delivery)

State Action Plan Table (Wyoming) - Perinatal/Infant Health - Entry 3

Priority Need

Prevent Infant Mortality

Objectives

Improve Newborn Screening Timeliness and Quality

Strategies

Development of the NBS QI dashboard.

Promote hospital participation in QI efforts around NBS.

Annual Report Fiscal Year 2017: This section provides a summary of FY17 activities, accomplishments, and challenges related to priorities, NPMs, and SPMs for the Perinatal/Infant Health Domain.

Priority: Prevent Infant Mortality
SPM (NPM 3): Percent of VLBW infants born in a hospital with a Level III+ NICU

Risk-Appropriate Perinatal Care is a key strategy for improving maternal and neonatal health outcomes. Studies conducted by the American College of Obstetrics and Gynecology (ACOG) as far back as the 1970's have demonstrated that access to risk-appropriate neonatal and obstetric care has the potential to decrease perinatal mortality and improve birth outcomes for both mothers and their infants. Risk appropriate care is defined as access to care that matches both the mother's and infant's level of risk, including a full range of specialists available to help care for complex medical conditions.

As a strategy to improve risk appropriate care in the Maternal and Child Health (MCH) Unit and MCH Epidemiology Program, in conjunction with the Centers for Disease Control (CDC) and ACOG, piloted the Levels of Care Assessment Tool (LOCATe) in early FY16 to determine levels of care for Wyoming hospitals. Wyoming lacks a formal system to designate or define neonatal or maternal levels of care.

LOCATe assessment results revealed that only 40% of hospitals had a maternal hypertensive emergency protocol in place, 72% had a maternal hemorrhage protocol in place and 56% had a thromboembolism protocol in place. While sharing Wyoming's LOCATe experiences and initial findings with colleagues at the 2016 MCH EPI/CityMatCH Conference, Wyoming MCH Epidemiology staff learned of Utah's work implementing the Alliance for Innovation on Maternal Health (AIM) patient safety bundles and discovered a partnership opportunity.

During 2017, the Women and Infant Health Program (WIHP) partnered with the Utah Department of Health and the University of Utah to offer an opportunity for Wyoming hospitals to participate a 7-month Extension for Community Healthcare Outcomes (ECHO) project focused on hypertension in pregnancy. All Wyoming facilities were invited to participate, and six hospitals officially joined the ECHO in mid-2017. The ECHO project implemented pre/post assessments, and allowed participating Wyoming hospitals to register as Alliance for Innovation in Maternal Health (AIM) facilities and upload data into the AIM portal, thus contributing to data capacity on maternal safety in the hospital setting. Participation in this effort has helped Wyoming hospitals establish and/or revise their current hypertension protocols and improve overall maternity care practice. The current ECHO project is wrapping up in mid-2018. However, the partnership between Utah and Wyoming has remained strong, and there are plans to continue to offer ongoing maternal safety ECHO's to Wyoming facilities through Utah's ECHO project. Current discussions are centered around whether to offer a Venous Thromboembolism or Opioid bundle in the next cycle, and input is being sought from Wyoming and Utah hospitals on what is most needed from the perspective of providers in the field.

Another activity that has grown from Wyoming's implementation of the LOCATe assessment is the opportunity to participate in an ACOG project that piloted in person verification of the maternal levels of care. Wyoming is one of three states (Georgia and Illinois are the others) that participated in the LOCATe pilot. ACOG visited six Wyoming hospitals to conduct a more comprehensive assessment of maternal levels of care during August/September of 2017. These visits provided additional information to our hospital assessments, and helped ACOG understand the perspective of rural facilities in the context of maternal levels of care. This effort also helped the WIHP to learn more about maternal safety protocols in place at Wyoming facilities, and helped to increase collaboration and engagement amongst Wyoming facilities.

The Maternal High Risk (MHR) and Newborn Intensive Care (NBIC) Programs ensure high-risk pregnant women and high-risk infants have access to care coordination services and limited gap-filling financial assistance to enhance perinatal outcomes. Promotion of these programs further support efforts to improve risk appropriate perinatal care, especially for families that require out-of-state care at a Level III facility. Referrals for these essential gap-filling programs come from providers around the state, as well as from our tertiary care facilities that are attending high-risk births from Wyoming mothers.

Another key effort to improve risk appropriate perinatal care in Wyoming has been the ongoing engagement of key program partners and stakeholders from the community around perinatal issues. Ongoing monthly meetings, in the form of the Coordinated Efforts workgroup, helped to ensure that these individuals and organizations were informed of the projects related to perinatal health within the Wyoming Department of Health (WDH), as well as presented with opportunities for collaboration. This group voted in late 2017 to become a Wyoming Perinatal Quality Collaborative (PQC), and efforts to establish a shared vision and goals for this group are ongoing. A group retreat is scheduled for June 2018, during which leadership of the PQC and future goals/projects will be established. Support from March of Dimes, the National Network of PQCs, and the Centers for Disease Control and Prevention will ensure experts on PQCs are on hand to guide this effort.

The WIHP continues to support the ongoing Fetal Infant Mortality Review (FIMR) project in Fremont County Wyoming, in collaboration with providers and community members on the Wind River Reservation. The FIMR project works with the FIMR Case Review Team (CRT) and the FIMR Community Action Team (CAT) to review fetal and infant losses in Fremont County. During FY17, 100% of fetal and infant deaths from the previous year in Fremont County were reviewed by the CRT. This group utilized the results of those reviews to make recommendations for action. A contract for a maternal interviewer was also established through this work, in order to contribute to richer narrative to the case review process. The interviewer hoped to conduct personal interviews with mothers who experienced a fetal or infant loss in order to learn about the experience from the mothers' perspective. While our contracted interviewer reached out to three mothers who experienced loss, she was unable to establish contact due to difficulty gaining accurate contact information. The interviewer will remain under contract through FY18, in order to contribute as possible to the next round of case reviews. The CRT provided summary recommendations based on case review findings, and the CAT will use those recommendations to develop interventions and projects aimed at reducing the infant mortality rate in the county. Current findings point to a need for preconception health training and education in the community. Additional support for the FIMR project was sought through a grant application to the Community Health Rankings/Robert Wood Johnson funding opportunity in early 2017. This grant has helped to provide funding support for the preconception health training project, and materials for providers in the county related to preconception health. The training, which will use expert trainers in preconception health, will cover patient-centered contraceptive counseling and chronic disease management in women of childbearing age and during pregnancy.

Priority: Increase Breastfeeding Duration
NPM 4: A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months (National Immunization Survey (NIS))

The Wyoming 5-year Title V needs assessment helped the MCH Unit identify seven key priority needs for the 2016-2020 period. One such priority aims to increase rates of
breastfeeding initiation, breastfeeding duration and exclusivity at 6 months in order to
improve perinatal and infant health. The American Academy of Pediatrics (AAP) recommends exclusive breastfeeding for the infant's first six (6) months and continued breastfeeding until at least the infant's first birthday in order to maximize the health benefits associated with breastfeeding. Breastmilk is recognized as the best source of nutrition and immune protection, and promoter of healthy growth and development in infants, and a variety of

protective benefits have been observed. Breastfed infants are less likely to experience a wide range of illnesses and diseases (including childhood leukemia, diabetes, and obesity). Medical evidence shows that both mothers and their infants enjoy better health through breastfeeding, and mothers have less risk of breast cancer, ovarian cancer, diabetes, and heart disease; they also recover from pregnancy faster.

Wyoming has historically had a very high rate of breastfeeding initiation, and we exceeded the Healthy People 2020 goal of 81.9 percent of infants who are ever breastfed as far back as 2007. In order to sustain the progress seen with this particular objective, and to promote a deeper focus on increasing duration and exclusivity rates in Wyoming, the MCH unit developed and released a breastfeeding mini-grant opportunity to Wyoming hospitals to increase provider awareness and implementation of evidence-based methods to promote breastfeeding initiation and duration. The program, Wyoming 5-Steps to Breastfeeding Success, is based on the Baby Friendly Hospital Initiative and the Colorado Can Do 5 Program, and uses evidence-based methods to increase breastfeeding initiation and duration within the labor and delivery environment. The development of the grant program, and the review of the request for applications (RFA) were guided by the Breastfeeding Grant Committee, a collaboration between MCH, Women, Infants and Children (WIC) and the Chronic Disease Prevention Program (CDPP). The request for applications resulted in four applications from facilities across the state, and because of a contribution of funding for this grant through an ongoing collaboration with the Association for State and Territorial Health Officials (ASTHO) and their Learning Community to Improve State Health Agency Capacity for Breastfeeding Promotion and Support, all four hospitals were funded starting in July 2017. Ongoing technical assistance (TA) and site visits have ensured that barriers to implementation are addressed and adequate evaluation data is collected.

Below are some highlights from the Wyoming 5-Steps funding facilities on steps they have taken to improve breastfeeding initiation and duration rates in their facility and surrounding community:

- Rooming-in policies implemented in all four facilities,
- Avoidance of pacifier use in the hospitals through policy change and education
- Implementation of education for mothers on milk supply and demand for newborns
- Certified Lactation Consultant (CLC) training for labor and delivery nurses
- Encouragement of the 'golden hour' for mothers to be skin to skin with their infant(s)
- Creation of a brochure for mothers educating on the benefits of breastfeeding
- Creation of donor milk policies in multiple facilities to encourage exclusive use of breastmilk for newborns. This has also led to marked increase in the donor milk program, as mothers from at least one facility are donating back after discharge
- Creation of ‘goody bags’ that remove evidence of formula branding or promotion, in order to comply with the International Code of Marketing of Breastmilk Substitutes
- Implementation of ongoing training for staff on hospital policies related to breastfeeding, including the priority of the hospital to promote exclusive breastfeeding
- Development of a breastfeeding policy or policies that address breastmilk as the preferred feeding method for medically stable infants and establish clear guidelines for supplementation
- Use of CDC-developed breastfeeding crib cards for all newborns in the facility
- Implementation of a toll-free helpline which mothers can call for breastfeeding support after hospital discharge

The MCH unit will also be developing a recognition program for any hospital that successfully implements the 5-steps program, regardless of whether they received grant funding to do so. The recognition program is expected to launch in the fourth quarter of calendar year 2017.

The Healthy Baby Home Visitation (HBHV) Program delivered by public health nurses (PHN) in all 23 counties in Wyoming also aligns with MCH state priority needs including breastfeeding promotion. Home visitation services are among the required activities of a contract held with 23 counties in Wyoming. Through the contract, each county is

required to ensure all PHNs delivering MCH services receive annual breastfeeding training. Each county is also responsible for providing breastfeeding education/support as part of the home visiting curriculum and for collecting data on initiation and duration of breastfeeding. Data on the breastfeeding support provided by PHNs and breastfeeding outcomes are tracked quarterly and provided to the counties to aid in program improvement.

The MCH Unit sponsored Certified Lactation Counselor (CLC) training for approximately 15 PHNs who deliver MCH services in August of 2017, a training brought to Wyoming by the Healthy Children Project. Ongoing support is provided to PHNs through the MCH contracts to ensure that all MCH nurses have access to CLC training. Additionally, the MCH unit is developing a training program for PHN to ensure that each PHN in the field has the subject matter expertise required to deliver home visiting services in a manner that is consistent with the MCH priorities established during the Title V needs assessment process, as well as to impact the emerging health issues identified through ongoing surveillance of health data in Wyoming. The training program was informed by an evaluation of nurse training and confidence in implementing the Healthy Baby Curriculum. The newly developed training program will include ongoing skills development in the area of breastfeeding support.

The MCH Unit offered community baby shower mini-grants to four communities. The community baby showers are organized by Wyoming Medicaid's Care Management organization, WYHealth.

The WIHP partnered with the CDPP on a worksite wellness grant opportunity for Wyoming businesses. The grant program included a section on creating and promoting a breastfeeding friendly workplace, and utilized the tools outlined in Health Resources and Services Administration (HRSA)'s *The Business Case for Breastfeeding*. The Women and Infant Health Program Manager (WIHPM) has offered ongoing TA in the development of breastfeeding friendly policies and practices for those awarded the worksite wellness grant under the CDPP.

Internally, the WIHP has been working closely with WIC to draft a breastfeeding at work policy for WDH employees. This policy has been modeled after those in place in other states, particular other state health departments, and would allow mothers to bring their infants to work for the purposes of breastfeeding for up to 6 months of age. The policy is currently under review by senior leadership to assess feasibility and potential liability issues. The WIHP also worked to establish and/or improve lactation rooms within the state buildings, including providing commercial-grade breast pumps and compatible pump kits for nursing mothers within the WDH.

Other Programmatic Activities:

Newborn Screening Program

Screening allows for early diagnosis and treatment of disorders that can negatively affect a child's mental and physical health for a lifetime. In some cases, these disorders can cause death if not diagnosed and treated early.

In FY17, the Wyoming NBS Program continued participation in NewSTEPs 360 (Newborn Screening Technical Assistance and Evaluation Program), a national project providing TA and access to data to improve NBS timeliness. NewSTEPs 360 is an extension of the national CoIIN focused on improving NBS timeliness. In 2017, the Wyoming/Colorado team partnered with West Edge Collective, a Wyoming-based digital marketing firm, to develop a 20-minute video on the importance of NBS and NBS timeliness. The video describes the importance of NBS timeline through education on processes and personal stories from parents whose children were affected by conditions tested in the NBS panel. The video was released to labor and delivery staff throughout the state in June 2017 during a newbo screening training conference that was supported by NewSTEPS 360, and included a branded hard-copy disk and marketing posters (also created by West Edge Collective) to promote the use of the video and pre/post assessments hospital staff trainings.

The NBS program offered a NBS conference, “Every Hour Counts” in June of 2017 as an educational opportunity for labor and delivery staff and midwives. The conference, which was funded under the NewSTEPS 360 grant, and covered timeliness and collection, quality improvement, CCHD screening education and rule updates, and birth certificate training. Under the updated rules, midwives are responsible for collecting newborn screens for families attended by a midwife, and the conference hosted a large number of Wyoming midwives to ensure adequate education and preparation for the implementation of this new rule. The rule officially went into effect in December of 2017, and data on CCHD implementation will be collected through a checkbox that was added to our electronic birth records maintained by Vital Records.

In May 2018, an issue was identified with specimens from Cheyenne Regional Medical Center (CRMC) reaching the Colorado Department of Public Health and Environment Laboratory (CDPHE) in an untimely manner. We were able to meet with our courier to address our concerns, and they have since altered their route to pick up specimens from CRMC at a time that allows them to reach CDPHE within 24-48 hours after collection.

In June of 2018, the Newborn Screening Coordinator met with our courier to be trained on their real time tracking data system. This system allows the coordinator to see the location of the courier at any given time, on their routes to pick up Wyoming specimens, for their journey to the CDPHE Laboratory. This tracking system ensures we maintain timely transport of specimens from our birthing hospitals to CDPHE.

Wyoming Home Visiting Activities

The WIHPM and partners from the PHN Unit will continue to participate in the Wyoming Home Visiting Network (WYHVN). This network of committed stakeholders promote quality home visiting from pregnancy through age three as a core early childhood service available to all Wyoming families. The WYHVN facilitates activities among its members:

- to promote program collaboration and to raise public awareness about home visiting,
- to expand and sustain home visiting services,
- to provide supplemental home visiting training,
- to collect and share data, and
- to share relevant policy and research information.

Wyoming Adverse Childhood Experiences (ACE) Interface Training

The MCH Unit contributed funding to the Wyoming Children’s Trust Fund (funded by the Wyoming Department of Family Services) to bring the ACE Interface Training to Wyoming. Two MCH staff members were trained. The MCH Unit will continue to support implementation of ACE training throughout the state. The training will help individuals all across Wyoming understand how the experiences and environments children have starting even before birth affect their lifelong outcomes. The training opportunity builds trainees’ presentation and facilitation skills to share recent advances in the science of brain development so that Wyoming can come together to solve some of our most challenging problems - school achievement, economic productivity and stability, health problems, thriving communities, and more.

Perinatal/Infant Health - Application Year

Application Year Plan (FY19): This section presents strategies/activities for 2016-2020 MCH priorities related to Perinatal/Infant Health. See Five-Year State Action Plan Table for more information.

Two Wyoming MCH priorities are addressed in the Women/Maternal Domain including:

1. Prevent Infant Mortality
2. Improve Breastfeeding Duration

Priority: Prevent Infant Mortality
SPM 1 (NPM 3): Percent of VLBW infants born in a hospital with a Level III Neonatal Intensive Care Unit (NICU)

Current, infant mortality prevention efforts are guided by the Wyoming Perinatal Quality Collaborative (WPQC), a newl formed state advisory group. This group is comprised of members from a wide variety of key stakeholders, including t Wyoming Hospital Association (WHA), Wyoming Primary Care Association (WYPCA), Medicaid, March of Dimes, B Cross Blue Shield, American College of Obstetricians and Gynecologists (ACOG), local providers, WYHealth, Wyom Medical Society, and several key Wyoming Department of Health (WDH) stakeholders. The group will guide future wo within the MCH Unit by helping to identify priority needs and target efforts where they will be most effective.

In FY19, we plan to impact NPM 3 (selected as a SPM (#1) in Wyoming)--percent of VLBW infants born in a hospital with a Level III+ NICU-- by implementing the following selected strategies:

- Use Levels of Care Assessment Tool (LOCATe) results to develop and disseminate facility-specific and statewide reports on hospital levels of care
    - # of facility-specific and statewide reports created and disseminated.
- Build capacity and formalize structure of the WPQC
        - # of engaged stakeholders participating in the PQC development process
        - Release of an Request for Proposal (RFP) for a PQC Coordinator
        - # of quality improvement projects implemented under the guidance of the PQC
- Continue to offer perinatal focused Project Extension for Community Healthcare Outcomes (ECHO) opportunities through an ongoing collaboration with the Utah Department of Health
    - # of hospitals participating in ECHO sessions
    - Improvement from baseline assessment for participating facilities

In addition to implementing strategies determined through our strategic planning process for this priority, MCH will continue to support the Maternal High Risk (MHR) and Newborn Intensive Care (NBIC) Programs to ensure high-risk pregnant women and high-risk infants have access to care coordination services and gap-filling financial assistance to enhance perinatal outcomes.

The WIHP will continue to support the Fremont County Fetal and Infant Mortality Review (FIMR) Project. In FY19, the Community Action Team will guide development of provider training and community interventions focused on preconception health, the prioritized recommendation. Expert trainers on the topics of contraceptive counseling, chronic disease management in women of childbearing age, and chronic disease management in pregnancy will train health and social service providers in the community. In the meanwhile, the MCH Unit will continue to support the Case Review Team by abstracting infant and fetal losses and creating case summaries for review. Lastly, the maternal interviewer will continue to offer interviews to women who have experienced a loss in order to capture more meaningful qualitative data. MCH will measure the success of this ongoing project by tracking the following:

- #of CRT/CAT meetings
- # of cases reviewed
- # of providers trained on preconception health topics
- #of preconception health projects implemented in the community

Lastly, the WIHP will revise the original FIMR project proposal submitted to WDH leadership in order to develop a toolkit for possible use by other counties if and when there is capacity to expand FIMR.

Priority: Improve Breastfeeding Duration
NPM 4: A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months (National Immunization Survey (NIS))

In FY19, we plan to impact NPM 4**:** A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months -- by implementing the following selected strategies:

1) Wyoming 5-Steps to Breastfeeding Success mini-grant project
    a) # of TA meetings with grantees
    b) # of hospitals demonstrating improvement from baseline
    c) # of hospitals implementing breastfeeding policy change in their facility
2) Work with WHA and the WDH Public Information Office to develop hospital recognition program based on the Wyoming 5-Steps to Breastfeeding Success.
    a) # of applications received for recognition
    b) # of hospitals awarded 5-Steps recognition

The WIHPM will also offer ongoing TA in the development of breastfeeding friendly policies and practices for those awarded a worksite wellness grant under the Chronic Disease Prevention Program.

MCH Epidemiology continues to collaborate with Women, Infants and Children (WIC) staff to develop WIC-specific products about breastfeeding initiation and duration among women enrolled in WIC. This information will be used to address barriers and educate staff to improve breastfeeding rates among women enrolled in WIC. This effort and the Wyoming 5-Steps to Breastfeeding Success program were selected to be a part of the Association of Maternal and Child Health Programs (AMCHP) Data Visualization Learning Collaborative in FY18. This collaborative will lead to the development of new factsheets and social media-ready infographics to better communicate breastfeeding data with the WIC and hospital communities.

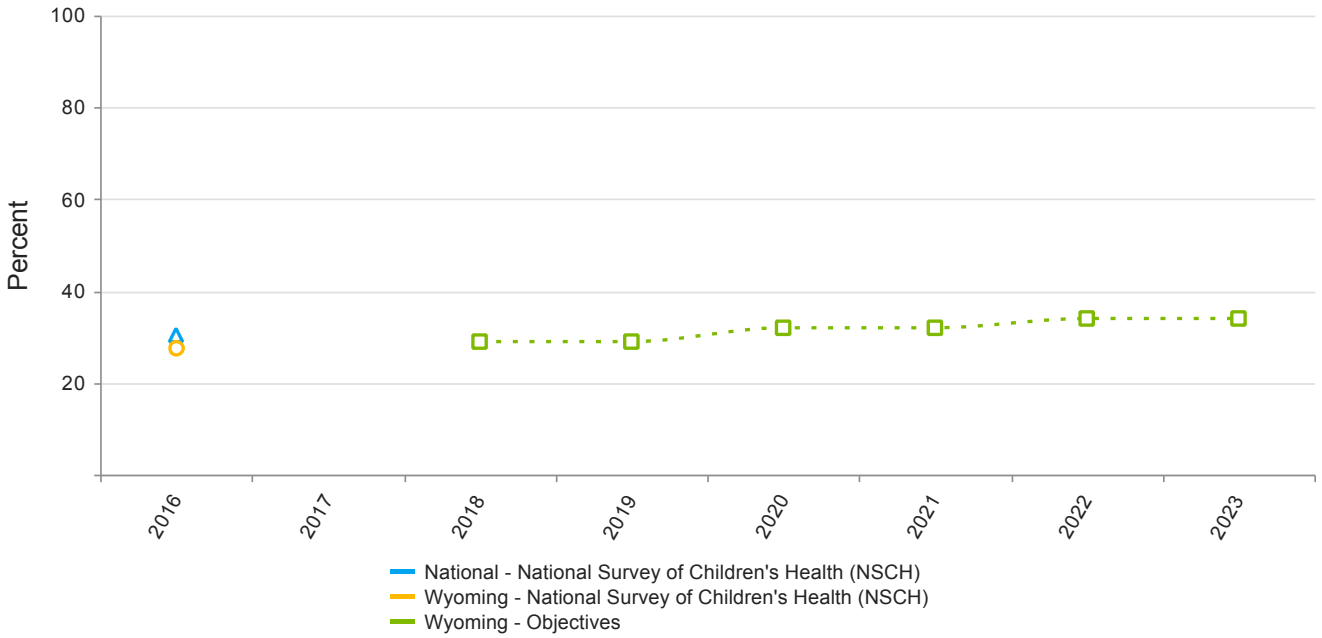
Child Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)	NSCH	Data Not Available	NPM 6
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2016	90.2 %	NPM 6

National Performance Measures

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year
Baseline Indicators and Annual Objectives



Federally Available Data		
Data Source: National Survey of Children's Health (NSCH)		
	2016	**2017**
Annual Objective		
Annual Indicator		27.6
Numerator		4,900
Denominator		17,751
Data Source		NSCH
Data Source Year		2016

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	29.0	29.0	32.0	32.0	34.0	34.0

Evidence-Based or –Informed Strategy Measures

ESM 6.3 - 211 Referrals to Help Me Grow

Measure Status:	Active

State Provided Data	
	2017
Annual Objective	30
Annual Indicator	39
Numerator	
Denominator	
Data Source	HMG Reports
Data Source Year	2017
Provisional or Final ?	Provisional

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	45.0	60.0	75.0	75.0	85.0	100.0

ESM 6.4 - Number of trained partners entering into the ASQ Enterprise System.

Measure Status:	Inactive - We are still exploring options for data collection that include but are not limited to the ASQ Enterprise system.

State Provided Data	
	2017
Annual Objective	2
Annual Indicator	0
Numerator	
Denominator	
Data Source	HMG Program Records
Data Source Year	2017
Provisional or Final ?	Final

ESM 6.5 - Total number of referrals received by HMG

Measure Status:	Active

State Provided Data	
	2017
Annual Objective	20
Annual Indicator	13
Numerator	
Denominator	
Data Source	HMG Program Records
Data Source Year	2017
Provisional or Final ?	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	25.0	30.0	40.0	40.0	50.0	50.0

ESM 6.6 - Number of connections made between local services and families by HMG.

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	50.0	51.0	52.0	53.0	55.0

State Performance Measures

SPM 2 - Rate of hospitalization for non-fatal injury per 100,000 children ages 1 through 11

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		20
Annual Indicator	25.3	32.2
Numerator	22	28
Denominator	86,903	86,855
Data Source	Wyoming Hospital Discharge Data	Wyoming Hospital Discharge Data
Data Source Year	FY 2015	CY 2016
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	30.0	30.0	29.0	29.0	28.0	28.0

SPM 5 - Percent of children (6-11 years) who are physically active at least 60 minutes per day.

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	32.0	34.0	35.0	36.0	38.0

State Action Plan Table

State Action Plan Table (Wyoming) - Child Health - Entry 1

Priority Need

Promote preventive and quality care for children and adolescents

NPM

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Objectives

Increase the percent of Wyoming children (9-35 months) who received a development screening in the past year.

Strategies

Develop infrastructure for Help Me Grow.

Provide Ages and Stages training to Wyoming health care providers.

ESMs	Status
ESM 6.1 - Help Me Grow contract to Wyoming 211, Inc. executed	Inactive
ESM 6.2 - Help Me Grow Implementation plan developed	Inactive
ESM 6.3 - 211 Referrals to Help Me Grow	Active
ESM 6.4 - Number of trained partners entering into the ASQ Enterprise System.	Inactive
ESM 6.5 - Total number of referrals received by HMG	Active
ESM 6.6 - Number of connections made between local services and families by HMG.	Active

NOMs

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

State Action Plan Table (Wyoming) - Child Health - Entry 2

Priority Need

Reduce and prevent childhood obesity

SPM

SPM 5 - Percent of children (6-11 years) who are physically active at least 60 minutes per day.

Objectives

Increase the percent of Wyoming children (6-11 years) who are physically active at least 60 minutes per day.

Strategies

Partner with the Wyoming Chronic Disease Program to implement evidence based prevention strategies in early childhood facilities and schools.

State Action Plan Table (Wyoming) - Child Health - Entry 3

Priority Need

Prevent injury in children

SPM

SPM 2 - Rate of hospitalization for non-fatal injury per 100,000 children ages 1 through 11

Objectives

Decrease the rate of injury mortality among Wyoming children (0-18 years).

Strategies

Implement community based grants with targeted evidence-based strategies to address the major causes of childhood injury/hospitalizations in Wyoming.

Annual Report Fiscal Year 2017: This section provides a summary of FY17 activities, accomplishments, and challenges related to NPMs and SPMs (2016-2020) for the Child Health Domain.

Priority: Improve Preventive and Quality Care for Children
NPM 6: Percent of children (10-71 months) receiving developmental screen using a parent-completed tool (National Survey of Children's Health (NSCH))

Early detection of developmental delays through screening is a cost-effective method to help address needs early and improve the health trajectory of children across the lifespan. Wyoming's priority to promote preventive and quality care for children and adolescents includes obtaining appropriate screening and preventive health interventions. Developmental surveillance, screening, and observations are important in all aspects of the child's growth and development. The American Academy of Pediatrics (AAP), Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescent recommends standardized developmental screening be used at 9 month, 18 month, and 2.5 year visits in addition to other times when concerns are identified.

The Wyoming Child Health Program (CHP) used two methods to increase developmental screenings: implementation of the Help Me Grow (HMG) model and distribution of Ages and Stages Questionnaire (ASQ) screening tools to partners.

HMG is a national model that takes a systems approach to improving access to existing developmental resources and services for children through age eight. The national model has three phases to implementation: building the infrastructure, building the system, and sustaining the system. During FY17, Wyoming moved from the infrastructure to the system building stage of HMG implementation. FY17 progress can be broken into the three components of system building: centralized telephone access; child health provider, community, and family outreach; and data collection and analysis.

Centralized telephone access

In October 2016, Wyoming Department of Health (WDH) contracted with Wyoming 211 to act as the centralized telephone access point for HMG. Wyoming 211 began with a regional approach focusing specifically on Albany and Laramie counties. The contract was amended and extended through August 30, 2018. Wyoming 211 began taking HMG calls in January of 2017. Referrals come from either directly to HMG (ESM 6.5) or are referred from calls made to 211(ESM 6.3). The referrals began slowly (<5 per month) but gained momentum throughout the year averaging nearly 10 per month by the end of 2017. In addition to fielding new referrals, HMG staff conducted follow-up with families who participated. During 2017, there were 95 follow-ups completed by HMG staff.

Child health provider, community, and family outreach

In October 2016, Wyoming 211 hired its first HMG Coordinator. The main goals of this Coordinator were to coordinate the workgroups and leadership group, build capacity through outreach in Albany and Laramie Countries to providers and community partners, and establish a timeline for HMG implementation.

In January 2017, the HMG Coordinator planned a community baby shower event as a way to reach out to community organizations and inform them of HMG efforts as well as have direct interaction with expecting and young families.

Turnover at Wyoming 211 and in the HMG Coordinator position have been a challenge for the HMG program. Both the HMG Coordinator and 211 Director resigned in late spring of 2017. A new 211 director was hired in July 2017

and a new HMG Coordinator in August 2017. Since that time both have left the organization and new staff are onboard as of June 2018.

Through the staffing changes the members of the Wyoming HMG Leadership team have been integral to the continuation of HMG efforts. To ensure a comprehensive systems approach for early childhood, members for the Wyoming HMG Leadership Team include representatives from the WDH (MCH, MCH Epidemiology, and Early Intervention), Wyoming Department of Family Services (DFS) Resource and Referral, the Governor's Early Childhood State Advisory Council, the Institute for Population Health at Cheyenne Regional Medical Center, the Children's Trust Fund, and the Wyoming Early Childhood Partnership (Ellbogen Foundation).

Data collection

During the reporting year, Wyoming 211 developed an internal monitoring system to track calls to Wyoming 211 and specifically to HMG. The initial data collection was completed via Microsoft Excel as Wyoming 211 was undergoing a transition to a new calling software. Data collection tools collected information on community outreach, family outreach, and marketing. The tools allowed the HMG staff to monitor their work and identify areas for improvement. Better reports will be built after the transition to the new data system. Additionally, HMG began looking into two additional systems to determine utility and feasibility: the Ages & Stages Questionnaires (ASQ) Enterprise System and Utah's HMG database. Further communication with vendors and cost analyses will help HMG make a decision on the best data collection tool for its purposes. Currently, the Child Health Program (CHP) is working with the Office of Privacy and Security, the HMG Leadership Team, and partners to put together a use case for the ASQ Enterprise System.

ASQ Screening Tools

In addition to the HMG Model, the CHP also provides trainings and ASQ screening tools to CDCs (child developmental centers), Public Health Nursing (PHN) offices and staff, Home Visitors, Early Care and Education Providers (both home and center based) and Primary Care Medical Home staff. PHN home visitors completed 1,241 ASQ screens in 2017. Limited data is available from other providers as they are not WDH employees.

Priority: Prevent Childhood Obesity
NPM 8: Percent of children (6-11 years) who are physically active at least 60 minutes per day (NSCH)

Prevention and reduction of childhood obesity was selected as a Wyoming priority. Physical activity is a key component in reducing the obesity rate.

In FY17, the Child Health Program Manager (CHPM) convened cross-agency physical activity workgroup meetings; however, each program brought a specific set of established goals and activities and it was difficult to produce buy-in around a shared vision and common measures. This was particularly true as many partners were nearing the end of their funding cycle and were uncertain of continued funding in this area. Despite these challenges, the workgroup met four times in 2017. The new CHPM will determine the utility of continuing these workgroup meetings.

The CHP provided financial support for a Comprehensive School Physical Activity Programs (CSPAP) training in September 2017 at the Wyoming Association for Health, Physical Education, Recreation, and Dance conference. CSPAP is a multi-component approach by which school districts and schools use all opportunities for students to be physically active, meet the nationally recommended 60 minutes of physical activity each day, and develop knowledge, skills and confidence to be physically active for a lifetime. The Centers for Disease Control and Prevention (CDC), in collaboration with SHAPE (Society of Health and Physical Educators) America, developed a step-by-step guide for school and school districts to develop, implement, and evaluate the CSPAP. The Wyoming

Chronic Disease Prevention Program led the CSPAP training and identified a teacher advocate who received national train the trainer guidance to bring to Wyoming. In addition to providing the in-person training, the teacher also provided technical assistance throughout the year to teachers interested in implementing a CSPAP in their school.

Priority: Prevent Childhood Injury
SPM 2: Rate of hospitalization for (non-fatal) injury per 100,000 children (1-11 yrs)

The CHP continues to provide financial support to Safe Kids Wyoming (SKW). During FY17, SKW focused on activities to prevent the leading causes of death and injury in Wyoming children ages 1-11 which include motor vehicle crashes, falls and poisonings. The CHPM, the WDH Injury Prevention Coordinator, and MCH Epidemiology Program advise the work of SKW as members of the SKW Leadership Team. Activities employed by local SKW coalition to reduce child and adolescent deaths included child passenger safety events, traveling safely with newborn classes, car seat installation and inspection station events, helmet distribution, and bike rodeos, among others.

SKW leadership developed a SKW Injury Prevention Toolkit and presented it to all local SKW coalitions and partners at the annual SKW Coordinator Meeting held in April 2017. The toolkit included data and evidence-based strategies for each of the leading causes of injury hospitalizations and deaths among Wyoming children. The toolkit was intended to empower and equip local partners to implement evidence-based strategies in their injury prevention efforts. During the SKW Coordinator Meeting, MCH Epidemiology presented on current injury data and strategies for using data to inform local prevention efforts. A follow-up survey was sent out approximately six-months after the toolkits were distributed to evaluate the effectiveness of the tool and to see if any changes or updates needed to be made. Ten of 11 (91%) SKW Coalitions and Partners who received the tool reported using it at the sixth month follow-up. The majority of organizations reported that the tool changed the way they did their work by serving as a resource, providing new and additional information, or by providing examples of new processes. The CHP and SKW will continue to evaluate the effectiveness of this tool and eliminate barriers to implementing evidence-based primary injury prevention strategies.

Identifying accurate ways to measure SKW impacts at the local level and how these impacts translate to statewide outcomes remains a challenge. The CHP and MCH Epidemiology have worked together to improve reporting and evaluation efforts.

Child Health - Application Year

Application Year Plan (FY19): This section presents strategies/activities for 2016-2020 MCH priorities related to C Health. See Five-Year State Action Plan Table for more information.

Three of the Wyoming MCH 2016-2020 priorities are included within the Child Health Domain. The three priorities include:

1. Promote Preventive and Quality Care for Children and Adolescents
2. Prevent Injury in Children
3. Reduce and Prevent Obesity in Children

Priority: Promote Preventive and Quality Care for Children
NPM 6: % of children (10-71 months) receiving developmental screen using a parent-completed tool (National Survey of Children's Health (NSCH))

In FY19, the Child Health Program (CHP) will continue to impact NPM 6--the percent of children (10-71 months) receiving a developmental screen using a parent completed tool-- by implementing the following strategies:

1. Support Help Me Grow (HMG) activities to increase access to developmental screening tools for families.
    a. # of calls to HMG
    b. # of referrals to HMG/211
2. Build capacity to track and monitor Ages and Stages Questionnaire (ASQ) screenings statewide via the ASQ Enterprise System.
    a. # of trained partners entering into the ASQ
3. Collaborate with Wyoming Medicaid and other partners to further the work of the Title V Summer Interns to educate providers about the American Academy of Pediatrics (AAP) Bright Futures (4th ed.) as part of efforts to improve access to and quality of Early and Periodic Screening, Diagnostic and Treatment (EPSDT)/well-visits.

The following HMG activities support CHP efforts to improve access to and completion of developmental screening:

- Outreach to child health care providers to support early detection and intervention.
- Outreach to communities to promote use of HMG and to provide networking opportunities among families and service providers.
- A centralized telephone access point for connecting children and their families to services and care coordination.
- Collection of data to understand all aspects of the HMG system, including the identification of gaps and barriers.
- Connecting families with available and appropriate resources based on screening results.

HMG will continue outreach efforts to providers, the early childhood community, and families in Albany and Laramie Counties in FY19 with the goal of strengthening the level of integration into both communities. As part of this goal, HMG will identify new potential referral sources and improve infrastructure within Albany and Laramie Counties to support long-term sustainability. HMG will also conduct an environmental scan of both counties to identify barriers to implementation and determine realistic target population goals.

Wyoming HMG also intends to expand its work with families completing ASQs telephonically and via mail, in both Laramie and Albany Counties. The Screening Team is working to acquire the ASQ Enterprise System for HMG staff and partners to use to track ASQ screenings and enable parents to complete the tool online. Work with the

Wyoming Office of Privacy and Security and the vendor, Brooks Publishing is ongoing.

As part of the HMG Leadership and Sustainability Team, the Early Intervention Program and HeadStart will be contributing financially towards the HMG contract in FY19. The Leadership Team is committed to sustainable funding and cost-sharing among the partners involved in HMG. With this increased funding, the HMG Contract will support continued capacity building with the goal of expanded outreach within Laramie and Albany Counties focus on screening children birth to 3 years of age.

MCH was successful in its application to receive two MCH Graduate Student Interns from the MCH Workforce Development Center for the summer of 2018. The interns project will focus on the rollout of the 4th Edition of Bright Futures screening recommendations from the AAP. Their work will build on review of Medicaid and Public Health Division data related to EPSDT. Within the 4th Edition of Bright Futures are recommendations for developmental screening. We see the infrastructure from HMG as a potential avenue for rollout of these new guidelines.

Priority: Reduce and Prevent Childhood Obesity
SPM 5: % of children (6-11 years) who are physically active at least 60 minutes per day. (NSCH)

Due to changes in funding for the Wyoming Chronic Disease Prevention Program (CDPP) within the Public Health Division and staff turnover within the CHP, MCH chose to transition the physical activity NPM to a SPM for the remainder of the grant's reporting cycle. The CDPP has implemented nutrition and physical activity promotion efforts in early childhood settings through the Centers for Disease Control and Prevention's (CDC) 1305 grant. Recently, this funding was divided into competitive grants by topic area. The Wyoming CDPP did not reapply for the physical activity grant for early childhood. The CDPP was a key partner in the internal workgroup on physical activity and therefore we see the activities around this priority changing based on their new role.

MCH plans to impact SPM 5—percent of children (6-11 years of age) who are physically active at least 60 minutes per day--by reviewing the work of the CDPP and learning how MCH may continue to support these efforts. The Child Health Program (CHP) will work in concert with the CDPP to identify areas for continued work. Possible areas of collaboration include:

- Active Play for Young Children trainings
    - Trainings provided to local Early Child Care and Education providers throughout the state by the University of Wyoming Extension, Nutrition and Food Safety program.
    - Active Play for Young Children Train the Trainer
- Partnership with Cent$ible Nutrition
    - Stencil Project - 6 sets of large playground stencils available for improving active play at schools and Early Childhood Care and Education Centers (ECE)
- School Health
    - Comprehensive School Physical Activity Program (CSPAP) training - Previously the CHP has provided scholarships for teachers interested in attending this training at the Wyoming Association of Health, Physical Education, Recreation, and Dance Conference. There may be an opportunity to provide more support in FY19 for technical assistance for schools where trained teachers are interested in implementing components of CSPAP in their schools.
- MCH Summit
    - MCH is partnering with the Wyoming Public Health Association (WPHA) to have an MCH tract at the WPHA annual meeting. This meeting provides the opportunity for training public health practitioners across the state.

The CHP has focused on the early childhood population in Wyoming in part because this is an area of current capacity and partnerships but also because it is believed that early intervention and habits created during the early childhood years will yield children who experience physical activity as the norm in their lives.

Priority: Prevent Injury in Children
SPM 2: Rate of hospitalization for (non-fatal) injury per 100,000 children (1-11 yrs) (Wyoming Hospital Discharge Data)

MCH plans to impact the Wyoming SPM--injury rate of hospitalization for (non-fatal) injury per 100,000 children (1-11 years)--by implementing the following selected strategies:

1. Provide Safe Kids Wyoming (SKW) with targeted evidence-based strategies to address the three major causes of injury/hospitalizations in Wyoming.
    a. # of strategies implemented to address motor vehicle crashes (MVC)
    b. # of strategies implemented to address falls
    c. # of strategies implemented to address poisonings

Both the CHP and the Wyoming Injury Prevention Program Specialist represent WDH on the SKW Leadership Team. The CHPM will continue to meet regularly with the Wyoming Injury Prevention Program, Public Health Nursing and Emergency Medical Services for Children (EMS-C) Program to identify ways to collaborate and to assure there is no duplication of effort.

Because the leading cause of death due to unintentional injuries for this population is Motor Vehicle Crashes, the CHP will continue to track Child Safety Restraint Misuse Rates as one of our performance measures. According to the National Highway Traffic Safety Association (NHTSA), the national misuse average is 80%, yet Wyoming's misuse rate is currently 85.2%, down from 91.4% last year. In addition, the CHP will continue to track the number of car seats distributed, inspected and the number of educational injury prevention efforts focused on the leading causes of injury hospitalizations.

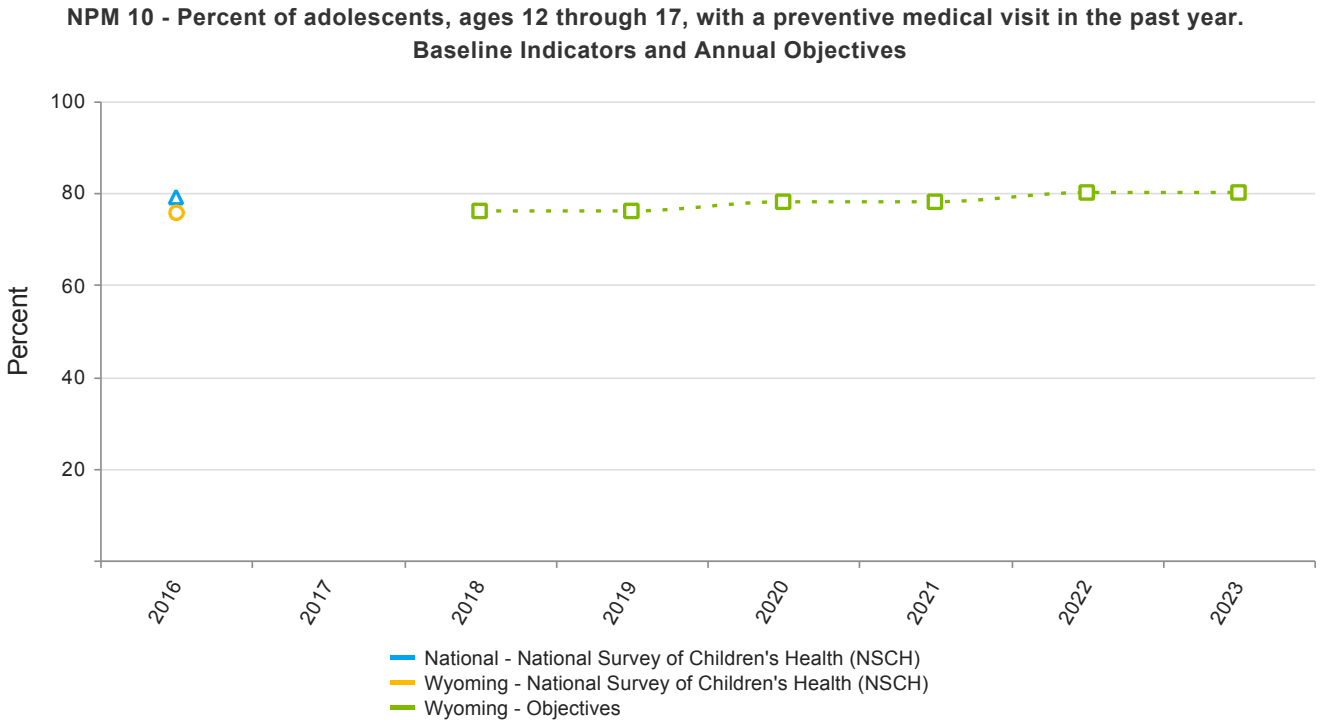
In FY17, a binder of evidence-based strategies specifically addressing the leading causes of unintentional death and injury in children was created through a partnership between SKW, the CHP, MCH Epidemiology, and the Wyoming Injury Prevention Program. Evaluation of the impacts of this binder on reducing child injury will be completed and changes will be made as needed to improve efforts.

Adolescent Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS-2016	43.8	NPM 10
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS-2014_2016	20.8	NPM 10
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2014_2016	28.9	NPM 10
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2016	68.5 %	NPM 10
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2016	90.2 %	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	NSCH-2016	12.9 %	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	WIC-2014	9.9 %	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	YRBSS-2015	11.0 %	NPM 10
NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza	NIS-2016_2017	43.1 %	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NISF-2016	50.4 %	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NISM-2016	36.9 %	NPM 10
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS-2016	86.7 %	NPM 10
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine	NIS-2016	54.2 %	NPM 10
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2016	26.1	NPM 10

National Performance Measures



Federally Available Data		
Data Source: National Survey of Children's Health (NSCH)		
	2016	**2017**
Annual Objective		
Annual Indicator		75.7
Numerator		34,569
Denominator		45,669
Data Source		NSCH
Data Source Year		2016

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	76.0	76.0	78.0	78.0	80.0	80.0

Evidence-Based or –Informed Strategy Measures

ESM 10.1 - Promotion of Adolescent Champion Model

Measure Status:	Inactive - Completed

State Provided Data		
	2016	2017
Annual Objective		Yes
Annual Indicator	No	Yes
Numerator		
Denominator		
Data Source	Program Data	Youth and Young Adult Health Program
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

ESM 10.2 - # QI cycles completed by participating practices

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	4.0	6.0	8.0	0.0	0.0

State Performance Measures

SPM 4 - Percentage of teens reporting 0 occasions of alcohol use in the past 30 days

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		70
Annual Indicator	68.4	68.4
Numerator		
Denominator		
Data Source	Prevention Needs Assessment	Prevention Needs Assessment
Data Source Year	2016	2016
Provisional or Final ?	Provisional	Provisional

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	70.0	70.0	72.0	72.0	74.0	74.0

State Action Plan Table

State Action Plan Table (Wyoming) - Adolescent Health - Entry 1

Priority Need

Promote preventive and quality care for children and adolescents

NPM

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Objectives

Increase the percent of Wyoming adolescents (12-17 years) with a preventive medical visit in the past year.

Strategies

Implement Adolescent Centered Environment Assessment Process in Wyoming clinics to improve the adolescent friendly environment.

Send well-visit appointment reminders to CSH clients.

Maintain state level youth council to ensure youth voices are included in program development, implementation, and evaluation.

ESMs	Status
ESM 10.1 - Promotion of Adolescent Champion Model	Inactive
ESM 10.2 - # QI cycles completed by participating practices	Active

NOMs

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

State Action Plan Table (Wyoming) - Adolescent Health - Entry 2

Priority Need

Promote healthy and safe relationships in adolescents

SPM

SPM 4 - Percentage of teens reporting 0 occasions of alcohol use in the past 30 days

Objectives

Decrease risky behaviors among youth and young adults.

Promote positive reproductive health behaviors.

Change knowledge, attitudes, and perspectives on sexual violence.

Strategies

Complete RFP process and community selection for Rape Prevention and Education (RPE) Program pilot community to implement strategies using a collective impact model.

Build statewide capacity for sexual violence prevention among youth and young adults through the Wyoming Sexual Violence Prevention Council.

Implement comprehensive sexual education curriculum which include content on reducing risky behaviors.

Maintain state level youth council to ensure youth voices are included in program development, implementation, and evaluation.

Annual Report Fiscal Year 2017: This section provides a summary of FY17 activities, accomplishments, and challenges related to NPMs and SPMs (2016-2020) for the Adolescent Health Domain.

Priority: Promote Preventive and Quality Care for Adolescents
NPM 10: % of adolescents with a preventive services visit in the last year (National Survey of Children's Health (NSCH))

In February of 2017, Wyoming was selected to be a part of the Association of Maternal and Child Health Programs (AMCHP) Adolescent and Young Adult Health Collaborative Improvement and Innovation Network (AYAH CoIIN). The Wyoming AYAH CoIIN team includes the Youth and Young Adult Health program manager (YAYAHPM) and representatives from Medicaid, Kid Care CHIP (Children's Health Insurance Program), Wyoming Department of Health (WDH), Wyoming Family Voices, WY-AAP (Wyoming American Academy of Pediatrics), WYPCA (Wyoming Primary Care Association), Optum (Medicaid contractor), youth, and young adults. The WYPCA serves as fiscal agent for the AYAH CoIIN.

Key team members attended an in-person AYAH CoIIN Summit in May 2017 to learn best practices from leading experts in the field of adolescent health and began developing a master action plan. Several AYAH CoIIN State Team meetings where held with all stakeholders.

The Adolescent Centered Environment Assessment Process (ACE-AP) from University of Michigan was identified as a strategy to improve the quality of the adolescent clinical environment with a long-term goal of increasing well-visits among youth and young adults. The ACE-AP is a facilitated, comprehensive self-assessment and guided improvement process that includes customized resources, recommendations, technical assistance (TA), and implementation plans using Plan, Do, Study, Act (PDSA) improvement cycles. At the end of FY17, the clinic environment workgroup of the AYAH CoIIN drafted an RFP (Request for Proposal) to bring on pilot clinics to implement the ACE-AP model. Rates of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) visits compared to primary care visits were calculated for all Medicaid clinics in Wyoming and used to inform the RFP distribution plan. Clinics with low rates of EPSDT visits compared to primary care visits were contacted directly and encouraged to apply. In December 2017, the pilot clinic mini-grant RFP was released and four clinics were selected in January 2018 to begin working with the University of Michigan.

In order to inform future efforts of the CoIIN project including educational and awareness campaigns targeted to youth and young adults and their parents/caregivers, two surveys were developed in FY17 by the Consumer Education workgroup of the AYAH CoIIN Team. A youth and young adult survey was developed by the youth and young adult representatives and asks youth about their awareness of EPSDT visits as well as their perceived barriers to having wellness visits. Another survey, created in conjunction with the youth and young adult survey, was targeted to parents and caregivers and asked similar questions regarding awareness of and barriers to wellness visits. Data from these surveys will be used to inform program efforts, promotional campaigns, and educational materials developed to increase well-visits moving forward.

One of the key challenges of this project was maintaining engagement of a large and diverse team of stakeholders. The YAYAHPM developed a CoIIN State Team Newsletter to keep all members of the larger team engaged and aware of what is happening with the project even if they were not involved in an active work group. The use of shared google folders which allowed for several team members to collaborate on work made space for more work to be done between in-person meetings.

Priority: Promote Preventive and Quality Care for Adolescents
NPM 12: % adolescents with special health care needs who received services necessary to make transitions to adult health care (NSCH)
(see also CYSHCN Narrative and Application)

Transition from pediatric to adult health care for youth with and without special health care needs was identified as a priority for the Youth and Young Adult Health Program (YAYAHP). Understanding how this project fits with the work of the AYAH CoIIN team was a challenge. The Transition Action Team is currently developing a training to be given to Public Health Nurses (PHN) and Tribal MCH care coordinators where they will be trained on health care transition best practices and how to use the transition resources. The Transition Readiness Assessment for Parent/Caregiver and Youth, a piece of the Transition toolkit, will be deployed after the training by PHN and Tribal MCH care coordinators for CSH (Children's Special Health program) clients aged 12+ at the client's annual renewal process.

Priority: Promote Healthy and Safe Relationships for Adolescents
SPM: % of high schoolers reporting 0 occasions of alcohol use in past 30 days (Prevention Needs Assessment (PNA))

This priority was identified due to Wyoming's high teen birth rate, early initiation of sexual activity, incidence of teen dating violence, and alcohol and drug use prior to sexual activity. Most of these activities were measured on the Youth Risk Behavior Surveillance System (YRBSS). In FY16, the Wyoming State Legislature eliminated the YRBSS in Wyoming. There is no longer an effective, statewide measure of youth sexual behavior. However, Wyoming does have a statewide survey called the Prevention Needs Assessment which includes questions about alcohol and drug use.

In 2017, the YAYAHPM identified Communities that Care (CTC) as the primary strategy to address this state priority need and State Performance Measure (SPM). CTC is an evidence-based framework that uses prevention science to increase protective factors in communities. Youth from CTC communities are more likely to delay initiation of alcohol and tobacco use.

FY17 was spent as an infrastructure and capacity building year. The YAYAHPM worked to inform all stakeholders about the framework as well as gain momentum for applying this framework. Many challenges were present with this strategy: buy-in of partners at both the State and local level, and staff turnover all presented barriers to the full implementation of this strategy. The new YAYAHPM will research available evidence-based strategies, including CTC, in order to determine next steps to address this state priority need.

Other Programmatic Activities:

Unlocking the Mysteries of the Adolescent Brain for Healthcare Providers
In FY17, the YAYAHP continued providing training on Unlocking the Mysteries of the Adolescent Brain, developed by the YAYAHPM in 2014 to train healthcare providers and those who work with youth and young adults including teachers, PHN, and coaches. In October 2016, the YAYAHPM provided this training as a workshop at the 9th Annual Wyoming Afterschool Alliance and at the Summer Technical Assistance Retreat for school superintendents from across the State . In addition, this training was incorporated into the facilitator training for Wyoming Personal Responsibility Education Program **(**WyPREP) instructors.

Wyoming Personal Responsibility Education Program (WyPREP)

The YAYAHPM partners with the Communicable Disease Unit (CDU) to manage and implement the WyPREP**.** WyPREP provides training, curricula, and support for implementation of evidence-based, medically accurate curriculum in school and community-based settings. In FY17, contracts with nine organizations were active; five school districts, two youth in out of home care facilities, Wyoming Institute for Disabilities, and one boys and girls club. In every community that contracts to implement WyPREP, a team of people are identified to support the implementation. This team includes: school health/physical education staff, school nurses, school counselors, public health and/or Title X nurses, and domestic violence/sexual assault program staff. This team supports the implementation and also provides a contact for youth in their community. In the 2016-2017 school year WyPREP reached over 900 Wyoming youth. The YAYAHP partners with MCH Epidemiology (MCH Epi) for evaluation of the WyPREP program. Each location is provided with a report card detailing the data from their students each school year. A statewide report card is produced for publication and shared with the public and policymakers. From the 2016-2017 school year exit surveys, half of all WyPREP participants stated that they were much more likely or somewhat more likely to delay initiation of sexual intercourse in the six (6) months following the program.

At the end of FY17, Wyoming was selected to participate in the 2018 Centers for Disease Control and Prevention (CDC) & Harvard School of Public Health Maternal and Child Health Program Evaluation Practicum to evaluate WyPREP. Program staff from MCH, MCH Epi, CDU, and the CDC MCH-Epidemiology Assignee participated in a week long training and workshop in January 2018 followed by a week in Wyoming working with two students to develop a comprehensive evaluation plan of the WyPREP program. The evaluation plan is two pronged in nature and looks to evaluate both fidelity to the model of WyPREP programming and the impacts of the program within the local communities where it is implemented.

The YAYAHP continued efforts to integrate messages about healthy sexuality and sexual violence prevention. This was done by integrating affirmative consent training with WyPREP facilitator trainings and implementing strategies that support healthy sexuality and sexual violence prevention. The upcoming WyPREP evaluation will include analysis of this effort.

Rape Prevention and Education (RPE) Grant

The YAYAHPM is the RPE Project Director and the MCH Epi Program provides evaluation and data support. The target audience for this work is adolescents ages 12-24. Three pilot communities are funded through this grant to conduct primary prevention in their local communities with a shared risk and protective factor approach. Some examples of programming implemented include Coaching Boys into Men and Athletes as Leaders which teach participants about healthy masculinity and how to be leaders in creating cultures of safety and respect. The connected risk and protective factor approach allows the program to implement strategies that will improve the overall environments for adolescents in Wyoming rather than looking at sexual violence in a silo. MCH contracts with the Wyoming Coalition Against Domestic Violence and Sexual Assault (WCADVSA) to complete the work of the RPE grant in Wyoming communities. The YAYAHPM continued to pursue the implementation of CTC in FY17 for future pilot communities.

Wyoming Sexual Violence Prevention Council (WSVPC)

The YAYAHPM and MCH Epi serve as steering committee members of the WSVPC. The council was developed to increase effectiveness of violence prevention efforts statewide. In FY17, the WSVPC underwent strategic planning including a revision of the vision, mission and core values. In addition, three work groups of this committee were identified in addition to the Steering Committee. They include the Policy and Legislation work group and the Education, Training and Awareness workgroup and the College Sexual Violence Prevention work group. These work groups continued to develop strategic goals and work towards statewide shared collective impact efforts for sexual

violence prevention. In January 2018, the WSVPC held an in-person meeting which brought together council members, key stakeholders, and local media. One of the goals of this meeting was to promote the work of the RPE pilot communities and the WSVPC to key stakeholders and the public. Several news organizations picked up the event and ran stories about the work done by the WSVPC as well as the RPE pilot communities.

College Consortium

In FY17, planning for the Wyoming College Consortium continued with the College Sexual Violence Prevention work group comprised of staff from WDH, WCADVSA, and University of Wyoming. A campus needs assessment was developed by this team and distributed to all Wyoming institutions of higher education. Eight (out of nine) community colleges and the University of Wyoming responded to the survey (90% response rate). Data from the survey included availability of sexual violence prevention and response on campus, infrastructure around Title IX and Clery Act requirements, and technical assistance needs. MCH Epi analyzed the results and prepared a summary presentation which was used to inform preparations for the College Consortium in-person meeting as well as inform schools of the current state of Wyoming institutions of higher education regarding these issues. The inaugural Wyoming College Consortium meeting was held in December 2017 co-facilitated by the YAYAHPM with participation from WCADVSA, MCH Epi and six institutions from across the State.

In FY2017, the University of Wyoming implemented an inaugural campus climate survey. The survey included several questions about experiences related to safe and healthy relationships among young adults both on campus and prior to attending school. Although this represents only a specific subset of the youth and young adult population, it will be a valuable new resource available to Wyoming MCH to fill in gaps for monitoring the health of young adults in Wyoming regarding safe and healthy relationship.

Adolescent Health - Application Year

Application Year Plan (FY19): This section presents strategies/activities for 2016-2020 MCH priorities related to Adolescent Health. See Five-Year State Action Plan Table for more information.

Priority: Promote Preventive and Quality Care for Adolescents
NPM 10: % of adolescents with a preventive services visit in the last year.
NPM 12: % adolescents with and without special health care needs who received services necessary to make transitions to adult health care.
(see CYSHCN Narrative and Application)

In FFY19, the Youth and Young Adult Health Program (YAYAHP) will implement the following strategies within the Promote Preventive and Quality Care for Adolescents priority:

1. The Wyoming Adolescent and Young Adult Collaborative Improvement and Innovation Network (WAYAH CoIIN) will continue to develop both short and long-term action plans to promote adolescent and young adult well-visits in Wyoming. This work will include identifying current barriers to well-visits from many different perspectives including system, clinic, provider, and consumer perspectives.
2. A transition toolkit training will be provided to all Public Health Nurses. Transition materials will be provided.
3. Four pilot clinics will implement the Adolescent Centered Environment (ACE)-AP model with contracted support provided by the University of Michigan.
4. Continue to engage youth and young adults in all aspects of the WAYAH CoIIN team goals including development of strategies and products.
5. Promote enhanced provider engagement.
6. The CSH (Children's Special Health) Program will continue to send reminders to enrolled clients to attend their annual well-visit to include the Parent FAQ Sheet developed by the AYAH (Adolescent & Young Adult Health) Center for all youth ages 12 to 18.

Priority: Promote Health and Safe Relationships for Adolescents
SPM: % of high schoolers reporting 0 occasions of alcohol use in past 30 days (Prevention Needs Assessment (PNA))

In FY19, the YAYAHP will implement the following strategies within the Promote Health and Safe Relationships for Adolescents priority:

1. Complete Request for Proposal (RFP) process and community selection for Rape Prevention and Education (RPE) Program pilot community to implement strategies using a collective impact model (e.g. Communities that Care).
2. Continue to build statewide capacity for sexual violence prevention among youth and young adults through the Wyoming Sexual Violence Prevention Council.
3. Continue to work with communities in implementation of the Wyoming Personal Responsibility Education Program (WyPREP) curriculum.
4. Complete program evaluation of WyPREP program created as part of participation in the CDC/Harvard Evaluation Practicum.
5. Continue to build/improve relationships with stakeholders to engage youth and establish a WDH State Youth Council.

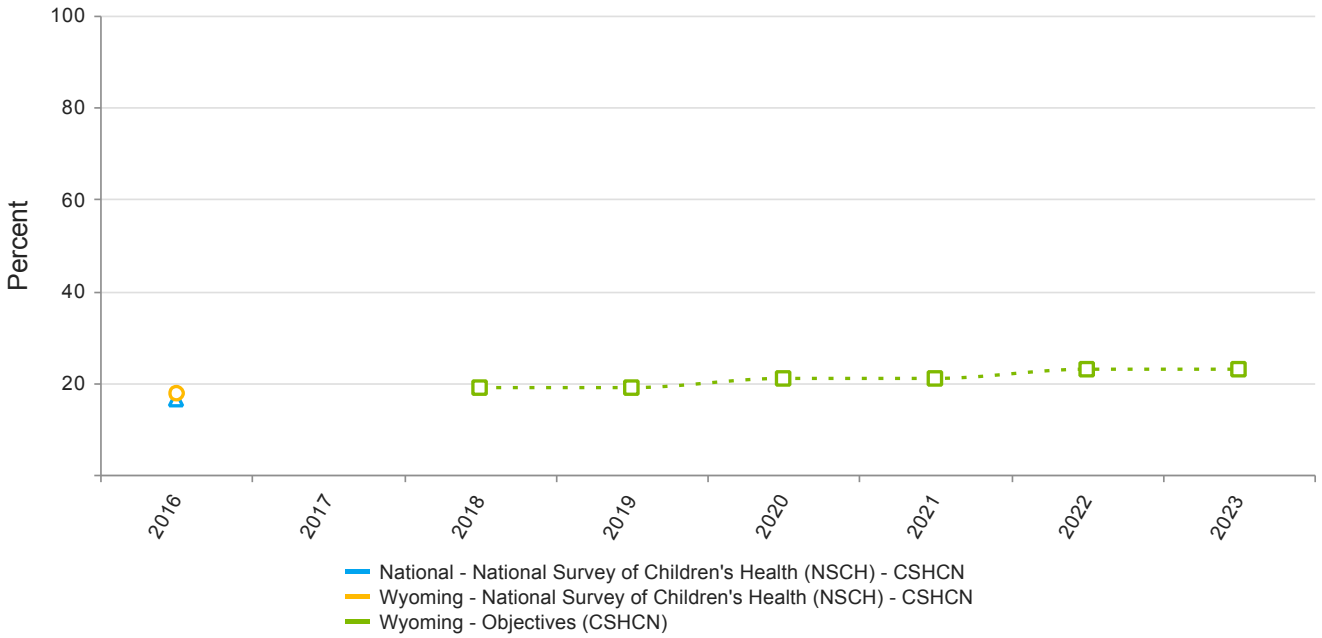
Children with Special Health Care Needs

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2016	21.5 %	NPM 12

National Performance Measures

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care
Baseline Indicators and Annual Objectives



NPM 12 - Children with Special Health Care Needs

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - CSHCN		
	2016	**2017**
Annual Objective		
Annual Indicator		17.9
Numerator		2,073
Denominator		11,609
Data Source		NSCH-CSHCN
Data Source Year		2016

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	19.0	19.0	21.0	21.0	23.0	23.0

Evidence-Based or –Informed Strategy Measures

ESM 12.1 - # of meetings of the Transition Action Team of the AYAH CoIIN

Measure Status:	Inactive - Replaced

State Provided Data		
	2016	2017
Annual Objective		2
Annual Indicator	0	0
Numerator		
Denominator		
Data Source	Youth and Young Adult Health Program	Youth and Young Adult Health Program
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

ESM 12.2 - # of provider champions participating on Transition Action Team

Measure Status:	Inactive - Replaced

State Provided Data		
	2016	2017
Annual Objective		1
Annual Indicator	0	0
Numerator		
Denominator		
Data Source	Youth and Young Adult Health Program	Youth and Young Adult Health Program
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

ESM 12.3 - # of adolescents participating on Transition Action Team

Measure Status:	Inactive - Replaced

State Provided Data		
	2016	2017
Annual Objective		1
Annual Indicator	0	0
Numerator		
Denominator		
Data Source	Youth and Young Adult Health Program	Youth and Young Adult Health Program
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

ESM 12.4 - # of parent or youth completed transition readiness assessments completed by PHN in CSH program

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	45.0	47.0	49.0	51.0	53.0

State Action Plan Table

State Action Plan Table (Wyoming) - Children with Special Health Care Needs - Entry 1

Priority Need

Promote preventive and quality care for children and adolescents

NPM

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

Objectives

Increase the percent of Wyoming adolescents with and without special health care needs who receive the necessary services to transition to adult health care.

Strategies

Distribute Wyoming modified ‘Got Transition’ materials to families of youth with special health care needs served through the CSH Program

Train Children's Special Health nurses on how to conduct a transition readiness assessment

ESMs	Status
ESM 12.1 - # of meetings of the Transition Action Team of the AYAH CoIIN	Inactive
ESM 12.2 - # of provider champions participating on Transition Action Team	Inactive
ESM 12.3 - # of adolescents participating on Transition Action Team	Inactive
ESM 12.4 - # of parent or youth completed transition readiness assessments completed by PHN in CSH program	Active

NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

State Action Plan Table (Wyoming) - Children with Special Health Care Needs - Entry 2

Priority Need

Promote preventive and quality care for children and adolescents

Objectives

Improve access to genetic services.

Strategies

Provide in person and telehealth services for ongoing genetic clinics.

State Action Plan Table (Wyoming) - Children with Special Health Care Needs - Entry 3

Priority Need

Promote preventive and quality care for children and adolescents

Objectives

Include family and consumer input and involvement in program development, implementation, and evaluation.

Strategies

Support the Parent Partner Project in health care settings.

Annual Report Fiscal Year 2017: This section provides a summary of FY17 activities, accomplishments, and challenges related to NPMs and SPMs (2016-2020) for the Children with Special Health Care Needs (CSHCN) Dom All Maternal and Child Health (MCH) Unit programs (Women and Infant Health, Child Health, Youth and Young Adult Health, and Children's Special Health (CSH)) support the efforts within this Domain.

Priority: Promote Preventive and Quality Care for Children and Adolescents
NPM 11: Percent of children with and without special health care needs having a medical home (National Survey of Children's Health (NSCH))

In 2016, 51.9% of children (ages 0-17) without special health care needs had a medical home and 53.1% of children (ages 0-17) with special health care needs had a medical home.

As the Child Health Program (CHP) and MCH Epidemiology Program evaluated available medical homedata, disparities were observed:

- Income: Of families whose income is greater than 400% of poverty level, 61.9% report having a medical home, while for those at less than 100% of poverty level, only 42.1% report having a medical home. This difference is not statistically significant.
- Race/Ethnicity: The new one-year state National Survey of Children's Health (NSCH) estimates are not stable enough to provide comparison by race and ethnicity in Wyoming. However, previous year's data indicated that 64.2% of white children report having a medical home, compared to only 43% of Hispanic children.

In 2017, evidence based strategy implemented to address this NPM was the Wyoming Parent Partner Program (PPP). The PPP came to Wyoming approximately six years ago as a partnership between the MCH Unit, the Mountain States Genetics Regional Collaborative (MSGRC, now the Mountain States Regional Genetics Network) and the Hali Project. This evidence-informed program helps medical homes identify and hire a parent within their practice who has a child with a special health care need. These parents, called Parent Partners, are on staff approximately 16 hours a week when the provider is seeing CSHCN. The Parent Partner works as a peer mentor to support the families and provide many of the elements of medical home.

The Child Health Program Manager (CHPM) tracks the number of families served by the Wyoming PPP. Between July 2017 and January 2018, the PPP served 150 families and 180 children. The PPP expanded to the clinic on Warren Air Force Base in Cheyenne but lost their Parent Partner due to the movement of military families. The process for identifying a new Parent Partner is ongoing.

The CHPM worked with the Clinical Quality Directors of both the Wyoming Primary Care Association (WYPCA) and the Wyoming Institute for Population Health to support a Patient Centered Medical Home (PCMH) partner training in September 2017. The CHPM provided an overview of Title V and potential partnerships including family engagement, EPSDT visits, and MCH Priorities at the training. The CHPM requested to sit on the Medicaid PCMH advisory team.

Public Health Nurses (PHNs) educate Children's Special Health (CSH) eligible families about the importance of a medical home. CSH families are strongly encouraged to select a medical home and follow up on all well-visit checks. Due to the rural and frontier nature of Wyoming, many families lack access to a true medical home. In these cases, PHNs and the CSH program encourage and support families in identifying and establishing relationships with their child's primary care provider. Appointment letters are sent to families and providers according to the periodicity

schedule reminding them when a well-visit is due. As an enclosure with the parent's appointment letter, we are including the Parent FAQ Sheet developed by the Adolescent & Young Adult Health (AYAH) Center for all youth ages 12 to 18.

Telehealth

In addition to access to Medical Homes, MCH is interested in improving general access to care across our frontier state. One effort to increase access to care is the partnership between the Wyoming Department of Health (WDH) and the University of Wyoming to expand telehealth services. HIPAA-compliant Zoom licenses and technical assistance were given to healthcare providers (clinics, hospitals, independent providers, etc.) who wished to begin telehealth services or to expand their use of telehealth. As of March 2018, over 223 licenses have been issued to individual providers, including 30 public health nursing offices and 19 Women, Infants & Children (WIC) offices. Several telehealth projects provide services for the MCH population.

Genetics Services and Telehealth

Wyoming has long offered genetics services for Wyoming families, in an effort to fill the gap left by an absence of genetics providers in Wyoming. The model previous meant that up to 25 in-person clinics were held throughout the state. In 2017, the MCH Unit convened stakeholders from Public Health Nursing, Rural and Frontier Health, and University of Utah to plan a Wyoming telehealth genetics pilot project. By using a telehealth follow-up model, the WDH could prioritize funding and reduce overall costs for genetics services, while still offering this critical service to families dealing with genetic-related issues. The pilot telehealth genetics clinics launched in early 2018 in two Wyoming locations, Casper and Cheyenne, selected for their high volume of patient referrals and central locations in the state. This partnership includes the WDH, the Wyoming Institute for Disabilities (University of Wyoming), and the Division of Medical Genetics, Department of Pediatrics (University of Utah). While initial visits will always be in person, Wyoming families will now be able to obtain follow-up genetic services via telehealth. This new model will be thoroughly evaluated, including using intake and post-visit surveys to ensure that the model is effective, that services are being offered to those with the highest need, and that telehealth is an acceptable mode of service for both clients and the PHN and genetics providers who help support the clinics. Additionally, under the new model, the WDH anticipates an annual cost savings of close to 75%.

As of September 20, 2018, the Wyoming Genetic Program provided services to 54 clients in the two clinic locations (Casper and Cheyenne). Of the total patients served, 51% of respondents (n=28) attended the clinic location in Cheyenne while 27 (49%) attended the Casper clinic. Over half (54%, n=29) were scheduled for an in-person visit with the remaining 12 individuals scheduled for a telehealth visit. The majority of individuals completing the post-visit survey had either less than a high school education or were high school graduates. Six individuals reported some college or a College Degree. The majority of respondents were enrolled in Wyoming Medicaid. Average income for this group was $35,000 with annual incomes ranging from $ 0.00 to $80,000. Mean travel time to the Wyoming Telehealth Genetic clinic was 39 minutes, with individual times ranging from less than 5 minutes to up to 4 hours. The median travel time was 15 minutes. The majority of clients (68%) were residents of one of Wyoming's two urban counties (Laramie, Natrona) and the remaining 32% were residents of counties designated as either Rural or Frontier.

Priority: Promote Preventive and Quality Care for Children and Adolescents

NPM 12: % adolescents with and without special health care needs who received services necessary to make transitions to adult health care (NSCH)

In 2016, 17.9% of Wyoming adolescents with special health care needs and 14.2% of adolescents without special health care needs received the necessary services to transition to adult health care.

In FY17, the Youth and Young Adult Health Program (YAYAHP) continued to develop partnerships to increase health care transition services for adolescents with and without special health care needs. However, program focus shifted in Spring 2017 to support Wyoming's participation in the Association of Maternal and Child Health Programs (AMCHP) Adolescent and Young Adult Health Collaborative Improvement and Innovation Network (AYAH CoIIN). A transition action team was formed as part of the AYAH CoIIN. In late 2017, the Children's Special Health Program reviewed Got Transition materials for use by PHNs. This work may inform future development of a transition toolkit for providers.

The CSH Program continues to provide limited gap-filling financial assistance and care coordination services to CYSHCN and their families. The program actively served 634 CSH clients during the past fiscal year. A fact sheet containing transition issues and community contacts is sent to CSH clients turning 18 and at age 19. Transition resources are also located on the CSH Program website.

Currently, CSH is providing web-based care coordination training for PHNs and Tribal MCH care coordinators. One of the upcoming sessions is related to health care transition for youth and young adults. Using resources from Got Transition, CSH has developed Transition Readiness Assessment tools to be used by the youth and parents/caregivers. Starting at age 14 through 18, CSH clients and families will complete the assessments at the time of their annual renewal. Their care coordinator will use results to address gaps in knowledge about health transition, and provide pertinent referrals.

Children's Special Health (CSH) Program is providing a virtual training series for PHNs and Tribal MCH care coordinators. In September 2017, we surveyed PHNs delivering CSH services in their communities about their training needs. We used the survey results and ongoing consultation with PHN staff to inform selection of training topics. Specifically, we heard that PHNs want more information about programs, services and resources available to provide comprehensive care coordination to their CSH clients and families. Training topics include:

- CSH 101 Part A
- CSH Part B Process & Documents
- Medicaid/Kid Care CHIP
- Travel Assistance
- Medicaid Support Waivers, DD Comprehensive & Respite
- UPLIFT (family support program for children with behavioral challenges)
- WYhealth (Care Management Program with WY Medicaid) & SSI
- Wyoming 211/Help Me Grow
- Magellan Health (Medicaid Mental Health Waiver)
- Early Childhood Transition (Part B & C)
- PIC/PEN (Parent Information Center)
- Medicaid Dental Assistance
- Health Care Transition for Young Adults

All trainings include a follow-up survey to better understand the utility of the information provided and the quality of the speaker. Feedback will be used to identify additional training needs or modifications to the current trainings. All trainings are being recorded and included in a CSH training plan on WyTRAIN, Wyoming's online training system. All CSH nurses will be expected to complete this training plan and it will be a resource for new CSH nurses.

Children with Special Health Care Needs - Application Year

Application Year Plan (FY19): This section presents the initial strategies for the 2016-2020 MCH priorities related to Children with Special Health Care Needs (CSHCN). All MCH programs (Women and Infant Health, Child Health, Youth and Young Adult Health, and Children's Special Health (CSH)) support the efforts within this Domain. The specific topic areas addressed in this domain include medical home and transition to adult health care.

Priority: Promote Preventive and Quality Care for Children and Adolescents
NPM 11: Medical home: % of children with and without special health care needs having a medical home (National Survey of Children's Health (NSCH))

Due to the changes in the Block Grant guidance and Wyoming MCH's capacity, National Performance Measure (NPM) 11 will be discontinued in FY19. Limited staff capacity, competing priorities, and the complexity of medical home as a topic led to the decision to discontinue the NPM.

The MCH Unit will continue to promote preventive and quality care for children and adolescents, including those with special health care needs through the following activities:

- Continue to contract with the Wyoming Parent Partner Program (PPP) to provide peer support to families of CSHCN within a medical home
    - # of unique families served through the PPP
- Complete the telegenetics pilot program to determine the appropriate next steps for genetic services provided through Title V.
    - # of clients served
    - Barriers addressed through telegenetics services measured by a survey
    - Acceptability of telegenetics services to clients and providers measured by a survey

Priority: Promote Preventive and Quality Care for Children and Adolescents
NPM 12: % adolescents with and without special health care needs who received services necessary to make transitions to adult health care (NSCH)

In FY19, we plan to impact NPM 12--percent adolescents with and without special health care needs who received services necessary to make transitions to adult health care--by implementing the following selected strategy paired with its associated evidence-based/informed strategy measure:

- Distribute modified 'Got Transition' materials to families of youth with special health care needs served through the CSH Program
    - # of *Got Transition* distributed to providers and consumers
- Train CSH nurses on how to conduct a transition readiness assessment
    - # of CSH clients assessed for transition readiness

In FY18 and FY19, the Transition Action Team will receive renewed focus as part of the Wyoming Adolescent and Young Adult Health (WAYAH) Collaborative Improvement and Innovation Network (CoIIN) team. In order for adolescent and young adult health care to be considered quality care, transition must be included. The Transition Action Team will review current evidence-based and evidence-informed resources from organizations such as *Got Transition* for their applicability to Wyoming populations. The team will include providers, youth, young adults, and their families. Various clinics across the state will work with the University of Michigan to implement techniques that assess knowledge and readiness of transition and encourage/support the transition process. Approved materials will be gathered into separate toolkits for providers and consumers. A dissemination and evaluation plan will be developed.

Cross-Cutting/Systems Building

Cross-Cutting/Systems Builiding - Annual Report

No content was entered for the Cross-Cutting/Systems Building - Annual Report in the State Action Plan Narrative by Domain section.

Cross-Cutting/Systems Building - Application Year

No content was entered for the Cross-Cutting/Systems Building - Application in the State Action Plan Narrative by Domain section.

III.F. Public Input

Public Input

Excerpts from the draft FY2019 application and FY2017 annual report were made available to the public via the Maternal and Child Health (MCH) Unit website in June 2018. The survey was shared with Parent Leadership Training Institute (PLTI) graduates and MCH Unit stakeholders, including program-specific advisory group members. The first 50 respondents will receive a $25 gift card if they choose to provide their contact information. The survey asks for general feedback on each National and State Performance Measure, about services/activities they were not aware of and services/activities that they know about but that were not included in the report, and about challenges and successes related to health in their community. The final two questions listed above were used in the 2015 needs assessment community meetings. Asking these questions of consumers and stakeholders will help ensure our needs assessment process is ongoing.

As of July 12, 2018, the MCH Unit received seven (7) survey responses, with respondents from five (5) of the 23 counties statewide. Approximately 77% of households who responded to the survey reported having women of childbearing age (15-44) and/or infants (ages 0-1) in their household, 55% reported having children (ages 1-11) in their household, and 50% reported having youth or young adults (aged 12-24) in their household.

Only one respondent reported that there are services/programs/activities listed in the Title V Block Grant that they were unaware of. 85% reported that they are willing to be contacted in the future to provide input on issues related to the health of Wyoming women, children, youth and families.

For each priority, opportunities for improvement in areas like program visibility and communication have been identified. The majority of comments received expressed some form of affirmation or support for the ongoing programs and services offered under MCH, and many offered anecdotal suggestions for additional improvement. The most common comment from respondents across all areas pointed to a need for greater community and stakeholder engagement. Many respondents expressed the need for MCH to conduct additional outreach in order to better inform the community regarding available services across all domains. The biggest barriers to health identified by respondents were affordability of care, transportation and access challenges due to rurality. There were also several respondents who indicated a need for greater community education on MCH priorities, and the impact of those issues on the health of our community.

In FY17, MCH worked with Lolina, Inc. who provided technical assistance to the MCH Unit related to improving community engagement strategies. The goal is to improve public input seeking strategies each year, including input from stakeholders and the general public. In FY17, we completed a collaboration survey of our partners and in FY18, we will work with Lolina Inc. to develop ways to receive more consumer feedback on the work of Title V. A summary of the collaboration survey follows:

To better understand how to improve communication, support partnership activities in all of its programs, and understand challenges faced by stakeholders, the MCH Unit created the MCH Collaboration Survey in late 2017. In early 2018, the survey was distributed to over 100 Wyoming partners, ranging from state and tribal public health to non-profits, hospitals, and private providers. The survey closed in spring 2018 with a response rate of 63%; representing input from sixty-six (n=66) stakeholders. Approximately one-third of respondents were internal partners (Wyoming Department of Health) while the remaining 65% represented external partnerships.

Areas of strength noted by respondents included MCH Unit's focus on population health (75%) and meaningful contribution to the MCH priority areas (70%). Participants also confirmed that MCH uses data to drive its decisions

(68%) and had a strong focus on health equity (60%). Opportunities for improvement primarily centered on improved communication skills including the dissemination of MCH priorities (49%), and how information was shared with community partners about activities, trainings, and events. The survey also measured strengths and weaknesses of MCH partnerships.

Finally, at the individual program level (Women and Infant Health; Child Health, Youth and Young Adult Health, CYSHCN; and MCH Epidemiology), stakeholders were asked to share their current level of involvement as compared to the level of desired involvement using six categories: no involvement, networking, cooperation, coordination, coalition, or collaboration. The difference between current and desired involvement was measured by category with most programs demonstrating a substantial increase at the level of collaboration.

In response to stakeholder feedback, the MCH Unit released its first quarterly newsletter in May 2018 highlighting program updates. A second newsletter will be distributed in August 2018.

III.G. Technical Assistance

Technical Assistance

The Maternal and Child Health (MCH) Unit met and discussed potential Technical Assistance (TA) needs. They include:

- **Children's Special Health (CSH) Program**:

  Update: *This TA request was submitted in 2017 but due to staffing turnover and staff leave, the MCH Unit has not been able to take advantage of opportunities offered by the MCH Workforce Development Center. However, the MCH Unit has increased partnership with many partners/organizations integral to the system of care serving children and youth with special health care needs in Wyoming. In addition, the MCH Unit met virtually with the Center for Medical Home Implementation to discuss options for care coordination training. Lastly, the CSH program is in the process of offering a CSH training web-series for Public Health Nurses.*

  The Children's Special Health (CSH) program in Wyoming has not changed for many years despite reductions in staff and budgets and a shift nationally away from direct services in favor of population-based, public health services. The program provides gap-filling financial assistance and care coordination to eligible families. There is currently no system-level activities occurring within this program despite efforts over the past couple years to adopt the Standards for Systems of Care for children and youth with special health care needs (CYSHCN). CSH Program leadership capacity is also limited. Currently, the CSH program does not have a dedicated program manager; the Title V Director assumes the CYSCHN Director responsibilities. Despite these facts, the program staffs three strong benefits and eligibility specialists who provide quality state-level care coordination. At the local level, Public Health Nurses (PHN) provides care coordination for CYSHCN; however, there has not been a formal training provided to these care coordinators for at least five years. At all levels, training gaps exist and the MCH Unit is requesting assistance from MCHB and/or other states to provide training and TA related to the Standards for Systems of Care for CYSHCN and their application in states comparable to Wyoming (e.g. rural and frontier).

- **Perinatal Quality Collaborative (PQC) Development**: The Women and Infant Health Program (WIHP) and MCH Epidemiology Program have increased hospital engagement and application of evidence-based practices with the implementation of 2016-2020 priorities. The implementation of the Levels of Care Assessment Tool (LOCATe) and subsequent quality improvement efforts (e.g. maternal patient safety bundles) have increased relationships and engagement with hospitals. Two staff also attended the November 2016 National Network of PQC launch meeting. The MCH Unit is interested in learning about how other states hire and/or contract with MCH clinical specialists or consultants to guide and advance perinatal quality work and other clinical quality topics. Currently, MCH does not staff a clinical specialist to guide these efforts. MCH is also interested in receiving TA related to possible funding sources for PQC work, as well as continued infrastructure building for a newly formed state PQC.

- **Provider engagement:** All MCH programs prioritize provider and consumer engagement in the promotion of 2016-2020 priorities. The MCH Unit is currently exploring virtual learning tools, including Project ECHO, to increase awareness and use of evidence-based practices throughout our provider communities including but not limited to primary care, family practice, pediatrics, obstetrics and gynecology, Indian Health Service (IHS), Federally Qualified Health Centers (FQHC), Title X, PHN, hospitals, midwifery, etc. The MCH Unit is also

hoping to improve consumer, family, and youth engagement especially as we look forward to the next needs assessment process. Potential topics discussed include EPSDT, youth and consumer engagement, genetics, etc. In Fall 2018, the Wyoming Public Health Association annual conference will feature MCH topic presentations. This is one strategy employed to build provider engagement around MCH state priority needs. TA on strategies used by other states are engaging providers in their work in meaningful and sustainable ways.

- **Maternal Mortality**
  Wyoming is in the early stages of building capacity for a maternal mortality review committee (MMRC), through ongoing work with the newly formed Wyoming PQC. The MCH Unit is supportive of a recently submitted Region VIII TA request which requests support for a Maternal Mortality Summit for Region VIII states. This TA request is needed in order to identify cross-state opportunities to leverage resources, to regionalize and strengthen the quality of the data, and to identify ways to use the data to drive public health recommendations to reduce maternal deaths. This support is needed because access to health care is not always determined by state lines; women may seek maternity care outside of their home state which presents both a shared responsibility and opportunity for collaboration between Region VIII states to prevent maternal deaths and improve maternal health. In cases of cross-border deaths, collaboration across states could have provided more information and a more comprehensive death review. Exploring opportunities to regionalize data would leverage resources across states and strengthen the quality of the data being used to drive public health recommendations to reduce maternal deaths. Also, because each state is in a different stage in the development and implementation of a MMRC process, there is the opportunity for peer learning to accelerate each other's work to stand-up and enhance MMRCs. A regional approach will help to ensure comparable data and processes, making it easier to identify regional opportunities for preventing maternal deaths and improving maternal health.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - MCH Intra agency agreement with Division of Healthcare Financing.pdf

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - 09-17-18 State of Wyoming Organizational Chart.pdf

Supporting Document #02 - 09-05-2018 WDH Org Chart.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - PHD Org Chart_May- June 2018 (final wo) 07-06-18.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Wyoming

	FY19 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 1,100,000	
A. Preventive and Primary Care for Children	$ 390,000	(35.4%)
B. Children with Special Health Care Needs	$ 345,000	(31.3%)
C. Title V Administrative Costs	$ 45,000	(4.1%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 780,000	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 1,736,286	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 639,305	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 2,375,591	
A. Your State's FY 1989 Maintenance of Effort Amount $ 2,375,591		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 3,475,591	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	$ 1,578,412	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 5,054,003	

OTHER FEDERAL FUNDS	FY19 Application Budgeted
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant	$ 12,602
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 232,498
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 114,369
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 101,602
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Temporary Assistance for Needy Families (TANF)	$ 1,117,341

	FY17 Annual Report Budgeted		FY17 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 1,125,000		$ 1,085,502	
A. Preventive and Primary Care for Children	$ 360,000	(32%)	$ 428,921	(39.5%)
B. Children with Special Health Care Needs	$ 360,000	(32%)	$ 401,471	(36.9%)
C. Title V Administrative Costs	$ 45,000	(4%)	$ 40,731	(3.8%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 765,000		$ 871,123	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 1,775,473		$ 1,867,148	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0		$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 600,119		$ 508,443	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0		$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 2,375,592		$ 2,375,591	
A. Your State's FY 1989 Maintenance of Effort Amount $ 2,375,591				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 3,500,592		$ 3,461,093	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$ 2,179,510		$ 1,534,364	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 5,680,102		$ 4,995,457	

OTHER FEDERAL FUNDS	FY17 Annual Report Budgeted	FY17 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Temporary Assistance for Needy Families (TANF)	$ 1,757,750	$ 1,024,467
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 128,539	$ 119,007
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 192,665	$ 262,468
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,556	$ 128,422

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**1. FEDERAL ALLOCATION**
	Fiscal Year:	**2019**
	Column Name:	**Application Budgeted**
	Field Note: Estimate based on prior year awards. Does not include direct assistance.	
2.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children**
	Fiscal Year:	**2019**
	Column Name:	**Application Budgeted**
	Field Note: FFVEN Phase including Child Health Program Manager salary/benefits and a portion of the Youth and Young Adult Health Program Manager salary/benefits. Funding for activities/programs for both programs including childhood injury prevention, Help Me Grow, physical activity promotion, etc.	
3.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs**
	Fiscal Year:	**2019**
	Column Name:	**Application Budgeted**
	Field Note: FFCSH Phase including Children's Special Health Benefits and Eligibility Specialists and .5 FTE of Newborn Screening and Genetics Coordinator salary/benefits. Funding for activities/programs such as genetics clinics, Parent Partner Project, and systems-building efforts to improve services for children and youth with special health care needs.	
4.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs**
	Fiscal Year:	**2019**
	Column Name:	**Application Budgeted**
	Field Note: FFADM Phase. Includes strategic planning consultant services.	
5.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2019**
	Column Name:	**Application Budgeted**

	Field Note: Includes SGF Epi funding, SGF funds provided to counties for provision of home visiting and CSH services, Immunization Prevnar funding, CSH payments to providers.	
6.	**Field Name:**	**5. OTHER FUNDS**
	Fiscal Year:	**2019**
	Column Name:	**Application Budgeted**
	Field Note: Newborn Screening T&A Account.	
7.	**Field Name:**	**7. TOTAL STATE MATCH**
	Fiscal Year:	**2019**
	Column Name:	**Application Budgeted**
	Field Note: Matches 1989 MOE requirement.	
8.	**Field Name:**	**1.FEDERAL ALLOCATION**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note: Federal phases FFCSH, FFVEN, FFADM, FFFMA. The entire FFY17 award was spent before September 30, 2018 as required.	
9.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children:**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note: Phases: FFVEN7 Includes Child Health personnel. ACES training support through Children's Trust Fund. GROW phone app support through WY Medicaid. PLTI contract and support. Communities that Care training for WY Coalition Against Domestic Violence and Sexual Assault. Safekids contract. Help Me Grow affiliate fee and contract costs. Wyoming Institute for Disabilities Vision Collaborative contract costs. The significant difference between budget and expended is accounted for by Vision Screening (UW WIND) and Help Me Grow costs being re-categorized as 'Preventive and Primary Care for Children' instead of 'Other' in WY's fiscal system.	
10.	**Field Name:**	**2. Subtotal of Lines 1A-C**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**

	Field Note: Excludes MCH Unit's FFFMA phases which cover predominantly Women and Infant Health program expenses.	
11.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs:**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note: Phases: FFCSH7 CSH Personnel. Support for high risk perinatal conference (Butterfield). Parent Partner project. Utah genetics clinics contract. CSH related travel/supplies.	
12.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note: Phases: FFADM7 Lolina contract for consultation/strategic planning. Travel for AMCHP and professional development. Supplies. Rent. Indirect costs.	
13.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note: As of 6/15/2018: MCH Epi and MCH SGF ($281,276) MCH/Home Visiting contracts with counties ($931,564) CSH expenses ($85,698) Immunizations Prevnar ($568,610)	
14.	**Field Name:**	**5. OTHER FUNDS**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note: Phases: TANBS7 Newborn screening funds which support contracts for lab services, courier services, and follow up for hemoglobinopathy, SCID, metabolic disorders.	
15.	**Field Name:**	**7. TOTAL STATE MATCH**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**

	Field Note: Matches 1989 MOE requirement.	
16.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Temporary Assistance for Needy Families (TANF)**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note: OTTAN7 Less than budgeted due to cuts from Department of Family Services, agency which provides TANF funding to MCH Unit for provision of MCH/home visiting services at county level.	
17.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note: FFPRM7	
18.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note: FFSVP7 FFSVC3 Includes carryover funding.	
19.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note: FFSSD7	

Data Alerts: None

Form 3a
Budget and Expenditure Details by Types of Individuals Served

State: Wyoming

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY19 Application Budgeted	FY17 Annual Report Expended
1. Pregnant Women	$ 160,000	$ 98,426
2. Infants < 1 year	$ 130,000	$ 111,171
3. Children 1 through 21 Years	$ 390,000	$ 428,921
4. CSHCN	$ 345,000	$ 401,471
5. All Others	$ 30,000	$ 4,782
Federal Total of Individuals Served	$ 1,055,000	$ 1,044,771

IB. Non-Federal MCH Block Grant	FY19 Application Budgeted	FY17 Annual Report Expended
1. Pregnant Women	$ 140,000	$ 129,697
2. Infants < 1 year	$ 1,800,000	$ 1,858,838
3. Children 1 through 21 Years	$ 140,000	$ 111,997
4. CSHCN	$ 210,000	$ 194,906
5. All Others	$ 85,591	$ 80,153
Non-Federal Total of Individuals Served	$ 2,375,591	$ 2,375,591
Federal State MCH Block Grant Partnership Total	$ 3,430,591	$ 3,420,362

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

1.	**Field Name:**	**IA. Federal MCH Block Grant, 1. Pregnant Women**
	Fiscal Year:	**2019**
	Column Name:	**Application Budgeted**
	Field Note: Related salary/benefits. PQC-related expenses including coordinator funding. Maternal Mortality Review capacity building expenses including possible coordinator funding. PQC QI mini-grants. Maternal smoking reduction activities (SCRIPT).	
2.	**Field Name:**	**IA. Federal MCH Block Grant, 2. Infant < 1 Year**
	Fiscal Year:	**2019**
	Column Name:	**Application Budgeted**
	Field Note: Related salary/benefits. Breastfeeding maintenance funding. Infant mortality reduction efforts including FIMR.	
3.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1 through 21 years**
	Fiscal Year:	**2019**
	Column Name:	**Application Budgeted**
	Field Note: Child Health and Youth and Young Adult Health Personnel. Activities related to child injury prevention, physical activity promotion, early childhood health promotion (e.g. Bright Futures, Help Me Grow, developmental screening activities), etc.	
4.	**Field Name:**	**IA. Federal MCH Block Grant, 4. CSHCN**
	Fiscal Year:	**2019**
	Column Name:	**Application Budgeted**
	Field Note: CSH Personnel. Genetics Clinics. Parent Partner. Addition of systems-building efforts for CSHCN.	
5.	**Field Name:**	**IA. Federal MCH Block Grant, 5. All Others**
	Fiscal Year:	**2019**
	Column Name:	**Application Budgeted**
	Field Note: Activities related to family planning and health/safe relationships in (older) adolescents priorities.	
6.	**Field Name:**	**IB. Non-Federal MCH Block Grant, 1. Pregnant Women**

	Fiscal Year:	**2019**
	Column Name:	**Application Budgeted**
	Field Note: SGF for Counties x Pregnant Women % + SGF Epi funding.	
7.	**Field Name:**	**IB. Non-Federal MCH Block Grant, 2. Infant < 1 Year**
	Fiscal Year:	**2019**
	Column Name:	**Application Budgeted**
	Field Note: Newborn Screening T&A funding. Immunizations Prevnar funding. SGF for Counties x Infant % + SGF Epi funding. FIMR support.	
8.	**Field Name:**	**IB. Non-Federal MCH Block Grant, 3. Children 1 through 21 years**
	Fiscal Year:	**2019**
	Column Name:	**Application Budgeted**
	Field Note: SGF for Counties x Children % + SGF Epi funding.	
9.	**Field Name:**	**IB. Non-Federal MCH Block Grant, 4. CSHCN**
	Fiscal Year:	**2019**
	Column Name:	**Application Budgeted**
	Field Note: SGF for Counties x CSHCN % + SGF Epi funding. CSH payments to covered providers for enrolled families.	
10.	**Field Name:**	**IB. Non-Federal MCH Block Grant, 5. All Others**
	Fiscal Year:	**2019**
	Column Name:	**Application Budgeted**
	Field Note: SGF for Counties x 'Others' % + SGF Epi funding.	
11.	**Field Name:**	**IA. Federal MCH Block Grant, 1. Pregnant Women**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note: .5FTE of Women and Infant Health Program Manager salary/benefits. Community Baby Shower expenditures. PQC-related expenditures (e.g. partner travel to AIM patient safety bundle event).	
12.	**Field Name:**	**IA. Federal MCH Block Grant, 2. Infant < 1 Year**

	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note:	
	.5FTE of Women and Infant Health Program Manager salary/benefits. Community Baby Shower expenditures. Breastfeeding mini-grants for hospitals. Certified Lactation Counselor scholarships for Public Health Nurses and community nurses. Fetal and Infant Mortality Review.	
13.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1 through 21 years**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note:	
	Phases: FFVEN7 Includes Child Health personnel. ACE Interface training support through Children's Trust Fund. GROW app support through WY Medicaid. PLTI contract and support. Communities that Care training for WY Coalition. Safekids contract. Help Me Grow. Vision Collaborative contract expenses.	
14.	**Field Name:**	**IA. Federal MCH Block Grant, 4. CSHCN**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note:	
	Phases: FFCSH7 CSH Personnel. Support for high risk perinatal conference (Butterfield). HMG membership. Parent Partner project. Utah genetics clinics contract. Minimal gap-filling financial assistance for CSH enrolled families.	
15.	**Field Name:**	**IA. Federal MCH Block Grant, 5. All Others**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note:	
	Expenses that do not directly impact a specific age group.	
16.	**Field Name:**	**IB. Non-Federal MCH Block Grant, 1. Pregnant Women**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note:	
	SGF for Counties x Pregnant Women % of 8.2% + SGF Epi funding (split evenly across programs they support).	
17.	**Field Name:**	**IB. Non-Federal MCH Block Grant, 2. Infant < 1 Year**
	Fiscal Year:	**2017**

	Column Name:	**Annual Report Expended**
	Field Note: Newborn Screening T&A funding. Immunizations Prevnar funding. SGF for Counties x Infant % of 69% + SGF Epi funding (split evenly across programs they support). FIMR Support.	
18.	**Field Name:**	**IB. Non-Federal MCH Block Grant, 3. Children 1 through 21 years**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note: SGF for Counties x Children % of 6.3% + SGF Epi funding (split evenly across programs they support).	
19.	**Field Name:**	**IB. Non-Federal MCH Block Grant, 4. CSHCN**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note: SGF for Counties x CSHCN % of 15.2% + SGF Epi funding (split evenly across programs they support). CSH payments to covered providers for enrolled families.	
20.	**Field Name:**	**IB. Non-Federal MCH Block Grant, 5. All Others**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note: SGF for Counties x 'Others' % of 1.3% + SGF Epi funding (split evenly across programs they support). Contraceptive funding.	

Data Alerts: None

Form 3b
Budget and Expenditure Details by Types of Services

State: Wyoming

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY19 Application Budgeted	FY17 Annual Report Expended
1. Direct Services	$ 58,000	$ 37,089
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 0	$ 0
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 58,000	$ 37,089
2. Enabling Services	$ 242,000	$ 176,324
3. Public Health Services and Systems	$ 800,000	$ 872,089
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 3,349
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 240
Laboratory Services		$ 0
Other		
Specialty genetics clinic		$ 33,500
Direct Services Line 4 Expended Total		$ 37,089
Federal Total	$ 1,100,000	$ 1,085,502

IIB. Non-Federal MCH Block Grant	FY19 Application Budgeted	FY17 Annual Report Expended
1. Direct Services	$ 70,591	$ 100,309
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 0	$ 14,611
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 70,591	$ 85,698
2. Enabling Services	$ 650,000	$ 577,570
3. Public Health Services and Systems	$ 1,655,000	$ 1,697,712
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 55,746
Physician/Office Services		$ 9,427
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 15,426
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 8,569
Laboratory Services		$ 0
Other		
Travel/Therapy		$ 11,141
Direct Services Line 4 Expended Total		$ 100,309
Non-Federal Total	$ 2,375,591	$ 2,375,591

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

1.	**Field Name:**	**IIA. Federal MCH Block Grant, 1. Direct Services**
	Fiscal Year:	**2019**
	Column Name:	**Application Budgeted**
	Field Note: Genetics clinics (now utilizing cost-effective telehealth methods)	
2.	**Field Name:**	**IIA. Federal MCH Block Grant, 1. A. Preventive and Primary Care Services for all Pregnant Women,Mothers, and Infants up to Age One**
	Fiscal Year:	**2019**
	Column Name:	**Application Budgeted**
	Field Note: Obstetrix payment for CSH/MHR/NBIC.	
3.	**Field Name:**	**IIA. Federal MCH Block Grant, 1. C. Services for CSHCN**
	Fiscal Year:	**2019**
	Column Name:	**Application Budgeted**
	Field Note: Genetics clinics (University of UT)	
4.	**Field Name:**	**IIA. Federal MCH Block Grant, 2. Enabling Services**
	Fiscal Year:	**2019**
	Column Name:	**Application Budgeted**
	Field Note: Child Injury Prevention expenditures, Help Me Grow, Parent Partner, Community Baby Showers, Breastfeeding Mini Grants, Certified Lactation Counselor training.	
5.	**Field Name:**	**IIA. Federal MCH Block Grant, 3. Public Health Services and Systems**
	Fiscal Year:	**2019**
	Column Name:	**Application Budgeted**
	Field Note: Personnel costs (Phases FFFMA, FFVEN, FFCSH) Lolina consultation/strategic planning, PLTI, Support services including travel and supplies, PQC and MMRC coordination and project related expenses.	
6.	**Field Name:**	**IIB. Non-Federal MCH Block Grant, 1. C. Services for CSHCN**

	Fiscal Year:	**2019**
	Column Name:	**Application Budgeted**
	Field Note: Provider payments for CSH program for enrolled families.	
7.	**Field Name:**	**IIB. Non-Federal MCH Block Grant, 2. Enabling Services**
	Fiscal Year:	**2019**
	Column Name:	**Application Budgeted**
	Field Note: SGF for Counties for MCH services (e.g. home visits, CSH care coordination)	
8.	**Field Name:**	**IIA. Federal MCH Block Grant, 1. C. Services for CSHCN**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note: Includes genetics clinics expenditures, payment to provider for CSH program, and purchase of special contact lens for CSH family.	
9.	**Field Name:**	**IIA. Federal MCH Block Grant, 2. Enabling Services**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note: Parent Partner Project. Safe Kids. Help Me Grow resource/referral/care coordination services. Breastfeeding mini-grants for hospitals. Support for community baby showers. Certified lactation counselor scholarships for Public Health Nurses. Difference between July and Sept submission due to improved reporting system.	
10.	**Field Name:**	**IIA. Federal MCH Block Grant, 3. Public Health Services and Systems**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note: Capacity/Infrastructure building expenditures including staff salary/benefits. Parent Leadership Training Institute. Affiliation Fee for Help Me Grow. Training for Communities that Care. Support for GROW App through WY Medicaid. Travel for MCH priority activities. Vision Screening/Education contract with Wyoming Institute for Disabilities. Support for MCH related conference. Difference between July and Sept submission due to improved reporting system.	
11.	**Field Name:**	**IIA. Federal MCH Block Grant, 4. Physician/Office Services**

	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note: payment to provider for CSH program	
12.	**Field Name:**	**IIA. Federal MCH Block Grant, 4. Durable Medical Equipment and Supplies.**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note: special contact lens for CSH enrolled family.	
13.	**Field Name:**	**IIB. Non-Federal MCH Block Grant, 1. Direct Services**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note: Contraceptive supply funding for counties with little to no Title X funding. CSH payments.	
14.	**Field Name:**	**IIB. Non-Federal MCH Block Grant, 1. A. Preventive and Primary Care Services for all Pregnant Women,Mothers, and Infants up to Age One**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note: Contraceptive supply funding for counties with little to no Title X funding.	
15.	**Field Name:**	**IIB. Non-Federal MCH Block Grant, 1. C. Services for CSHCN**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note: CSH expenses ($85,698)	
16.	**Field Name:**	**IIB. Non-Federal MCH Block Grant, 2. Enabling Services**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note: SGF for Counties x 62% (% of time spent on enabling activities, e.g. home visits)	
17.	**Field Name:**	**IIB. Non-Federal MCH Block Grant, 3. Public Health Services and Systems**

	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note: SGF for Counties x 38% (% of time spent on public health services/systems activities, e.g. MCH training). SGF Epi expenses. MCH and MCH Epi payroll. Supplies/travel.	
18.	**Field Name:**	**IIB. Non-Federal MCH Block Grant, 4. Pharmacy**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note: Contraceptives + CSH payments (x 48% estimate of pharmacy related costs)	
19.	**Field Name:**	**IIB. Non-Federal MCH Block Grant, 4. Physician/Office Services**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note: CSH payments total x 11% (estimate for physician related costs) = $9,427	
20.	**Field Name:**	**IIB. Non-Federal MCH Block Grant, 4. Hospital Charges (includes inpatient and outpatient services)**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note: CSH payments total x 18% (estimate for hospital related costs) = $15,426	
21.	**Field Name:**	**IIB. Non-Federal MCH Block Grant, 4. Durable Medical Equipment and Supplies**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note: CSH payments total x 19% (estimate for DME related costs) = $8,569	
22.	**Field Name:**	**IIA. - Other - Specialty genetics clinic**
	Fiscal Year:	**2019**
	Column Name:	**Annual Report Expended**
	Field Note: genetics clinics expenditures	

23.	**Field Name:**	**IIB. - Other - Travel/Therapy**
	Fiscal Year:	**2019**
	Column Name:	**Annual Report Expended**

Field Note:
CSH payments total x 13% (estimate for travel/therapy related costs) = $

Form 4
Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: Wyoming

Total Births by Occurrence: 6,273 **Data Source Year: 2017**

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Screen	(B) Aggregate Total Number Presumptive Positive Screens	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	6,135 (97.8%)	6	6	6 (100.0%)

Program Name(s)				
Argininosuccinic aciduria	Citrullinemia, type I	Homocystinuria	Maple syrup urine disease	Classic phenylketonuria
Tyrosinemia, type I	Congenital adrenal hyperplasia	Primary congenital hypothyroidism	Carnitine uptake defect/carnitine transport defect	Long-chain L-3 hydroxyacyl-CoA dehydrogenase deficiency
Very long-chain acyl-CoA dehydrogenase deficiency	Medium-chain acyl-CoA dehydrogenase deficiency	Trifunctional protein deficiency	S, ßeta-Thalassemia	S,S disease (Sickle cell anemia)
S,C disease	3-Hydroxy-3-methyglutaric aciduria	3-Methylcrotonyl-CoA carboxylase deficiency	Biotinidase deficiency	ß-Ketothiolase deficiency
Glutaric acidemia type I	Isovaleric acidemia	Propionic acidemia	Cystic fibrosis	Severe combined immunodeficiences
Classic galactosemia	Methylmalonic acidemia (methylmalonyl-CoA mutase)	Methylmalonic acidemia (cobalamin disorders)		

2. Other Newborn Screening Tests

None

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

Wyoming does not have the capacity to conduct long term follow-up.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

1.	**Field Name:**	**Data Source Year**
	Fiscal Year:	**2017**
	Column Name:	**Data Source Year Notes**
	Field Note: Wyoming Vital Statistics Services	

Data Alerts: None

Form 5a
Count of Individuals Served by Title V

State: Wyoming

Annual Report Year 2017

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	1,227	33.6	0.0	59.3	7.1	0.0
2. Infants < 1 Year of Age	2,294	34.6	0.0	58.4	7.0	0.0
3. Children 1 through 21 Years of Age	1,080	57.5	2.8	22.7	13.0	4.0
3a. Children with Special Health Care Needs	845	65.1	3.6	11.6	14.6	5.1
4. Others	2,913	9.3	0.0	79.3	11.4	0.0
Total	7,514					

Form Notes for Form 5a:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2017**
	Field Note: Wyoming Title V serves pregnant women through the maternal high risk program (16) and through home visiting services (1211). Insurance coverage for women in the maternal high risk program is based on programmatic information. Coverage for women receiving prenatal home visiting services is based on Wyoming coverage for pregnant women.	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2017**
	Field Note: Wyoming Title V serves infants through the Newborn Intensive Care Program (66) and postpartum home visitation (2228). Insurance coverage for NBIC is based on programmatic information. Coverage for infants in home visitation is based on estimates for Wyoming infants.	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2017**
	Field Note: Wyoming Title V serves Children through genetics clinics (41) and family home visitation services (194). Coverage information for genetics comes from programmatic data. Estimates for primary coverage type for home visitation services are based on Wyoming insurance coverage for children.	
4.	**Field Name:**	**Children with Special Health Care Needs**
	Fiscal Year:	**2017**
	Field Note: Wyoming Title V serves Children with Special Health Care Needs through the Children's Special Health Program (605) and the Parent Partner Program (240). Insurance coverage information comes from programmatic data.	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2017**
	Field Note: Wyoming Title V serves parents through home visiting serves both when their children are infants (2473) and when they are older (240) and through the Parent Partner Program (200). Estimation for coverage type for home visiting services are based on the Wyoming data for adults aged 22 and older.	

Data Alerts: None

Form 5b
Total Percentage of Populations Served by Title V

State: Wyoming

Annual Report Year 2017

Populations Served by Title V	Total % Served
1. Pregnant Women	100
2. Infants < 1 Year of Age	100
3. Children 1 through 21 Years of Age	20
3a. Children with Special Health Care Needs	22
4. Others	3

Form Notes for Form 5b:

None

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women**
	Fiscal Year:	**2017**
	Field Note: Title V activities reach all pregnant women in the state. Women are reached through the following example activities: Perinatal home visitation (all 23 counties) Infrastructure building for maternal mortality review and perinatal quality collaborative Breastfeeding grants to hospitals (4 hospitals) Certified Lactation Consultant training for nurses (21 counties) Hospitals participation in the AIM initiative to reduce maternal morbidity (4 hospitals) Development of pregnant women Quitline materials Infrastructure building for immediate postpartum long acting reversible contraception (1 hospital)	
2.	**Field Name:**	**Infants Less Than One Year**
	Fiscal Year:	**2017**
	Field Note: Title V activities reach all infants in the state. Infants are reached through the following example activities: Postpartum and family home visitation (all 23 counties) Parent Partner Program Fetal and Infant Mortality Review (FIMR) (1 county) Breastfeeding mini-grants (4 hospitals) Community baby showers Infrastructure/systems building through Help Me Grow	
3.	**Field Name:**	**Children 1 Through 21 Years of Age**
	Fiscal Year:	**2017**
	Field Note: Title V activities reach all children in the state. Children (and adolescents) are reached through the following example activities: Postpartum and family home visitation (all 23 counties) Parent Partner Program Genetics clinics Help Me Grow Safe Kids Vision Screening/Education RPE program Adolescent Clinics PREP	
4.	**Field Name:**	**Children With Special Health Care Needs**
	Fiscal Year:	**2017**

Field Note:
Title V reaches Children with Special Health Care Needs specifically through the following programs:
Children's Special Health Program (all 23 counties)
Parent Partner Program (4 clinics)

Additionally, CSHCN are reached through programs serving all children. We therefore calculated the percentage of CSHCN served by using the following formula:
[(5B Percent of Children Served x CSHCN) + 5A CSHCN x (1 - 5B Percent of Children Served)] ÷ CSHCN

Population-based services + Direct/enabling only

5.	**Field Name:**	**Others**
	Fiscal Year:	**2017**

Field Note:
Title V reaches other individuals through the following programs:
Postpartum and family home visitation (all 23 counties)
Parent Partner Program (4 clinics)
Preconception Health Provider Training (1 county)
Parent Leadership Training Institute (1 county)
Wyoming College Campus Consortium (University of Wyoming)

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Wyoming

Annual Report Year 2017

I. Unduplicated Count by Race/Ethnicity

	(A) Total	(B) Non-Hispanic White	(C) Non-Hispanic Black or African American	(D) Hispanic	(E) Non-Hispanic American Indian or Native Alaskan	(F) Non-Hispanic Asian	(G) Non-Hispanic Native Hawaiian or Other Pacific Islander	(H) Non-Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	6,273	4,913	39	833	203	78	2	146	59
Title V Served	1,227	0	0	0	0	0	0	0	1,227
Eligible for Title XIX	2,197	1,450	21	446	167	15	3	66	29
2. Total Infants in State	7,311	5,862	178	1,015	237	19	0	0	0
Title V Served	2,294	0	0	0	0	0	0	0	2,294
Eligible for Title XIX	0	0	0	0	0	0	0	0	0

Form Notes for Form 6:

None

Field Level Notes for Form 6:

1.	**Field Name:**	**1. Total Deliveries in State**
	Fiscal Year:	**2017**
	Column Name:	**Total**
	Field Note: 2017 Vital Statistics Services	
2.	**Field Name:**	**1. Title V Served**
	Fiscal Year:	**2017**
	Column Name:	**Total**
	Field Note: This represents the number of of women that were served through Healthy Baby Home Visitation and the Maternal High Risk program. Data on race and ethnicity are not reliably collected. However, a new data system is currently being implemented which should enable this in future reporting years.	
3.	**Field Name:**	**1. Eligible for Title XIX**
	Fiscal Year:	**2017**
	Column Name:	**Total**
	Field Note: Data are from the 2016 Wyoming Birth Certificates. Medicaid eligibility is determined by payment source indicated on the birth record.	
4.	**Field Name:**	**2. Total Infants in State**
	Fiscal Year:	**2017**
	Column Name:	**Total**
	Field Note: CDC Wonder	
5.	**Field Name:**	**2. Title V Served**
	Fiscal Year:	**2017**
	Column Name:	**Total**
	Field Note: This represents the number of infants served through the Newborn Intensive Care Program and the Best Beginnings Home Visitation Program. Data on race and ethnicity are not reliably collected. However, a new data system is currently being implemented which should enable this in future reporting years.	

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: Wyoming

A. State MCH Toll-Free Telephone Lines	2019 Application Year	2017 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 438-5795	(800) 438-5795
2. State MCH Toll-Free "Hotline" Name	Maternal and Family Health	Maternal and Family Health
3. Name of Contact Person for State MCH "Hotline"	Danielle Marks	Danielle Marks
4. Contact Person's Telephone Number	(307) 777-6326	(307) 777-6326
5. Number of Calls Received on the State MCH "Hotline"		208

B. Other Appropriate Methods	2019 Application Year	2017 Annual Report Year
1. Other Toll-Free "Hotline" Names		
2. Number of Calls on Other Toll-Free "Hotlines"		
3. State Title V Program Website Address	https://health.wyo.gov/publichealth/mch/	https://health.wyo.gov/publichealth/mch/
4. Number of Hits to the State Title V Program Website		2,847
5. State Title V Social Media Websites		
6. Number of Hits to the State Title V Program Social Media Websites		

Form Notes for Form 7:

None

Form 8
State MCH and CSHCN Directors Contact Information

State: Wyoming

1. Title V Maternal and Child Health (MCH) Director	
Name	Danielle Marks
Title	Maternal and Child Health Unit Manager/Title V and CSCHN Director
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2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Danielle Marks
Title	Maternal and Child Health Unit Manager/Title V and CSCHN Director
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3. State Family or Youth Leader (Optional)	
Name	
Title	
Address 1	
Address 2	
City/State/Zip	
Telephone	
Extension	
Email	

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: Wyoming

Application Year 2019

No.	Priority Need
1.	Prevent Infant Mortality
2.	Improve breastfeeding duration
3.	Improve access to and promote use of effective family planning
4.	Reduce and prevent childhood obesity
5.	Promote preventive and quality care for children and adolescents
6.	Promote healthy and safe relationships in adolescents
7.	Prevent injury in children

Form 9 State Priorities-Needs Assessment Year - Application Year 2016

No.	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure
1.	Prevent Infant Mortality	New	
2.	Improve breastfeeding duration	Continued	
3.	Improve access to and promote use of effective family planning	New	
4.	Reduce and prevent childhood obesity	New	
5.	Promote preventive and quality care for children and adolescents	New	
6.	Promote healthy and safe relationships in adolescents	New	
7.	Prevent injury in children	Continued	

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 10a
National Outcome Measures (NOMs)

State: Wyoming

Form Notes for Form 10a NPMs, NOMs, SPMs, SOMs, and ESMs.

The data from 2015 represents only 75% of the year due to the change from ICD-9 to ICD-10 coding in October 2015.

NOM 1 - Percent of pregnant women who receive prenatal care beginning in the first trimester

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	77.8 %	0.5 %	5,678	7,301
2015	77.6 %	0.5 %	5,912	7,622
2014	75.4 %	0.5 %	5,578	7,396
2013	72.0 %	0.5 %	5,452	7,571
2012	73.9 %	0.5 %	5,554	7,516
2011	74.4 %	0.5 %	5,477	7,360
2010	75.4 %	0.5 %	5,630	7,468
2009	73.9 %	0.5 %	5,682	7,691

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 1 - Notes:

None

Data Alerts: None

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	107.9	14.8	54	5,003
2014	109.4	12.5	78	7,131
2013	87.3	11.0	63	7,218
2012	114.0	12.7	82	7,196
2011	93.4	11.5	67	7,175
2010	89.6	11.2	65	7,257
2009	103.4	11.7	79	7,643
2008	81.3	10.5	61	7,502

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 2 - Notes:

None

Data Alerts: None

NOM 3 - Maternal mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012_2016	26.3 ϟ	8.3 ϟ	10 ϟ	38,063 ϟ
2011_2015	NR ⚑	NR ⚑	NR ⚑	NR ⚑
2010_2014	NR ⚑	NR ⚑	NR ⚑	NR ⚑
2009_2013	NR ⚑	NR ⚑	NR ⚑	NR ⚑
2008_2012	NR ⚑	NR ⚑	NR ⚑	NR ⚑
2007_2011	NR ⚑	NR ⚑	NR ⚑	NR ⚑
2006_2010	28.2 ϟ	8.5 ϟ	11 ϟ	39,040 ϟ
2005_2009	33.6 ϟ	9.3 ϟ	13 ϟ	38,723 ϟ

Legends:

⚑ Indicator has a numerator <10 and is not reportable

ϟ Indicator has a numerator <20 and should be interpreted with caution

NOM 3 - Notes:

None

Data Alerts: None

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	8.5 %	0.3 %	628	7,380
2015	8.6 %	0.3 %	666	7,759
2014	9.2 %	0.3 %	704	7,687
2013	8.6 %	0.3 %	660	7,636
2012	8.5 %	0.3 %	645	7,565
2011	8.1 %	0.3 %	600	7,393
2010	9.0 %	0.3 %	679	7,552
2009	8.4 %	0.3 %	661	7,873

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 4 - Notes:

None

Data Alerts: None

NOM 5 - Percent of preterm births (<37 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	9.5 %	0.3 %	700	7,385
2015	9.8 %	0.3 %	762	7,764
2014	11.2 %	0.4 %	863	7,691
2013	10.4 %	0.4 %	792	7,643
2012	9.1 %	0.3 %	685	7,571
2011	9.9 %	0.4 %	731	7,398
2010	10.5 %	0.4 %	794	7,556
2009	9.9 %	0.3 %	780	7,851

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 5 - Notes:

None

Data Alerts: None

NOM 6 - Percent of early term births (37, 38 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	25.4 %	0.5 %	1,878	7,385
2015	25.6 %	0.5 %	1,988	7,764
2014	25.6 %	0.5 %	1,965	7,691
2013	25.5 %	0.5 %	1,945	7,643
2012	27.6 %	0.5 %	2,087	7,571
2011	27.8 %	0.5 %	2,058	7,398
2010	29.8 %	0.5 %	2,254	7,556
2009	30.9 %	0.5 %	2,429	7,851

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 6 - Notes:

None

Data Alerts: None

NOM 7 - Percent of non-medically indicated early elective deliveries

Data Source: CMS Hospital Compare

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016/Q2-2017/Q1	1.0 %			
2015/Q2-2016/Q1	5.0 %			
2015/Q1-2015/Q4	4.0 %			
2014/Q4-2015/Q3	4.0 %			
2014/Q3-2015/Q2	6.0 %			
2014/Q2-2015/Q1	6.0 %			
2014/Q1-2014/Q4	6.0 %			
2013/Q4-2014/Q3	6.0 %			
2013/Q3-2014/Q2	5.0 %			
2013/Q2-2014/Q1	6.0 %			

Legends:

Indicator results were based on a shorter time period than required for reporting

NOM 7 - Notes:

None

Data Alerts: None

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	5.5	0.8	43	7,787
2014	6.6	0.9	51	7,713
2013	4.6	0.8	35	7,662
2012	5.4	0.9	41	7,591
2011	6.5	0.9	48	7,424
2010	5.9	0.9	45	7,578
2009	6.5	0.9	51	7,909

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 8 - Notes:

None

Data Alerts: None

NOM 9.1 - Infant mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	4.9	0.8	38	7,765
2014	6.4	0.9	49	7,696
2013	4.8	0.8	37	7,644
2012	5.6	0.9	42	7,572
2011	6.6	1.0	49	7,399
2010	6.9	1.0	52	7,556
2009	6.0	0.9	47	7,881

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.1 - Notes:

None

Data Alerts: None

NOM 9.2 - Neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	3.1	0.6	24	7,765
2014	5.2	0.8	40	7,696
2013	3.0	0.6	23	7,644
2012	3.4	0.7	26	7,572
2011	4.1	0.7	30	7,399
2010	4.1	0.7	31	7,556
2009	3.7	0.7	29	7,881

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.2 - Notes:

None

Data Alerts: None

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	1.8	0.5	14	7,765
2014	NR	NR	NR	NR
2013	1.8	0.5	14	7,644
2012	2.1	0.5	16	7,572
2011	2.6	0.6	19	7,399
2010	2.8	0.6	21	7,556
2009	2.3	0.5	18	7,881

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.3 - Notes:

None

Data Alerts: None

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	167.4	46.5	13	7,765
2014	155.9	45.1	12	7,696
2013	143.9	43.4	11	7,644
2012	184.9	49.5	14	7,572
2011	NR	NR	NR	NR
2010	198.5	51.3	15	7,556
2009	177.6	47.5	14	7,881

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.4 - Notes:

None

Data Alerts: None

NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	NR	NR	NR	NR
2014	NR	NR	NR	NR
2013	NR	NR	NR	NR
2012	NR	NR	NR	NR
2011	NR	NR	NR	NR
2010	NR	NR	NR	NR
2009	165.0	45.8	13	7,881

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.5 - Notes:

None

Data Alerts: None

NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	6.2 %	1.2 %	460	7,374
2014	6.2 %	1.1 %	465	7,519
2013	4.9 %	1.0 %	362	7,343
2012	6.9 %	1.3 %	511	7,368
2011	5.5 %	1.0 %	396	7,164
2010	4.9 %	0.8 %	361	7,311
2009	6.6 %	1.1 %	503	7,622
2008	5.3 %	0.8 %	409	7,762
2007	6.5 %	0.9 %	491	7,579

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 10 - Notes:

None

Data Alerts: None

NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	3.3 ϟ	0.8 ϟ	17 ϟ	5,089 ϟ
2014	4.2	0.8	28	6,670
2013	2.5 ϟ	0.6 ϟ	17 ϟ	6,726 ϟ
2012	3.5	0.7	24	6,784
2011	NR ⚑	NR ⚑	NR ⚑	NR ⚑
2010	NR ⚑	NR ⚑	NR ⚑	NR ⚑
2009	NR ⚑	NR ⚑	NR ⚑	NR ⚑
2008	NR ⚑	NR ⚑	NR ⚑	NR ⚑

Legends:

⚑ Indicator has a numerator ≤10 and is not reportable

ϟ Indicator has a numerator <20 and should be interpreted with caution

NOM 11 - Notes:

None

Data Alerts: None

NOM 12 - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

FAD Not Available for this measure.

NOM 12 - Notes:

None

Data Alerts: None

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

FAD Not Available for this measure.

NOM 13 - Notes:

None

Data Alerts: None

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	11.7 %	1.6 %	15,341	130,633

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 14 - Notes:

None

Data Alerts: None

NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	19.7	5.3	14	70,988
2015	28.0	6.3	20	71,467
2014	22.6	5.7	16	70,803
2013	22.6	5.6	16	70,960
2012	24.3	5.9	17	70,037
2011	21.5	5.6	15	69,796
2010	17.2	5.0	12	69,630
2009	23.4	5.8	16	68,449

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 15 - Notes:

None

Data Alerts: None

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	43.8	7.6	33	75,332
2015	45.9	7.9	34	74,053
2014	41.5	7.5	31	74,698
2013	41.5	7.5	31	74,696
2012	32.6	6.7	24	73,556
2011	60.0	9.1	44	73,287
2010	45.9	7.9	34	74,097
2009	66.8	9.5	50	74,834

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.1 - Notes:

None

Data Alerts: None

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014_2016	20.8	4.3	23	110,845
2013_2015	22.4	4.5	25	111,820
2012_2014	19.5	4.2	22	112,773
2011_2013	25.8	4.8	29	112,344
2010_2012	24.0	4.6	27	112,581
2009_2011	34.1	5.5	39	114,373
2008_2010	30.2	5.1	35	116,043
2007_2009	37.8	5.7	44	116,541

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.2 - Notes:

None

Data Alerts: None

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014_2016	28.9	5.1	32	110,845
2013_2015	30.4	5.2	34	111,820
2012_2014	22.2	4.4	25	112,773
2011_2013	20.5	4.3	23	112,344
2010_2012	20.4	4.3	23	112,581
2009_2011	22.7	4.5	26	114,373
2008_2010	20.7	4.2	24	116,043
2007_2009	18.0	3.9	21	116,541

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.3 - Notes:

None

Data Alerts: None

NOM 17.1 - Percent of children with special health care needs (CSHCN), ages 0 through 17

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	20.3 %	1.9 %	28,106	138,601

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.1 - Notes:

None

Data Alerts: None

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	21.5 %	4.9 %	6,048	28,106

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	1.9 %	0.6 %	2,108	113,581

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.3 - Notes:

None

Data Alerts: None

NOM 17.4 - Percent of children, ages 3 through 17, diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	8.6 %	1.4 %	9,720	113,392

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.4 - Notes:

None

Data Alerts: None

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	68.5 %	6.4 %	11,415	16,676

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 18 - Notes:

None

Data Alerts: None

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	90.2 %	1.5 %	124,790	138,423

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 19 - Notes:

None

Data Alerts: None

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	9.9 %	0.5 %	368	3,731
2012	10.6 %	0.5 %	445	4,198
2010	11.8 %	0.5 %	521	4,413
2008	10.5 %	0.5 %	367	3,494

Legends:

Indicator has a denominator <50 or a relative standard error ≥30% and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	11.0 %	0.8 %		
2013	10.7 %	0.7 %		
2011	11.1 %	0.7 %		
2009	9.7 %	0.6 %		
2007	9.2 %	0.7 %		
2005	8.3 %	0.6 %		

Legends:

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	12.9 %	2.4 %	6,705	52,131

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children, ages 0 through 17, without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	7.6 %	1.3 %	10,653	140,140
2015	6.3 %	1.0 %	8,713	139,430
2014	6.7 %	1.1 %	9,200	137,343
2013	6.3 %	0.9 %	8,827	140,268
2012	9.9 %	1.2 %	13,426	136,250
2011	8.8 %	1.3 %	11,773	134,617
2010	7.3 %	1.1 %	10,014	136,499
2009	9.0 %	1.6 %	11,586	129,393

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 21 - Notes:

None

Data Alerts: None

NOM 22.1 - Percent of children, ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3*:3:1:4)

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	62.8 %	3.5 %	6,450	10,264
2015	73.3 %	3.6 %	7,484	10,205
2014	64.0 %	4.7 %	6,859	10,724
2013	70.0 %	3.9 %	7,386	10,551
2012	67.2 %	3.5 %	7,710	11,473
2011	59.1 %	4.9 %	6,858	11,595
2010	52.0 %	4.0 %	6,097	11,726
2009	43.6 %	3.5 %	4,776	10,961

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.1 - Notes:

None

Data Alerts: None

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

Data Source: National Immunization Survey (NIS) – Flu

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2017	43.1 %	2.3 %	56,675	131,650
2015_2016	41.7 %	2.3 %	53,885	129,220
2014_2015	45.6 %	2.2 %	59,103	129,498
2013_2014	42.1 %	2.5 %	53,704	127,561
2012_2013	46.0 %	3.0 %	58,498	127,308
2011_2012	45.2 %	3.4 %	55,904	123,614
2010_2011	49.0 %	5.5 %	60,314	123,090
2009_2010	44.1 %	2.7 %	55,091	124,923

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.2 - Notes:

None

Data Alerts: None

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

Data Source: National Immunization Survey (NIS) - Teen (Female)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	50.4 %	4.6 %	8,803	17,473
2015	47.7 %	4.9 %	8,283	17,356
2014	50.3 %	4.2 %	8,945	17,799
2013	54.3 %	4.8 %	9,664	17,795
2012	53.9 %	5.1 %	9,544	17,714
2011	60.9 %	5.4 %	10,760	17,666
2010	53.2 %	4.6 %	9,341	17,575
2009	43.6 %	4.1 %	7,539	17,287

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

Data Source: National Immunization Survey (NIS) - Teen (Male)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	36.9 %	4.1 %	6,869	18,611
2015	37.1 %	4.5 %	6,915	18,654
2014	29.3 %	3.8 %	5,553	18,945
2013	16.6 %	3.1 %	3,160	18,985
2012	11.2 %	2.5 %	2,106	18,798
2011	NR	NR	NR	NR

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.3 - Notes:

None

Data Alerts: None

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	86.7 %	2.3 %	31,286	36,083
2015	87.9 %	2.1 %	31,647	36,011
2014	89.1 %	1.8 %	32,738	36,744
2013	92.3 %	1.5 %	33,957	36,780
2012	85.4 %	2.5 %	31,167	36,512
2011	86.2 %	2.5 %	31,319	36,319
2010	65.0 %	3.2 %	23,566	36,267
2009	48.2 %	3.0 %	17,231	35,752

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.4 - Notes:

None

Data Alerts: None

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	54.2 %	3.1 %	19,549	36,083
2015	58.7 %	3.3 %	21,130	36,011
2014	55.6 %	2.9 %	20,431	36,744
2013	63.1 %	3.2 %	23,216	36,780
2012	59.1 %	3.4 %	21,559	36,512
2011	60.8 %	4.1 %	22,068	36,319
2010	51.5 %	3.3 %	18,667	36,267
2009	47.8 %	3.0 %	17,074	35,752

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.5 - Notes:

None

Data Alerts: None

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	26.1	1.2	463	17,711
2015	28.8	1.3	510	17,682
2014	30.5	1.3	545	17,858
2013	29.8	1.3	540	18,135
2012	34.8	1.4	622	17,855
2011	35.2	1.4	625	17,753
2010	39.5	1.5	723	18,328
2009	43.4	1.5	814	18,773

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 23 - Notes:

None

Data Alerts: None

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	11.5 %	1.6 %	850	7,374
2014	13.6 %	1.6 %	1,017	7,503
2013	11.9 %	1.6 %	868	7,319
2012	13.8 %	1.8 %	1,018	7,360

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% and should be interpreted with caution

NOM 24 - Notes:

None

Data Alerts: None

NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	3.0 %	1.0 %	4,142	138,417

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 25 - Notes:

None

Data Alerts: None

Form 10a
National Performance Measures (NPMs)

State: Wyoming

NPM 4A - Percent of infants who are ever breastfed

Federally Available Data		
Data Source: National Immunization Survey (NIS)		
	2016	**2017**
Annual Objective	90	92
Annual Indicator	89.7	88.3
Numerator	5,817	5,853
Denominator	6,486	6,628
Data Source	NIS	NIS
Data Source Year	2013	2014

State Provided Data		
	2016	**2017**
Annual Objective	90	92
Annual Indicator	91	90.7
Numerator		
Denominator		
Data Source	PRAMS	PRAMS
Data Source Year	2014	2016
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	93.0	93.0	93.0	93.0	93.0	93.0

Field Level Notes for Form 10a NPMs:

None

NPM 4B - Percent of infants breastfed exclusively through 6 months

Federally Available Data		
Data Source: National Immunization Survey (NIS)		
	2016	**2017**
Annual Objective	26	29
Annual Indicator	27.0	32.0
Numerator	1,693	2,049
Denominator	6,263	6,412
Data Source	NIS	NIS
Data Source Year	2013	2014

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	32.0	32.0	34.0	34.0	35.0	35.0

Field Level Notes for Form 10a NPMs:

None

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH)		
	2016	**2017**
Annual Objective		
Annual Indicator		27.6
Numerator		4,900
Denominator		17,751
Data Source		NSCH
Data Source Year		2016

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	29.0	29.0	32.0	32.0	34.0	34.0

Field Level Notes for Form 10a NPMs:

None

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH)		
	2016	**2017**
Annual Objective		
Annual Indicator		75.7
Numerator		34,569
Denominator		45,669
Data Source		NSCH
Data Source Year		2016

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	76.0	76.0	78.0	78.0	80.0	80.0

Field Level Notes for Form 10a NPMs:

None

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care - Children with Special Health Care Needs

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - CSHCN		
	2016	**2017**
Annual Objective		
Annual Indicator		17.9
Numerator		2,073
Denominator		11,609
Data Source		NSCH-CSHCN
Data Source Year		2016

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	19.0	19.0	21.0	21.0	23.0	23.0

Field Level Notes for Form 10a NPMs:

None

NPM 14.1 - Percent of women who smoke during pregnancy

Federally Available Data		
Data Source: National Vital Statistics System (NVSS)		
	2016	**2017**
Annual Objective	15	14
Annual Indicator	15.2	14.6
Numerator	1,148	1,043
Denominator	7,540	7,152
Data Source	NVSS	NVSS
Data Source Year	2015	2016

State Provided Data		
	2016	**2017**
Annual Objective	15	14
Annual Indicator	13.5	11.2
Numerator		
Denominator		
Data Source	PRAMS	PRAMS
Data Source Year	2015	2016
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	14.0	13.5	13.0	12.5	12.0	11.5

Field Level Notes for Form 10a NPMs:

None

Form 10a
State Performance Measures (SPMs)

State: Wyoming

SPM 1 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		54
Annual Indicator	51.9	68
Numerator	42	68
Denominator	81	100
Data Source	Wyoming Vital Statistics Services	Wyoming Vital Statistics Services
Data Source Year	2015	2016
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	70.0	71.0	72.0	73.0	74.0	75.0

Field Level Notes for Form 10a SPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: Wyoming does not have a Level III NICU in state, nor does it have access currently to LOCATe results from surrounding states where Wyoming residents deliver. Assessment of a hospitals Level III status is based on the hospital's claims on their website.	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Wyoming does not have a Level III NICU in state, nor does it have access currently to LOCATe results from surrounding states where Wyoming residents deliver. Assessment of a hospitals Level III status is based on the hospital's claims on their website.	

SPM 2 - Rate of hospitalization for non-fatal injury per 100,000 children ages 1 through 11

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		20
Annual Indicator	25.3	32.2
Numerator	22	28
Denominator	86,903	86,855
Data Source	Wyoming Hospital Discharge Data	Wyoming Hospital Discharge Data
Data Source Year	FY 2015	CY 2016
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	30.0	30.0	29.0	29.0	28.0	28.0

Field Level Notes for Form 10a SPMs:

1. **Field Name:** **2017**

Column Name: **State Provided Data**

Field Note:
We changed to reporting calendar year so that all codes would be in ICD-10 for the reporting year. Since the transition to ICD-10, Wyoming has seen a significant decrease in the use of external cause codes. Though it does not affect our ability to calculated the overall injury hospitalization rate, it does impact the state's ability to further investigate the causes of injury. Due to the change from ICD-9 to ICD-10 coding the two numbers are not comparable.

SPM 3 - Number of Wyoming birthing hospitals billing Medicaid for immediate postpartum LARCs

Measure Status:	Inactive - Replaced

State Provided Data		
	2016	2017
Annual Objective		2
Annual Indicator	0	1
Numerator		
Denominator		
Data Source	Medicaid Billing Data	Medicaid Billing Data
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Field Level Notes for Form 10a SPMs:

None

SPM 4 - Percentage of teens reporting 0 occasions of alcohol use in the past 30 days

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		70
Annual Indicator	68.4	68.4
Numerator		
Denominator		
Data Source	Prevention Needs Assessment	Prevention Needs Assessment
Data Source Year	2016	2016
Provisional or Final ?	Provisional	Provisional

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	70.0	70.0	72.0	72.0	74.0	74.0

Field Level Notes for Form 10a SPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: On how many occasions (if any) have you had beer, wine, sweetened, or hard liquor to drink during the past 30 days? Restricted to 10th and 12th grades, 'zero occasions' From the 2016 Prevention Needs Assessment	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: The Prevention Needs Assessment is completed only in even years.	

SPM 5 - Percent of children (6-11 years) who are physically active at least 60 minutes per day.

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	32.0	34.0	35.0	36.0	38.0

Field Level Notes for Form 10a SPMs:

1.	**Field Name:**	**2019**
	Column Name:	**Annual Objective**

Field Note:
In 2016, 29.3% of Wyoming children aged 6-11 were physically active everyday for 60 minutes or more. We expect a gradual increase in the rate.

SPM 6 - Use of most/moderately effective contraception by postpartum women

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	66.0	68.0	70.0	71.0	72.0

Field Level Notes for Form 10a SPMs:

1.	**Field Name:**	**2019**
	Column Name:	**Annual Objective**

Field Note:
65.8% of Wyoming mothers in 2016 reported using most/moderately effective contraceptive methods in the postpartum period. We aim to see a 10% increase in use over the next five years to bring us to 72%

Form 10a
Evidence-Based or –Informed Strategy Measures (ESMs)

State: Wyoming

ESM 4.1 - Mini-grant program structure developed

Measure Status:	Inactive - Completed

State Provided Data		
	2016	2017
Annual Objective		Yes
Annual Indicator	Yes	Yes
Numerator		
Denominator		
Data Source	Women and Infant Program	Women and Infant Program
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Field Level Notes for Form 10a ESMs:

None

ESM 4.4 - Implementation of Wyoming 5-Steps to Breastfeeding Success Program

Measure Status:	Active

State Provided Data	
	2017
Annual Objective	4
Annual Indicator	4
Numerator	
Denominator	
Data Source	Women and Infant Program
Data Source Year	2017
Provisional or Final ?	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	4.0	4.0	4.0	4.0	4.0	4.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
Four hospitals applied for and received funding to improve their breastfeeding practices.

ESM 4.5 - Hospitals Recognized by Wyoming 5-Steps Program

Measure Status:	Inactive - Replaced

State Provided Data	
	2017
Annual Objective	2
Annual Indicator	0
Numerator	
Denominator	
Data Source	Women and Infant Program
Data Source Year	2017
Provisional or Final ?	Final

Field Level Notes for Form 10a ESMs:

None

ESM 4.6 - Percent of hospitals demonstrating an increase in at least one step from baseline based on hospital self-reported assessment

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	100.0	100.0	100.0	100.0	100.0

Field Level Notes for Form 10a ESMs:

None

ESM 4.7 - Percent of counties that have at least one public health nurse trained as a Certified Lactation Consultant (CLC)

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	90.0	90.0	95.0	95.0	95.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**Annual Objective**

Field Note:
In 2018, 21 out of 23 counties had a public health nurse trained as a CLC.

ESM 6.3 - 211 Referrals to Help Me Grow

Measure Status:	Active

State Provided Data	
	2017
Annual Objective	30
Annual Indicator	39
Numerator	
Denominator	
Data Source	HMG Reports
Data Source Year	2017
Provisional or Final ?	Provisional

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	45.0	60.0	75.0	75.0	85.0	100.0

Field Level Notes for Form 10a ESMs:

None

ESM 6.4 - Number of trained partners entering into the ASQ Enterprise System.

Measure Status:	Inactive - We are still exploring options for data collection that include but are not limited to the ASQ Enterprise system.

State Provided Data	
	2017
Annual Objective	2
Annual Indicator	0
Numerator	
Denominator	
Data Source	HMG Program Records
Data Source Year	2017
Provisional or Final ?	Final

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
The HMG program and WDH are currently working on clarifying the necessary data sharing agreements that need to be established prior to sharing data using the ASQ Enterprise system. It is expected to put forth a use case and establish necessary agreements in the summer and fall of 2018.

ESM 6.5 - Total number of referrals received by HMG

Measure Status:	Active

State Provided Data	
	2017
Annual Objective	20
Annual Indicator	13
Numerator	
Denominator	
Data Source	HMG Program Records
Data Source Year	2017
Provisional or Final ?	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	25.0	30.0	40.0	40.0	50.0	50.0

Field Level Notes for Form 10a ESMs:

None

ESM 6.6 - Number of connections made between local services and families by HMG.

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	50.0	51.0	52.0	53.0	55.0

Field Level Notes for Form 10a ESMs:

None

ESM 10.1 - Promotion of Adolescent Champion Model

Measure Status:	Inactive - Completed

State Provided Data		
	2016	2017
Annual Objective		Yes
Annual Indicator	No	Yes
Numerator		
Denominator		
Data Source	Program Data	Youth and Young Adult Health Program
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Field Level Notes for Form 10a ESMs:

None

ESM 10.2 - # QI cycles completed by participating practices

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	4.0	6.0	8.0	0.0	0.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**Annual Objective**
	Field Note: There are currently four participating clinics in the CoIIN project. We anticipate each clinic participating in one QI cycle.	
2.	**Field Name:**	**2022**
	Column Name:	**Annual Objective**
	Field Note: The current contract for supporting clinics does not extend to 2022. We will re-evaluate the ability to provide support to these clinics based on performance under the current contract.	

ESM 12.1 - # of meetings of the Transition Action Team of the AYAH CoIIN

Measure Status:	Inactive - Replaced

State Provided Data		
	2016	2017
Annual Objective		2
Annual Indicator	0	0
Numerator		
Denominator		
Data Source	Youth and Young Adult Health Program	Youth and Young Adult Health Program
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
The program manager determined it was best to wait for the CoIIN award to begin prior to development of the action team. The award was given in February 2017; therefore, no meetings were held in 2016.

ESM 12.2 - # of provider champions participating on Transition Action Team

Measure Status:	Inactive - Replaced

State Provided Data		
	2016	2017
Annual Objective		1
Annual Indicator	0	0
Numerator		
Denominator		
Data Source	Youth and Young Adult Health Program	Youth and Young Adult Health Program
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
The program manager determined it was best to wait for the CoIIN award to begin prior to development of the action team. The award was given in February 2017; therefore, no meetings were held in 2016.

ESM 12.3 - # of adolescents participating on Transition Action Team

Measure Status:	Inactive - Replaced

State Provided Data		
	2016	2017
Annual Objective		1
Annual Indicator	0	0
Numerator		
Denominator		
Data Source	Youth and Young Adult Health Program	Youth and Young Adult Health Program
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
The program manager determined it was best to wait for the CoIIN award to begin prior to development of the action team. The award was given in February 2017; therefore, no meetings were held in 2016.

ESM 12.4 - # of parent or youth completed transition readiness assessments completed by PHN in CSH program

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	45.0	47.0	49.0	51.0	53.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**Annual Objective**

Field Note:
About 20% of the CSH population is eligible for transition services each year. Our first year we intend to reach 2/3 of those enrolled or 45 children. We intended to reach more each year and reach 77% of eligible children by 2023.

ESM 14.1.1 - # of pregnant women referred to the WY Quitline services from Healthy Baby Home Visitation

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	25.0	30.0	30.0	35.0	35.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**Annual Objective**

Field Note:
Currently, around 20 women who smoke when they enroll in the Healthy Baby program are fax referred to the Quitline. This represents 8.3% of smoking women. To be fax referred to the Quitline the mother has to consent to the referral.

ESM 14.1.2 - # of providers trained on SCRIPT implementation

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	7.0	7.0	8.0	10.0	10.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**Annual Objective**

Field Note:
The women and infant health program anticipates one SCRIPT training each year with between 5 and 10 participants.

Form 10b
State Performance Measure (SPM) Detail Sheets

State: Wyoming

SPM 1 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)
Population Domain(s) – Perinatal/Infant Health

Measure Status:	Active
Goal:	Increase the percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)
Definition:	**Numerator:** Number of VLBW infants born in a hospital with a Level III+ NICU **Denominator:** Number of VLBW infants **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	MICH-33: 83.7%
Data Sources and Data Issues:	Numerator: Vital Records-number of VLBW infants delivered; delivery hospital Denominator: Vital Records- number of VLBW infants delivered Limitation: LOCATe has not been completed in all states where Wyoming babies are delivered.
Significance:	Neonatal intensive care has improved the outcomes of high risk infants who were born too early or with serious medical conditions. The American Academy of Pediatrics defines levels of neonatal care to allow for regionalization of efforts to ensure that babies born preterm or with serious medical conditions receive the neonatal services they need to address the often severe morbidity they endure. Most infant deaths occur in the United States among very preterm infants in the first days of life. This measure captures the ability for these babies to access necessary services through a regionalized system. (Levels of Neonatal Care: Policy Statement, Pediatrics, 130(3), September 2012)

SPM 2 - Rate of hospitalization for non-fatal injury per 100,000 children ages 1 through 11
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	Reduce the rate of hospitalization for non-fatal injury per 100,000 children ages 1 through 11
Definition:	**Numerator:** Inpatient hospitalizations for non-fatal injuries in Wyoming hospitals for children aged 1 through 11 **Denominator:** Children aged 1 through 11 in Wyoming **Unit Type:** Rate **Unit Number:** 100,000
Data Sources and Data Issues:	Numerator: Hospital Discharge Data (HDD) Denominator: Census population estimates Limitation: HDD is only available for Wyoming hospitals. It is possible that individuals with more severe injuries may be taken immediately out of state for treatment as there are no Level I trauma centers in Wyoming.
Significance:	Injury is the number one cause of death and hospitalization among children 1-11 in Wyoming and nationally. Wyoming's rates of injury are consistently higher than the national rates.

SPM 3 - Number of Wyoming birthing hospitals billing Medicaid for immediate postpartum LARCs
Population Domain(s) – Women/Maternal Health

Measure Status:	Inactive - Replaced
Goal:	Increase capacity of Wyoming birthing hospitals to bill Medicaid for immediate postpartum LARCs
Definition:	**Numerator:** Number of Wyoming birthing hospitals billing Medicaid for immediate postpartum LARCs **Denominator:** No Denominator **Unit Type:** Count **Unit Number:** 23
Data Sources and Data Issues:	Numerator: Medicaid billing data Denominator: Wyoming Hospital Association Issue: Potential issue for non-response
Significance:	'The immediate postpartum period is a particularly favorable time for IUD or implant insertion. Women who have recently given birth are often highly motivated to use contraception, they are known not to be pregnant, and the hospital setting offers convenience for both the patient and the health care provider.' (ACOG Practice Bulletin, Number 121, July 2011, http://www.acog.org/Resources-And-Publications/Practice-Bulletins/Committee-on-Practice-Bulletins-Gynecology/Long-Acting-Reversible-Contraception-Implants-and-Intrauterine-Devices) This indicator measures a woman's access to this service across Wyoming. The goal of the Title V program is to ensure access and education on immediate postpartum LARC insertion for the patient if she chooses this method of contraception.

SPM 4 - Percentage of teens reporting 0 occasions of alcohol use in the past 30 days
Population Domain(s) – Adolescent Health

Measure Status:	Active
Goal:	Increase the number of teens reporting 0 occasions of alcohol use in the past 30 days
Definition:	**Numerator:** total # of high school students reporting 0 occasions of alcohol use in the past 30 days **Denominator:** total # of high school students **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Wyoming Prevention Needs Assessment
Significance:	In February 2016, legislation was passed to no longer accept federal funding to conduct the Youth Risk Behavior Surveillance System (YRBSS). This SPM was selected as alcohol is a risk factor related to adolescents having safe and healthy relationships and is available through another state source.

SPM 5 - Percent of children (6-11 years) who are physically active at least 60 minutes per day.
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	Increase the percent of children (6-11 years) who are physically active at least 60 minutes per day.
Definition:	**Numerator:** Number of children (6-11 years) who are physically active at least 60 minutes per day. **Denominator:** Number of children (6-11 years) **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	National Survey of Children's Health State-level data available every other year.
Significance:	Childhood obesity is a state priority for Wyoming. Focusing on increasing the activity among children 6-11 years old will impact the overall health and obesity rate among children.

SPM 6 - Use of most/moderately effective contraception by postpartum women
Population Domain(s) – Women/Maternal Health

Measure Status:	Active
Goal:	Increase access to most and moderately effective contraception for postpartum women
Definition:	**Numerator:** Number of women reporting use of most (IUD, implant, vasectomy, tubal ligation) or moderately (pill, patch, ring, shot) effective contraception postpartum **Denominator:** Number of postpartum women at risk for pregnancy (excludes women that report they are not currently sexually active) **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Wyoming PRAMS
Significance:	Ensuring women have access to most and moderate effective birth control in the postpartum period enables women to plan their families. Effective methods of birth control in the postpartum period helps reduce the risk becoming pregnant again too soon which is associated with poorer outcomes for moms and babies.

Form 10b
State Outcome Measure (SOM) Detail Sheets

State: Wyoming

No State Outcome Measures were created by the State.

Form 10c
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: Wyoming

ESM 4.1 - Mini-grant program structure developed
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Inactive - Completed
Goal:	Award mini-grants and provide technical assistance to hospitals for participation in Wyoming 5-Steps to Breastfeeding Success, a Wyoming-developed initiative based on the Baby Friendly Hospital Initiative
Definition:	**Numerator:** Yes/No **Denominator:** n/a **Unit Type:** Text **Unit Number:** Yes/No
Data Sources and Data Issues:	Women and Infant Program
Significance:	The Baby Friendly Hospital Initiative provides ten practices that hospitals can implement to improve breastfeeding rates in their hospital. To support hospitals understanding and adopting these practices the Women and Infant Health Program will provide mini-grants for hospitals interested in pursuing these practices. mPINC data was used to determine Wyoming's 5 selected steps for focus. This indicator measures the success in developing and gaining approval for this process.

ESM 4.4 - Implementation of Wyoming 5-Steps to Breastfeeding Success Program
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	Increase the number of hospitals participating in the Wyoming 5-Steps to Breastfeeding Success Mini-Grant Program
Definition:	**Numerator:** Number of hospitals participating in the Wyoming 5-Steps to Breastfeeding Success Program **Denominator:** N/A **Unit Type:** Count **Unit Number:** 26
Data Sources and Data Issues:	Survey of hospital policies and grant reporting
Significance:	Supporting changes to hospital polices can significantly impact breastfeeding initiation and duration rates for mother's who deliver in the hospital. Wyoming is promoting it's 5-Steps to Breastfeeding Success Program which is modeled off the Baby-Friendly Hospital Initiative and the Colorado Can Do 5 Initiative. The Women and Infant Program will support hospitals as they engage in policy change and quality improvement efforts around these five steps to improve the breastfeeding rates among the new moms they serve.

ESM 4.5 - Hospitals Recognized by Wyoming 5-Steps Program
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Inactive - Replaced
Goal:	Increase the number of hospitals meeting the requirements to be recognized by the Wyoming 5-Steps to Breastfeeding Success Program.
Definition:	**Numerator:** Number of hospitals meeting the requirements to be recognized by the Wyoming 5-Steps to Breastfeeding Success Program. **Denominator:** n/a **Unit Type:** Count **Unit Number:** 23
Data Sources and Data Issues:	Survey of Hospital Policy, Grant Reporting Requirements for Wyoming 5-Steps to Breastfeeding Success Program
Significance:	Hospital policies and practices significantly impact the rates of breastfeeding initiation and duration rates for the new moms they serve. Increasing the number of hospitals that meet the recognition requirements increases the number of new moms exposed to maternity care practices supportive of breastfeeding.

ESM 4.6 - Percent of hospitals demonstrating an increase in at least one step from baseline based on hospital self-reported assessment
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	Increase the percent of hospitals demonstrating an increase in the number of steps they are implementing
Definition:	**Numerator:** # of hospitals with a self-reported increase in steps implemented in their hospital **Denominator:** # of hospitals **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Women and Infant Program
Significance:	The Baby Friendly Hospital Initiative provides ten practices that hospitals can implement to improve breastfeeding rates in their hospital. To support hospitals understanding and adopting these practices the Women and Infant Health Program will provide mini-grants for hospitals interested in pursuing these practices. This indicator measures the success in hospitals implementing the 5-Steps program

ESM 4.7 - Percent of counties that have at least one public health nurse trained as a Certified Lactation Consultant (CLC)
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	Greater than 90% of counties have at least one PHN certified as a CLC
Definition:	**Numerator:** # of counties with at least one CLC **Denominator:** # of counties **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Women and Infant Program
Significance:	Certified Lactation Consultants receive extensive training to help new mothers breastfeed. Access to a local nurse to help with breastfeeding gives mothers access to experts who are easy to contact and can help them troubleshoot problems that arise and support continued breastfeeding.

ESM 6.3 - 211 Referrals to Help Me Grow
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Active
Goal:	Increase the number of referrals from 211 to HMG
Definition:	**Numerator:** Number of referrals from 211 to HMG **Denominator:** N/A **Unit Type:** Count **Unit Number:** 100
Data Sources and Data Issues:	HMG calls are tracked through the 211 data system
Significance:	HMG system is a coordinated referral system for developmental screening for children aged birth through eight. Increasing the number of referrals from 211 indicates the program is functioning as intended.

ESM 6.4 - Number of trained partners entering into the ASQ Enterprise System.
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Inactive - We are still exploring options for data collection that include but are not limited to the ASQ Enterprise system.
Goal:	Increase the number of partners entering data into the ASQ Enterprise System
Definition:	**Numerator:** Number of trained partners entering into the ASQ Enterprise System. **Denominator:** N/A **Unit Type:** Count **Unit Number:** 100
Data Sources and Data Issues:	ASQ Enterprise System; Wyoming is currently in the process of procuring this data system.
Significance:	The strength of HMG is in it's partnership and referral process. Increasing the number of community partners entering into the ASQ Enterprise system shows commitment to the HMG system and strengthens the ability to refer children to necessary services and follow-up on additional services as needed.

ESM 6.5 - Total number of referrals received by HMG
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Active
Goal:	Increase the number of referrals to HMG
Definition:	**Numerator:** Number of referrals to HMG **Denominator:** N/A **Unit Type:** Count **Unit Number:** 500
Data Sources and Data Issues:	211 data system
Significance:	HMG is most successful with broad community buy-in. Tracking the number of referrals to HMG indicates awareness of the program from our partners and a confidence in the HMG's ability to help refer and follow-up with children and families regarding identified needs.

ESM 6.6 - Number of connections made between local services and families by HMG.
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the number of connections made between local services and families by HMG.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Numerator:</td><td>Number of referrals from HMG that result in a connection to services</td></tr>
<tr><td>Denominator:</td><td>N/A</td></tr>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>500</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>211 System</td></tr>
<tr><td>Significance:</td><td>HMG is a coordinated referral system for developmental screening for children aged birth to eight. It is critical that children receive appropriate services based on the results of their screening to minimize impact of delays.</td></tr>
</table>

ESM 10.1 - Promotion of Adolescent Champion Model
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Measure Status:	Inactive - Completed
Goal:	Promote the Adolescent Champion Model through mini-grants to health care providers
Definition:	**Numerator:** Yes/No **Denominator:** n\a **Unit Type:** Text **Unit Number:** Yes/No
Data Sources and Data Issues:	Adolescent Health Program
Significance:	The Adolescent Health Program will partner with the University of Michigan to bring the Adolescent Champion Model to Wyoming. The goal of this program is to train adolescent and family providers and their staffs to create a more adolescent friendly environment in their clinics. By increasing the knowledge of providers and their staffs of caring for adolescents is that more adolescents will receive their recommended annual well visit.

ESM 10.2 - # QI cycles completed by participating practices
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Measure Status:	Active
Goal:	Increase the number of QI cycles completed by participating practices
Definition:	**Numerator:** Number of QI cycles completed by participating practices **Denominator:** N/A **Unit Type:** Count **Unit Number:** 10
Data Sources and Data Issues:	CoIIN documentation
Significance:	The Adolescent Health Program will partner with the University of Michigan to bring the Adolescent Champion Model to Wyoming. The goal of this program is to train adolescent and family providers and their staffs to create a more adolescent friendly environment in their clinics. By increasing the knowledge of providers and their staffs of caring for adolescents is that more adolescents will receive their recommended annual well visit.

ESM 12.1 - # of meetings of the Transition Action Team of the AYAH CoIIN
NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

Measure Status:	Inactive - Replaced
Goal:	Develop the Transition Action Team
Definition:	**Numerator:** # of meetings of the Transition Action Team of the AYAH CoIIN **Denominator:** n/a **Unit Type:** Count **Unit Number:** 10
Data Sources and Data Issues:	Transition Action Team meeting minutes
Significance:	The participation in the Adolescent and Young Adult Health CoIIN Team will provide a Wyoming perspective on the needs of youth with special health care needs when transitioning to adult health care. This team will have an Action Team tasked with developing a transition plan to address identified needs in the state. One of the key tasks of transition action team will be to review Got Transition materials for use and distribution in Wyoming.

ESM 12.2 - # of provider champions participating on Transition Action Team
NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

Measure Status:	Inactive - Replaced
Goal:	Develop the Transition Action Team
Definition:	**Numerator:** # of provider champions participating on Transition Action Team **Denominator:** n/a **Unit Type:** Count **Unit Number:** 10
Data Sources and Data Issues:	Transition Action Team meeting minutes
Significance:	The provider perspective will be critical to the success of the Transition Action Team meetings. Providers will contribute the realities of their clinics, identify limitations, and provide potential solutions to solve problems related to transition.

ESM 12.3 - # of adolescents participating on Transition Action Team
NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

Measure Status:	Inactive - Replaced
Goal:	Develop the Transition Action Team
Definition:	**Numerator:** # of adolescents participating on Transition Action team **Denominator:** n/a **Unit Type:** Count **Unit Number:** 10
Data Sources and Data Issues:	Transition Action Team meeting minutes
Significance:	The Adolescent and Young Adult Health CoIIN team will be convened to determine best-practice for Wyoming providers in increasing adolescent well-visits and improving adolescent health outcomes. The Transition Action Team will consist of providers, parents, and adolescents. The purpose of the action team is to review current transition resources and create a Wyoming Transition plan and toolkit from current resources that meets the needs of Wyoming consumers and providers.

ESM 12.4 - # of parent or youth completed transition readiness assessments completed by PHN in CSH program
NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

Measure Status:	Active
ESM Subgroup(s):	CSHCN
Goal:	Increase the number of eligible CSH parents or youth who complete a transition readiness assessment annually
Definition:	**Numerator:** Number of eligible CSH parents or youth that completed a transition readiness assessment **Denominator:** N/A **Unit Type:** Count **Unit Number:** 1,000
Data Sources and Data Issues:	CSH tracking
Significance:	Children and youth enrolled in Wyoming's Children's Special Health program have a qualifying medical condition to receive gap-filling support. The youth and families in this program do not currently receive any kind of guidance on transition. Providing transition resources to these youth and families will improve the quality of care provided by the CSH program. Additionally, this will provide an opportunity to pilot transition materials to Wyoming families and potentially spread beyond families served by the CSH program.

ESM 14.1.1 - # of pregnant women referred to the WY Quitline services from Healthy Baby Home Visitation
NPM 14.1 – Percent of women who smoke during pregnancy

Measure Status:	Active
ESM Subgroup(s):	Pregnant Women
Goal:	Increase the number of pregnant smokers referred to the Quitline from the Healthy Baby Home Visitation Program
Definition:	**Numerator:** # of smoking HB clients referred to the Quitline **Denominator:** N/A **Unit Type:** Count **Unit Number:** 100
Data Sources and Data Issues:	Best Beginnings Database
Significance:	The Wyoming Quit Tobacco Program is focused on increasing the number of pregnant women that call the Wyoming Quitline. The Quitline is an evidenced based strategy for quitting tobacco. Wyoming has an incentive program for enrollment in the program during pregnancy. This indicator will measure the success of the partnership between home visiting, MCH, and tobacco in getting women who smoke during pregnancy to enroll in the Quitline services.

ESM 14.1.2 - # of providers trained on SCRIPT implementation
NPM 14.1 – Percent of women who smoke during pregnancy

Measure Status:	Active
ESM Subgroup(s):	Pregnant Women
Goal:	Increase the number of providers trained in SCRIPT
Definition:	**Numerator:** # of providers trained in SCRIPT **Denominator:** N/A **Unit Type:** Count **Unit Number:** 100
Data Sources and Data Issues:	Women and Infant Program
Significance:	Public Health Nursing in Wyoming delivers home visiting services to pregnant women in 22/23 counties across the state. SCRIPT is an evidence-based pregnancy smoking cessation program that takes very little time to implement as part of the home visiting program, and has the potential to have a greater impact on maternal smoking rates than the current model.

Form 11
Other State Data

State: Wyoming

The Form 11 data are available for review via the link below.

Form 11 Data