Maternal and Child Health Services Title V Block Grant

Wyoming

FY 2020 Application/ FY 2018 Annual Report

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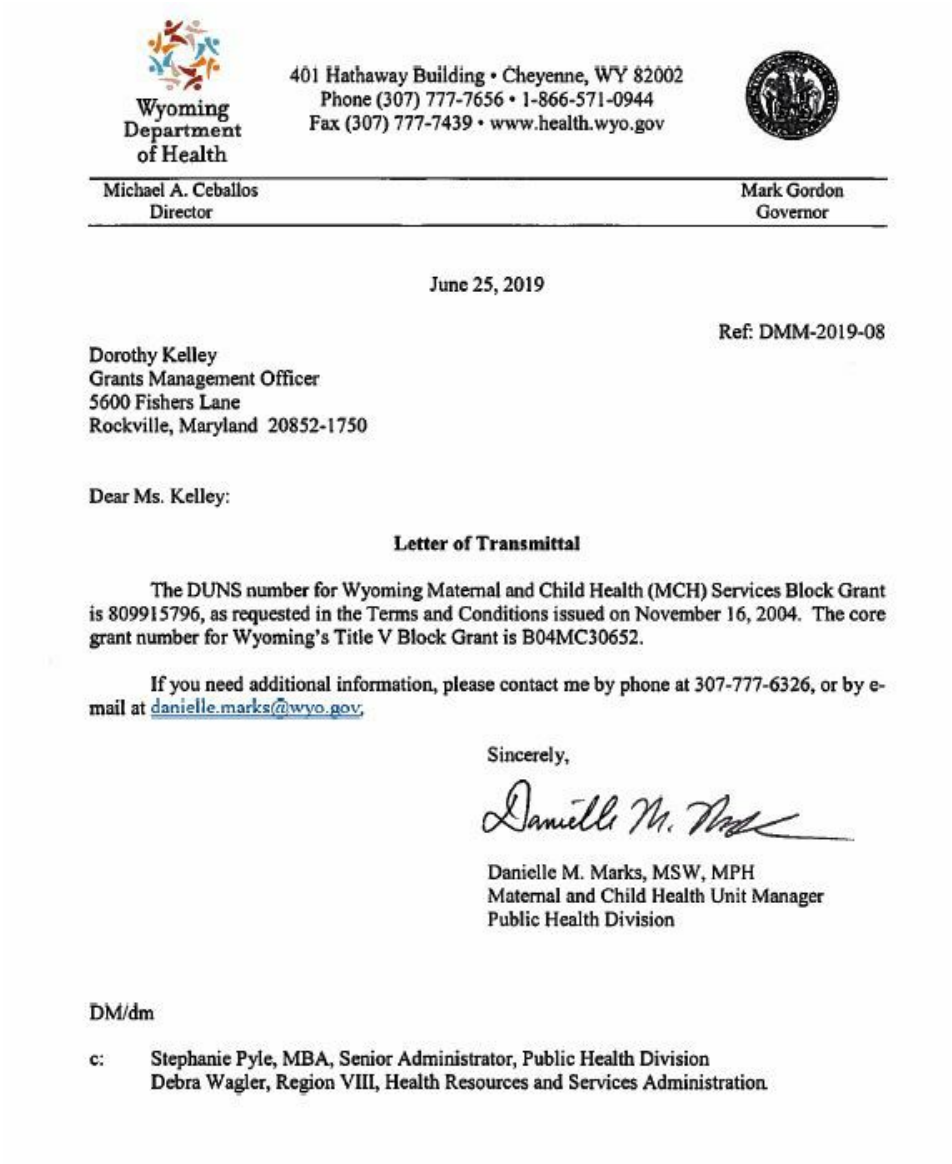
I. General Requirements

I.A. Letter of Transmittal



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Michael A. Ceballos
Director

Mark Gordon
Governor

June 25, 2019

Ref: DMM-2019-08

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, 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

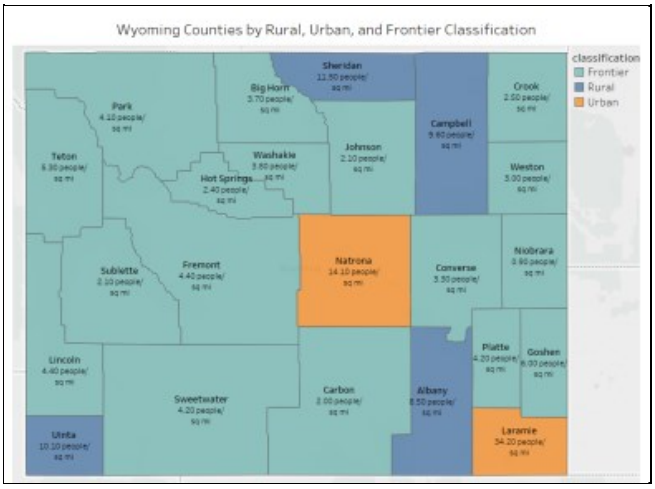
Please refer to figure 4 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms," OMB No: 0915-0172; Expires: December 31, 2020.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

The Maternal and Child Health (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 Wyoming Department of Health (WDH). Structurally, the Unit's programs are divided according to the population groups they serve: women and infants, children, youth and young adults, and children and youth with special health care needs (CYSHCN). This structure addresses all Title V population domains.



The MCH Unit receives approximately $1,100,000 in federal Title V funding annually and employs nine full-time staff. Title V, state matching funds, and other federal funding support programming for an estimated population of 577,737 (2018 estimate, American FactFinder, U.S. Census) spanning 97,813 square miles. Wyoming is a rural/frontier state with 23 counties ranging from the Great Plains to the Rocky Mountains. The Wind River Indian Reservation (WRIR), located toward the center of the state in Fremont County, is home to two federally recognized tribes, the Eastern Shoshone and Northern Arapaho. Wyoming's public health system is mixed (centralized and decentralized), with four independently run county health departments and the remaining 19 counties utilizing both state and county staff. Wyoming lacks Level III facilities for both neonatal and maternal levels of care and lacks sufficient specialty care. This requires families, especially those with special health care needs, to travel long distances for health care, miss work, and coordinate care for children left at home.

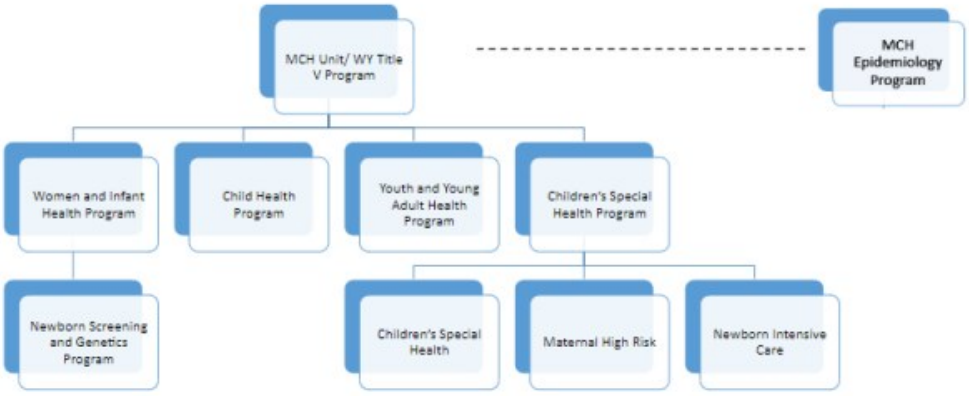
According to America's Health Rankings (2018), Wyoming's strengths include low levels of air pollution and a low proportion of children in poverty. Challenges include a high percentage of uninsured and low rates of primary care physicians.

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 mission of the Wyoming MCH Unit 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.

Organizational Structure



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. The MCH Unit works closely with both state and county staff in all 23 counties to assure access to community-level MCH services including home visiting, care coordination services for CYSHCN, high risk pregnant women, and high risk infants, and genetics clinics (in 3 counties).

Through statutory requirement, the MCH Unit and Public Health Nursing (PHN) jointly receive Temporary Assistance for Needy Families (TANF) funding from the Wyoming Department of Family Services to support the implementation of home visiting. 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 CYSHCN 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, National/State Performance Measures (NPM/SPM) Status, and Related Activities by Population Domain

Women/Maternal Health Domain		
State Priority Need	**NPM/SPM**	**Status of NPM/SPM**
Prevent infant mortality	NPM 14.1: Percent of women who smoke during pregnancy	In Calendar Year (CY) 2017, 14.4% of women smoked during pregnancy compared to 17.6% in 2012 (National Vital Statistics Services (VSS)).
Improve access to and promote use of effective family planning	SPM 6: Use of most/moderately effective contraception by postpartum women	No data available for Federal Fiscal Year 2018 (FFY18) as SPM changed in FFY19.

Through an MCH contract with all counties, MCH requires PHNs to ask about smoking status at every home visit, and provide appropriate cessation education and referrals to the Wyoming Quitline as appropriate. The Women and Infant Health Program (WIHP) is available to provide training on the evidence-based Smoking Cessation and Reduction in Pregnancy Treatment (SCRIPT) program.

The WIHP, MCH Epidemiology Program, Wyoming Medicaid, and a provider champion participated in the Association of State and Territorial Health Officials (ASTHO) Learning Community on Increasing Access to Contraception from 2016 to 2018. In FFY19, the WIHP shifted its focus to address long-acting reversible contraception (LARC) reimbursement challenges in Rural Health Clinics (RHC), Federally Qualified Health Centers (FQHC), and Indian Health Service with the goal of changing Medicaid policies. A grant from the National Institute for Reproductive Health supported completion of a cost analysis comparing the cost of LARCs compared to costs related to unintended pregnancy. A request for a State Plan Amendment changing reimbursement policies for FQHCs and FHCs is anticipated in 2019.

In 2019, the MCH Unit partnered with the Utah Department of Health to apply for Centers for Disease Control and Prevention (CDC) funding to review Wyoming maternal deaths as part of the Utah Perinatal Mortality Review Program. This application addresses an emerging need and topic of interest identified by the Wyoming Perinatal Quality Collaborative (WYPQC).

Perinatal/Infant Health 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 2017, 80.6% (50/62) of VLBW infants in Wyoming were born at facilities with the appropriate level of care compared to 68% in 2016 and 51.9% in 2015. The Healthy People (HP) 2020 goal is 83.7%.
Improve breastfeeding duration	NPM 4a: Percent of infants who are ever breastfed (National Immunization Survey (NIS))	In 2015, 90% of infants were ever breastfed compared to 88.3% in 2014.
	NPM 4b: Percent of infants breastfed exclusively through 6 months (NIS)	In 2015, 28.8% of infants were exclusively breastfed through 6 months compared to 27% in 2013 and 32% in 2014.

In FFY18, the WIHP officially launched the WYPQC. See ***MCH Success Story*** for additional details.

The Levels of Care Assessment Tool (LOCATe) continued to inform the work of the WIHP in 2017 and 2018. Assessment results revealed opportunities for quality improvement efforts with hospitals (e.g. implementation of patient safety bundles). In 2017 and 2018, six Wyoming hospitals participated in a Utah Project Extension for Community Healthcare Outcomes (ECHO) focused on maternal hypertension. In 2019, up to five hospitals will receive mini-grants to join an opioid-focused safety bundle ECHO.

In 2018, the WIHP leveraged Title V and ASTHO funding to offer four mini-grants to hospitals participating in the Wyoming 5-Steps to Breastfeeding Success Program. All hospitals demonstrated improvement in breastfeeding practices from baseline.

Child Health 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 2016-17, 27% 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 2016-17 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 every day for 60 minutes or more. Due to changes in the NSCH, data are not comparable between 2016 and 2012.

In FFY18, the Child Health Program (CHP) continued implementation of two strategies to increase developmental screenings: implementation of the Help Me Grow (HMG) model and Ages and Stages Questionnaire (ASQ) training and resource distribution. In partnership with key stakeholders and funders, the CHP evaluated the progress of the HMG pilot project and decided to end the program as of June 30, 2019 and shift resources towards building an effective early childhood system in preparation for the 2021-2025 MCH Needs Assessment and new priority selection. The CHP will work closely with early childhood system partners, in particular the Wyoming MIECHV program grantee, Parents as Teachers National Center (PATNC), to identify needs and gaps within the early childhood system. In July 2019, the early childhood system partners will participate in a MCH Workforce Development Center Learning Institute.

The Prevent Childhood Injury priority expanded in 2018 to include a broader age group, ages 0-19, due to high rates of injury hospitalizations across many age groups. Together, all MCH program managers worked together to release a mini-grant for community organizations to address the top causes of childhood injury using evidence-based or –informed strategies. In FFY20, nine organizations will implement projects with TA provided by all MCH program managers depending on topic/age of focus.

The CHP worked closely with the Wyoming Chronic Disease Prevention Program (CDPP) to fund training and certification of 45 University of Wyoming Extension Office nutrition educators as child obesity prevention educators. In addition, the CHP will continue a partnership with the Head Start State Collaboration Office to develop and release a Wyoming Healthy Policies Toolkit for early childcare providers.

Adolescent Health Domain		
Priority	**NPM/SPM**	**Status of NPM/SPM**
Promote preventive and quality care in adolescents	NPM 10: Percent of adolescents with a preventive services visit in the last year (NSCH)	In 2016-17, 78.2% 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 2016-17 and 2012.
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 2018, 66.3% of Wyoming High School students reported zero occasions of alcohol use in the past 30 days compared to 68.4% in 2016.

The Youth and Young Adult Health Program (YAYAHP), in partnership with the PREP Program, continues to provide training on Making Proud Choices and Reducing the Risk curricula to promote healthy and safe relationships in adolescents through youth-serving organization programming.

During FFY18 and FFY19, four pilot clinics participated in the University of Michigan's Adolescent Centered Environment Assessment Process (ACE-AP) as a strategy to improve the quality of the adolescent clinical environment. The clinics received mini-grants from the Adolescent and Young Adult Health Collaborative Improvement and Innovation Network (AYAH CoIIN) budget to support practice/clinic environment improvements and technical assistance from the University of Michigan to identify and respond to opportunities to improve adolescent well visits. Four new clinics will begin work with University of Michigan in FFY20.

Children with Special Health Care Needs (CSHCN) Domain		
Priority	**NPM/SPM**	**Status of NPM/SPM**
Promote preventive and quality care in children and adolescents	SPM 7 (formerly NPM 11): Percent of children with and without special health care needs having a medical home (NSCH)	In 2016-17, 43.8% of children (ages 0-17) with special health care needs had a medical home. In 2016-17, 50.8% of children (ages 0-17) **without** 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, 16.5% of adolescents with and without special health care needs received services necessary to make transitions to adult health care compared to 17.9% in 2016.

The MCH Unit continued implementation of the Wyoming Parent Partner Program (PPP) as a strategy to increase access to medical home. In FFY18, the PPP served 189 unique families and 233 unique children. Parent Partners serve clinics in Cheyenne, Casper, Riverton, and the F.E. Warren Air Force Base (Cheyenne, Wyoming).

In FFY18, the YAYAHP and CSH program staff presented a comprehensive training on transition for PHNs and Tribal MCH Nurses. As a result of their work, all CSH clients ages 14 and up and their parents will complete a transition readiness assessment tool annually and will receive customized evidence-based teaching on how to prepare for transition to adult health care services.

In FFY18, the Wyoming Genetics Clinics Program, CSH Program, PHN, Rural and Frontier Health Unit, and MCH Epidemiology Program partnered to implement and evaluate a telegenetics pilot to address a gap in specialty genetics services in Wyoming. As of December 31, 2018, the Wyoming Genetics Clinics Program enrolled 69 clients with services provided to 63 individuals. Of these, 24 patients had a telehealth visit. Those receiving telehealth services (n=24) felt that telegenetics made it easier for them or their child to receive services and that telemedicine was more convenient than traveling out-of-state. All were satisfied with the quality of services received and said their questions were answered. It was the first time that most families had used telemedicine.

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

The MCH Unit leverages a wide range of partnerships to implement strategies that impact national and state performance measures associated with the state's MCH priorities. Title V funds and matching funds are distributed to internal and external partners to maximize alignment and coordination of efforts for each MCH priority area. In addition, a significant portion of Title V and matching funds supports internal (MCH and MCH Epidemiology) staff capacity to develop, implement, and evaluate strategies within each MCH population domain to meet priority needs.

Without Title V funding, the 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 suicide, and strengthening Wyoming's rural health care infrastructure.

Where possible, Title V funding is blended with other sources to meet programmatic needs. For example, the MCH Unit supported a Strengthening Families Protective Factors Framework Training in partnership with the Children's Trust Fund. All MCH program managers attended to learn about the five protective factors (Parental Resilience, Knowledge of Parenting, Knowledge of Child Development, Concrete Support in Times of Need, and Social Connections) and how to use the factors to address social determinants of health, promote health equity, and promote a life course approach.

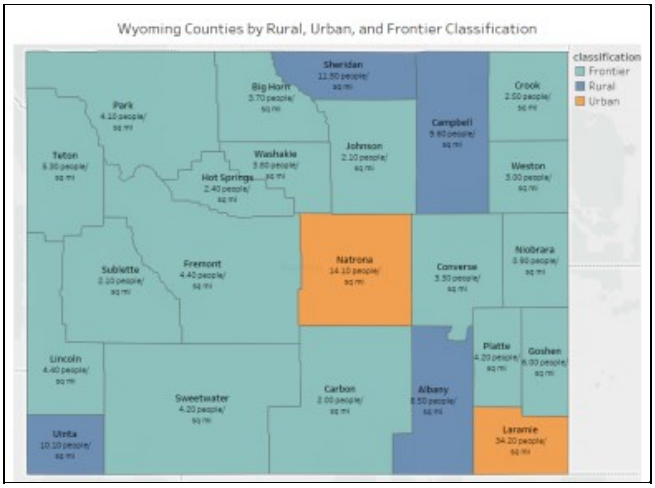
III.A.3. MCH Success Story

Efforts to develop a perinatal quality collaborative serve as one example of a Wyoming MCH success story. In FFY18, the WIHP launched the Wyoming Perinatal Quality Collaborative (WYPQC). The earliest form of this collaborative started in 2013 when a multi-disciplinary group of stakeholders came together to address Wyoming's high preterm birth rate. Past group successes include a Medicaid policy change disincentivizing low-risk cesarean sections and a widespread 39 Weeks is Worth the Wait campaign. In 2017, the Utah Department of Health invited Wyoming hospitals to participate in an Extension for Community Healthcare Outcomes (ECHO) project focused on hypertension in pregnancy. Six Wyoming hospitals participated in the ECHO project and many of these same hospital partners are now key members of the WYPQC. In 2018, the WYPQC developed its vision, mission, and core principles and in 2019, a WYPQC Coordinator began work. Since its inception, the group's core membership has remained the same—Department of Health MCH Unit, Medicaid, Wyoming Hospital Association, Wyoming Business Coalition on Health, Wyoming Medical Society, among others--and now expands to include an increasing number of hospital representatives, non-profit organizations, providers, and interested stakeholders. The WYPQC is in the process of selecting its first official projects and establishing a Maternal Mortality Subcommittee to guide Wyoming's efforts to begin reviewing and responding to maternal deaths.

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 Northern Arapaho.

Wyoming is the least populous state in the U.S. with an estimated population of 577,737 (2018 estimate, American FactFinder, U.S. Census) representing a slight decline from the 2017 estimate of 578,934**.** The population is predominantly White alone (92.8%). The remaining population is Black or African American alone (1.3%), American Indian and Alaska Native alone (2.7%), Asian alone (1.0%), Native Hawaiian and Other Pacific Islander alone (0.1%), Two or More Races (2.1%), and Hispanic or Latino (10.0%) (2018, U.S. Census QuickFacts). In 2017, of the population aged 5 years and older, 92.7% speak only English at home and 7.3% speak a language other than English.



Almost one quarter of the population is under 18 years of age. Nearly 93% of persons over 24 years of age have a high school education or higher. Over one quarter of this group (26.7%) have at least a Bachelor's degree. The median household income is $60,938. Persons in poverty are estimated to be 11.3% of the population (U.S. Census Quick Facts, Wyoming; 2013-2017).

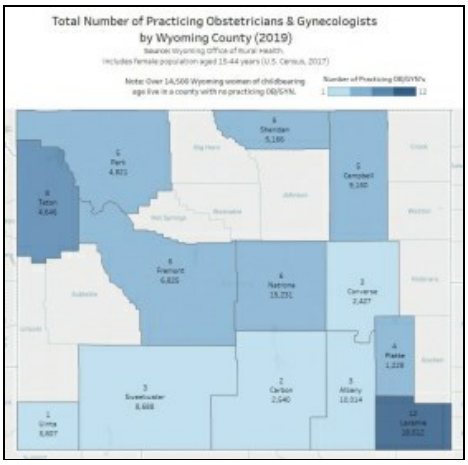
Wyoming is a rural/frontier state. Two counties, Laramie and Natrona, each have a town with over 60,000 people and are considered urban. Seventeen of the remaining 21 counties are considered frontier with less than six persons per square mile. These 17 counties are home to 46% of the population (Wyoming Economic Analysis Division, Estimates of Wyoming and County Population: April 1, 2010 to July 1, 2018).

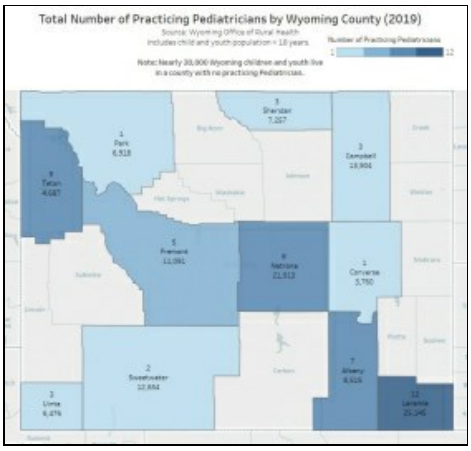
In the recent past, the economy in the state suffered from the weak demand for oil, warmer weather, and increases in domestic supply for natural gas. However, the most recent unemployment rate (2018, Q4) is 4.1 percent; just slightly higher than the U.S. level of 3.8 percent. Wyoming experienced an overall growth in employment by 1 percent (representing about 2,800 jobs) between the fourth quarter of 2017 and 2018. (Economic Analysis Division, Wyoming).

According to America's Health Rankings (2018), Wyoming's strengths include low levels of air pollution and a low proportion of children in poverty. Challenges include a high percentage of uninsured and low rates of primary care physicians.

The top two leading causes of death for children between ages 1-24 years in Wyoming are unintentional injury (n=33) and suicide (n=27). Homicide is the third leading cause of death 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 Fact Finder (2017, U.S. Census) reports that the percent of Wyoming residents with no health insurance coverage was 12.3%; higher than the U.S. (8.7%) in the same year and ranked as 7th highest in the nation. In Wyoming, among children and youth aged 18 or younger, 9.5% had no health insurance as compared to 5.0% nationally. Wyoming has not expanded Medicaid.





According to the Health Resources and Services Administration's Designated Health Provider Shortage Areas (HPSA) Quarterly Summary Report, Wyoming had a total of 44 Primary Care Health Provider Shortage Area (HPSA) Designations, with 187,903 residents residing in primary care shortage areas. There were 28 Dental HPSA designations in the state with a total of about 49,650 Wyoming residents residing in these areas. Finally, the entire state (comprised of five regions) is considered a HPSA for mental health. Per HRSA's Designated HPSA Quarterly Summary (12/31/18); only 31% of the mental health needs are being met and 25 full-time psychiatrists are needed to meet the need of the population.

There are currently 63 physicians practicing Obstetrics and Gynecology (OB/GYN) in Wyoming and 54 practicing Pediatricians. Ten counties have no OB/GYN and 12 counties have no Pediatrician.

Over 14,500 Wyoming women of childbearing age (15-44 years) live in a county with no practicing OB/GYN and approximately 30,000 Wyoming children and youth (<18 years of age) live in a county with no practicing Pediatrician.

There are 179 family practice physicians in the state. Twenty-nine individuals practice in Natrona County, 28 in Laramie County, 15 in Park County, and 12 in Fremont County. Nine counties have fewer than 5 family practice physicians.

Results from the CDC-developed Levels of Care Assessment Tool (LOCATe) reported 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. In many cases, families must cross state boundaries to receive care.

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 rolling rates and data aggregation. Too often, even with multiple years, numbers are too small to report. In 2019, the MCH Unit will work to operationalize all of its core values with specific emphasis on health equity.

As stated in the 2019 Robert Wood Johnson County Health Rankings & Roadmaps, Wyoming fares well compared to the nation for children in poverty (13% versus 18%) but the proportion of children in poverty varies widely by county, with rates ranging from 7% (Teton) to 22% (Fremont). When race and ethnicity are examined, child poverty rates range from 13% to 32%.

Wyoming's overall high school graduation rates have risen steadily over the past five years. Since the 2013-2014 school year, high school graduation rates have increased from 78.6% (2013-2014) to 81.7% (2017-2018). However, gaps continue to exist by racial and ethnic categories. While 83.7% of White youth graduated from high school in the 2017-2018 school year, only 75.4% of Hispanic youth and 58.8% of American Indian youth graduated during the school year (Wyoming State 4-Year Graduation Rates, 2017-2018). Educators report that the four-year graduation rate for Native American youth increased substantially from the previous period but recognized that more work needs to be done.

Agency Organizational Structure and Role

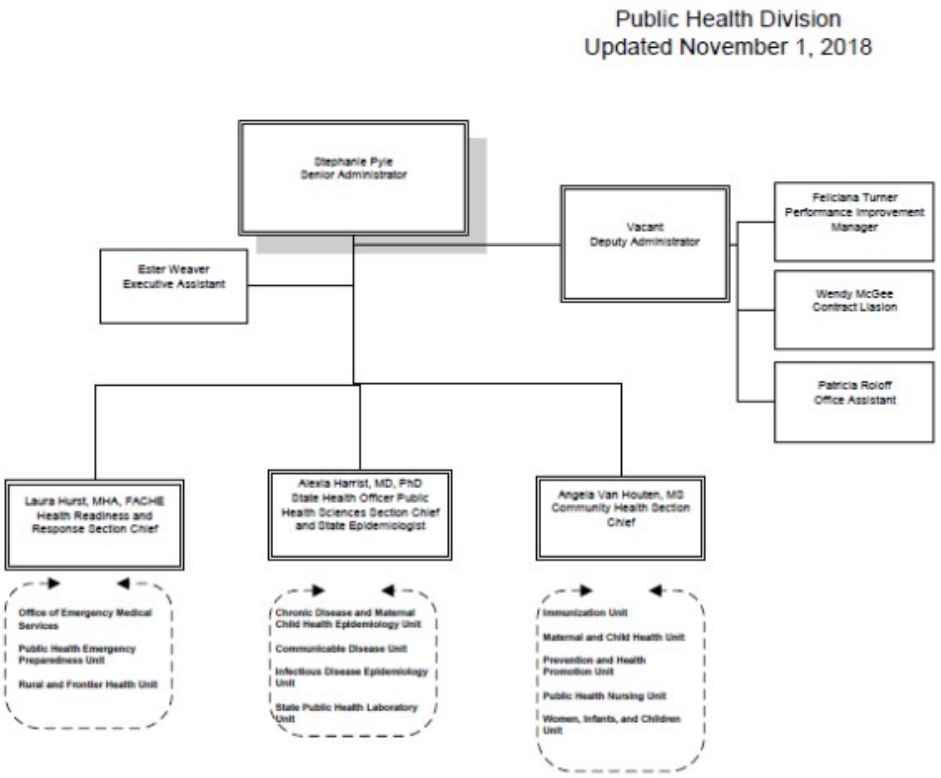
The Maternal and Child Health (MCH) Services Title V Block Grant is managed by the MCH Unit within the Community Health Section (CHS) and Public Health Division (PHD) of the WDH. The mission of the WDH is to promote, protect, and enhance the health of all Wyoming residents. The 2014-2018 WDH priorities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

- Implement Medicaid reform, including improving health outcomes while containing cost and redesigning waivers to increase access;
- Redesign the mental health and substance abuse systems 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.

A summary of the PHD organizational structure is included below.



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 process, WDH completed the required state health assessment (SHA) and is working on the state health improvement plan (SHIP). A member of the MCH Epidemiology staff is on the leadership team for the assessment. To view the results from the recently completed SHA, visit: https://health.wyo.gov/publichealth/sha/.

The MCH Unit provides leadership for state and local level efforts that improve the health of the maternal and child health population. Structurally, the 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.

In 2016, the MCH Unit updated its vision and mission and developed core values. The core values were last updated in 2018 ahead of the current needs assessment planning process.

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.

MCH Core Values (updated December 2018):

- **Data-driven:** Utilize data, evidence, and continuous quality improvement
- **Engagement:** Cultivate authentic collaboration and trust with families and community partners
- **Health Equity and Life Course Perspective:** Integrate an understanding of how differences in social, economic, cultural, and environmental factors across generations and throughout the lifespan impact health
- **Systems-Level Approach:** Prioritize work that addresses community structures, social norms, environment, and policies to maximize impact

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 the 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 was not 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 (children and youth with special health care needs, high risk pregnant women, and high risk infants) 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.

In 2016, the Wyoming State Legislature faced difficult decisions to address decreasing state revenues. As a result, the Public Health Oral Health Program was eliminated as part of the Department's budget reduction. The decision closed the following programs: Dental Sealants, Public Health Severe Malocclusion Program, Marginal Dental Program, Community Oral Health Coordinator Program (Public Health Dental Hygienists), Healthy Mouth Healthy Me, and the Cleft Palate Speciality Clinic. Despite a lack of state-level leadership on oral health, MCH Unit continues to participate in a Wyoming Oral Health Coalition led by the Wyoming Primary Care Association.

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 NBS Program. Additionally, funds are used for contracts with a courier to transport the blood spots to CDPHE. In 2019, current contracts with specialists to provide follow-up for abnormal screens will expire and follow-up services will be added to a contract with CDPHE. The Wyoming Newborn Screening and Genetics Coordinator is funded by both Title V and state Trust and Agency funding, demonstrating the partnership between Title V and the WDH to assure access to newborn screening statewide.

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 implement Nurse Family Partnership (NFP), an evidence-based home visiting model, in all 23 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, PHN, 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, 2019, four counties (Albany, Carbon, Natrona, and Sweetwater) deliver NFP. All 23 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 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 the 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. *See Women/Maternal Health Domain Annual Report for more information about current family planning activities.*

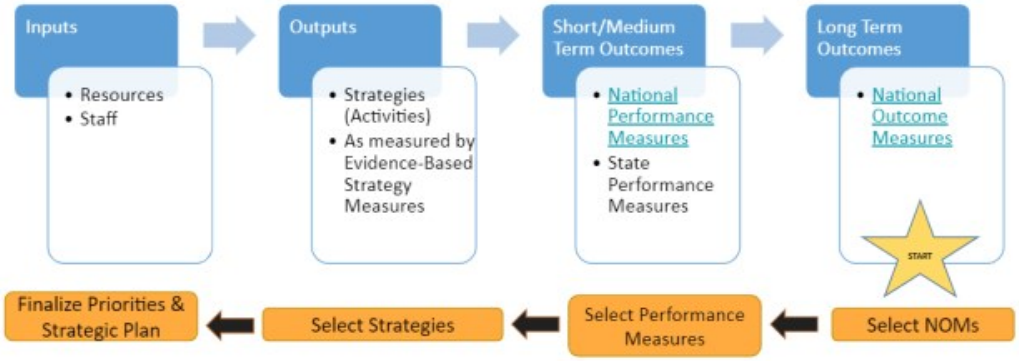
III.C. Needs Assessment

FY 2020 Application/FY 2018 Annual Report Update

Ongoing Needs Assessment Activities

Planning for the 2021-2025 Maternal and Child Health (MCH) Needs Assessment began in 2018 with the development of a project charter (Appendix A). The first MCH Needs Assessment Steering Committee meeting occurred in May 2019. The project charter was approved during this meeting. In June 2019, the MCH Unit hosted a needs assessment launch webinar.

The image below shows the process of selecting priorities beginning with selecting national outcome measures and moving backwards along a logic model continuum.



A stakeholder survey released in early 2019 asked about stakeholder needs assessment requirements. Forty-seven percent of respondents (n=24) responded that their organization had needs assessment requirements. The MCH Unit helped establish a crosswalk of needs assessment requirements including but not limited to Title V, Maternal, Infant, and Early Childhood Home Visiting (MIECHV), Mental Health and Substance Abuse Block Grant, State Primary Care Office, Child Abuse Prevention and Treatment Act (CAPTA), Head Start community-wide needs assessments, State Health Assessment, hospital community health needs assessments, etc.

The MCH Unit and MCH Epidemiology Program routinely review available performance and outcome measure data to inform programmatic decisions. Ongoing surveillance is being developed for key MCH indicators using Tableau software. Stakeholder/consumer input is important and efforts are underway to develop a youth council and parent advisory council, both of which will be useful for ongoing needs assessment.

MCH Population Needs

Women's/Maternal

Pregnancy Risk Assessment Monitoring System (PRAMS) data indicate a continued reduction in maternal smoking. In 2017, 10% of new mothers reported smoking during the last three months of pregnancy as compared to 15.9% in 2012. This difference is not statistically significant. Despite the reduction in smoking during pregnancy, Wyoming's rates of maternal smoking are persistently higher than the U.S. 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 Behavioral Risk Factor Surveillance System (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 are also of concern for Wyoming mothers. PRAMS data (2016-2017) revealed that 5.9% 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.

In 2015, Wyoming's severe maternal morbidity rate (108/10,000 delivery hospitalizations) was lower than the U.S. rate (144/10,000 delivery hospitalizations). Comparisons since the implementation of ICD10 are not possible. The most common severe maternal morbidity is transfusion, followed by eclampsia.

Emerging Issue - Maternal Mortality
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 2013-2017 is similar to the national rate. An analysis of Wyoming pregnancy-associated deaths from 2013-2015 vital records mortality files indicates 58% of the deaths were classified as accidental with half due to overdose and half due to motor vehicle crashes. Suicide accounted for 16% of the pregnancy-associated deaths during that time. Planned development of a joint UT-WY Maternal Mortality Review will improve understanding of these causes of maternal deaths. The MCH Epidemiology Assignee is working to evaluate the pregnancy checkbox on the death certificate and participating with a CDC workgroup for maternal mortality case finding. These activities will lead to improved surveillance of maternal mortality in Wyoming.

Wyoming PRAMS data are used to track changes in the use of contraception after delivery. In 2017, 43.2% of Wyoming women reported that they use the most effective contraceptive method, which include both permanent methods such as vasectomy or tubal ligation, and highly effective reversible methods such as implants or intrauterine devices. The proportion of women who report using the most effective method increased over 2016 levels (34.6%), although the difference was not statistically significant. Another quarter (26.5%) reported the use of moderately effective birth control including birth control pills, injectables, and the patch, ring, or diaphragm.

The use of long acting reversible contraception (LARC) in 2017 was 21.9%. This total was not statistically different than use reported in 2016 (15.8%).

Emerging Issue - Maternal Mental Health and Substance Abuse
As with other states, opioid use in pregnant women and neonatal abstinence syndrome (NAS) are emerging concerns in Wyoming. Although NAS rates have been increasing, the NAS rates and numbers are relatively low, especially compared to U.S. rates and rates in states ravaged by the opioid epidemic. Wyoming PRAMS recently added fifteen questions about opioid use before and during pregnancy to better track this emerging issue.

Postpartum depression is similar to the U.S. at 12.7% of new moms reporting postpartum depression in 2017 (PRAMS data). Suicide and drug overdoses are a leading cause of maternal mortality in Wyoming.

Perinatal/Infant
Infant mortality in Wyoming was 4.9 deaths per 1,000 live births during the period of 2014 - 2018, slightly lower than the U.S. 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 63% of Wyoming infant deaths in 2017. As noted above, preconception health is one contributing factor to infant mortality in Wyoming. Wyoming infant mortality data indicate an increase in the rate of sleep related sudden unexpected infant (SUID) death in 2016-2017. PRAMS data from 2017 indicate that 77% of infants always or often sleep alone in a crib and 86% of infants are put to sleep on their backs.

Wyoming's 2017 preterm birth (<37 weeks) and low birth weight (LBW) rates have not significantly changed since

2009, and in 2017 were 8.9% and 8.7%, respectfully Both 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 and rates are significantly higher than the U.S. rates. 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. There are challenges in collecting accurate and consistent non-fatal injury data. In addition, the switch from ICD-9-CM to ICD-10-CM in Wyoming hospitals led to difficulty in classifying injury hospitalizations. MCH Epidemiology is working with a subcontractor to survey hospitals to understand 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.

Twenty seven percent of Wyoming children (6-11 years) were active for 60 minutes every day, similar to the U.S. rate (NSCH, 2016-2017). 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 31.7% of Wyoming parents reported that they completed a developmental screen for their child (9-35 months old) in the last year (NSCH, 2016/2017). This low screening rate and the rate of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screening in Wyoming (41.4% of 1-14 years old eligible in FY18 received a screen) are concerning.

Adolescent

As seen nationally, the Wyoming teen birth rate continues to steadily decline. However, the Wyoming teen birth rate (24.6 births per 1,000 women aged 15-19, 2017) remains higher than the national rate (18.8 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. In 2017, the Native American birth rate (44.2 births per 1,000) was just over twice as high as the White rate (19.8 births per 1,000) while the Hispanic rate has declined to 31.5 births per 1,000.

The Wyoming adolescent suicide rate of 31.1 deaths per 100,000 during 2015 - 2017 (15-19 years old) is more than two times the national rate (10.5 per 100,000) and has increased slightly since 2012. 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% reported no bullying in 2016, 68% in 2018) and marijuana use; in both 2014 and 2016, about 78% of youth report zero occasions of lifetime use and in 2018, 77.5% reported 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 2018 (Wyoming Prevention Needs Assessment).

The last available year for Wyoming Youth Risk Behavior Surveillance System (YRBSS) in Wyoming is 2015 as the state has not applied for the grant. As a result infrastructure and capacity for data surveillance among the adolescent population 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. Based on data from the NSCH, only 17.9% of Wyoming adolescents with special

health care needs received the necessary services to transition to adult health care, which is similar to the National number of 17%. Less than 12% of Wyoming CSHCN received care in a well-functioning system compared to 14.8% of all CSHCN nationally.

Crosscutting

Insurance Coverage
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. The 2017 American Community Survey data reports that 9.9% of Wyoming children are uninsured, as compared to 4.8% of U.S. children. Proportions are higher for children with a reported disability (defined as activity limitations) at 11.2%; for those who do not speak English (18.5%); and for children who are non-Hispanic American Indian/Alaskan Native (32.5%).

Title V Program Capacity Updates

In FFY18, the MCH Unit filled 3 vacancies including two program managers and an administrative assistant. As of June 15, 2019, the MCH Unit has two additional vacancies. A new Women and Infant Health Program Manager (WIHPM) will start August 1st and MCH leadership is in the process of redesigning the MCH administrative assistant position to provide additional Title V grant coordination support.

Currently, MCH does not have a family/parent representative on staff. However, a statewide youth council is in development.

Title V Partnerships and Collaborations Updates

In an effort to better support MCH collaborations, the Wyoming MCH Unit Collaboration Survey launched in early 2018. Through this survey, staff hoped to learn how to improve partnership activities like communication, and understand our current level of stakeholder partnership. Sixty-six (66) individuals completed the survey, representing a 63% response rate. A summary of the comments received through the MCH Collaboration Survey is attached as Appendix B.

Other MCH Bureau investments
Two graduate student interns joined the MCH team in May/June 2018 as part of the MCH Workforce Development Center's MCH Title V Summer Internship Program. The student interns worked 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. See Appendix C.

MCH continues to partner with Parents as Teachers National Center (PATNC), the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) grantee in Wyoming, to build and support a network of home visiting organizations. In FFY18, the MCH Unit and PATNC met several times to discuss development of a Memorandum of Understanding (MOU) between organizations and coordination of the MIECHV and Title V needs assessments. A MOU will be established in 2019. To assure coordination of needs assessment activities, the MCH Unit Manager sits on the MIECHV Needs Assessment Steering Committee and the Wyoming MIECHV Director sits on the Title V/MCH Needs Assessment Steering Committee.

Other Federal investments

MCH continues to partner with Wyoming's Title X grantee, WHC, to ensure optimal coordination of activities related to family planning. A new WHC Executive Director began in June 2019 and monthly Title V/Title X partnership meetings are scheduled to continue to maintain and strengthen partnerships.

Other HRSA programs

The Wyoming Primary Care Association (WYPCA) is a key partner in MCH priority activities. Specifically in FFY18, the WYPCA supported promotion of adolescent well visits through participation in the AYAH CoIIN project. Currently (FFY19), WYPCA provides leadership and support to identify and respond to challenges related to reimbursement for LARCs in rural health clinics, federally qualified health centers, HIS clinics, and hospitals.

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.

Tribes

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.

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.

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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 (CollN) 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.

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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

o **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

o **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

o **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

o **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

o **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

o **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

o **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

	2016		2017	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$1,100,000	$1,105,862	$1,125,000	$1,085,502
State Funds	$1,951,264	$1,815,114	$1,775,473	$1,867,148
Local Funds	$0	$0	$0	$0
Other Funds	$599,192	$560,477	$600,119	$508,443
Program Funds	$0	$0	$0	$0
SubTotal	$3,650,456	$3,481,453	$3,500,592	$3,461,093
Other Federal Funds	$2,192,704	$1,447,303	$2,179,510	$1,534,364
Total	$5,843,160	$4,928,756	$5,680,102	$4,995,457

	2018		2019	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$1,125,000	$1,083,689	$1,100,000	
State Funds	$1,825,591	$1,948,353	$1,736,286	
Local Funds	$0	$0	$0	
Other Funds	$550,000	$427,238	$639,305	
Program Funds	$0	$0	$0	
SubTotal	$3,500,591	$3,459,280	$3,475,591	
Other Federal Funds	$1,600,234	$1,559,910	$1,578,412	
Total	$5,100,825	$5,019,190	$5,054,003	

	2020	
	Budgeted	Expended
Federal Allocation	$1,100,000	
State Funds	$1,825,591	
Local Funds	$0	
Other Funds	$550,000	
Program Funds	$0	
SubTotal	$3,475,591	
Other Federal Funds	$1,877,176	
Total	$5,352,767	

III.D.1. Expenditures

In FFY18, Wyoming received $1,083,689 in Title V federal funding. 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.

As of September 25, 2019, the MCH Block Grant expenditures ($1,083,689) for FFY18 were categorized into the following categories:

- Prevention and Primary Care for Children (35.3%);
- Children with Special Health Care Needs (39.9%);
- Administrative (3.4%); and
- Other (Family) (21.4%).

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 WIHP.

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 FTE program manager positions which are organized according to the population groups they serve and 3 FTE 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 one staff position in the Injury and Violence Prevention Program.

In FFY18, 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)
- Wyoming Genetics Program (Promote preventive and quality care for children/adolescents, including those with special health care needs)
- Adolescent-Centered Environment Assessment Process (ACE-AP) facilitated by the University of Michigan and provided to four pediatric/family practice clinics (Promote preventive and quality care for adolescents)
- Parent Leadership Training Institute (all priorities and overall MCH Unit core value of engagement)

The MCH Unit provides funding to support initiatives of partner organizations such as the Wyoming Department of Family Services (Children's Trust Fund), Wyoming Department of Workforce Services (Wyoming Headstart Collaboration Office), and Wyoming Department of Transportation (Highway Safety). Examples include funding to support a Strengthening Families Protective Factors training and funding to support the development of a healthy policies toolkit for early care centers.

Using state matching funds, MCH continues to fund local-level care coordination services and 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 PHN jointly receive 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, also assist with meeting the required MOE.

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

The MCH 3.0 framework, the required Title V needs assessment, and strategic planning processes provides 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 direct assistance funded CDC-assigned MCH Epidemiologist. Three positions, the MCH Administrative Assistant, MCH Unit Manager and one epidemiologist, are funded with nearly 100% state match/maintenance of effort (MOE) dollars.

Wyoming's required MOE is greater than the legislatively-required match. Several programs assist in maintaining this level of funding effort: NBS, CSH and Immunizations. 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 CDPHE to analyze the laboratory specimens and provide confirmatory testing and follow-up care to diagnosis, as needed. 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 care coordination services for CYSHCN 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 CYSHCN, state matching funds support local care coordination services by PHNs and limited gap filling financial assistance for those children who qualify financially and medically.

The MCH Unit remains able to meet the required MOE of $2,375,591.

Wyoming's proposed budget for FFY 2020, as reflected on Form 2, includes the following budget items:

- Prevention and Primary Care for Children: $400,000 (36%)
- Children with Special Health Care Needs: $385,000 (35%)
- Administrative Costs: $45,000 (4%)
- State MCH Funds: $1,825,591
- Other Funds (NBS): $550,000
- State MOE: $2,375,591

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

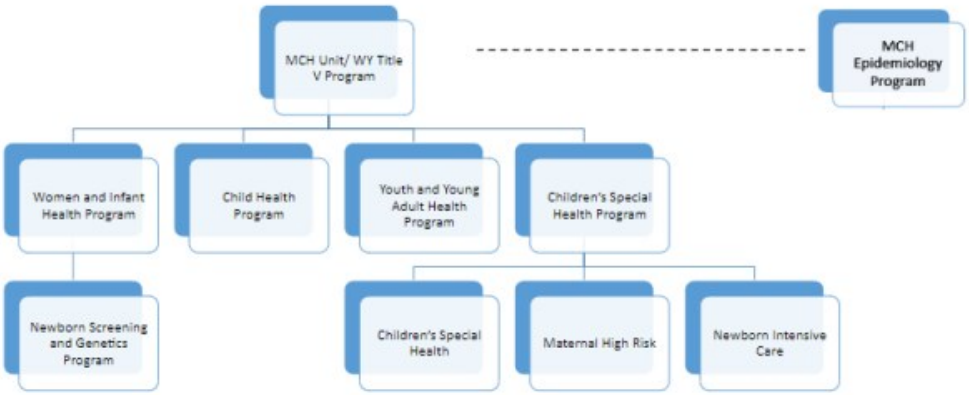
III.E.2. State Action Plan Narrative Overview

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 (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.

Organizational Structure



The Wyoming Title V Program receives approximately $1,100,000 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. To view a summary of the collaboration survey results, see Appendix B.

The MCH Unit is committed to partnerships that assure access to the delivery of quality health care services for mothers, infants, 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 EPSDT rates and our assessment of levels of maternal and neonatal care.

The MCH Unit revised its core values in 2018. They are: data driven, engagement, health equity and life course perspective, and systems level approach. This framework along with realistic assessments of staff capacity allows MCH to determine the most appropriate role in priority-related work.

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 MCH Unit has a current staff of nine. In 2019, the Women and Infant Health Program Manager and MCH Administrative Assistant positions became vacant. Both will be hired before end of Summer 2019.

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 WDH PHD. The program includes an MCH Epidemiology Program Manager, an MCH Epidemiologist/Pregnancy Risk Assessment Monitoring System (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 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.

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. See Attachment D to view 2018 Healthsat documents for each three MCH programs who are required to report program documentation to the legislature each year. 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 Unit staff participate on the PHD Performance Management and Quality Improvement Council (PMQIC). Council members offer technical assistance and quality improvement tools to programs to help increase program effectiveness and efficiency. The PMQIC vision is that PHD will have a culture of performance management and quality improvement that is fully embedded into the way PHD does business, across all levels. Leadership and staff will be fully committed to performance management and quality improvement and related efforts will be communicated regularly internally and externally.

Currently, the MCH Unit Manager serves on the PHD Workforce Development Workgroup. In 2019, the group finalized a Workforce Development Plan.

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 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 assesses 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.

The MCH Unit submitted a Public Health Associate Program (PHAP) application to enhance parent/family

engagement efforts and increase capacity to monitor Title V block grant activities. Although the application was not accepted, the MCH Unit continues to seek out opportunities to increase workforce capacity through internships. In 2018, the MCH Unit repurposed a PHAP application to develop a workplan for a Master of Social Work student intern from University of Wyoming. The MCH Unit plans to have at least one Master's or Bachelor's level social work intern join the team each year. This opportunity resulted from strong partnership between the MCH Unit and Rural and Frontier Health Unit due to the fact that both Unit Managers are social workers and both completed a collaboration project together as part of the Certified Public Manager Course.

During Summer 2018, two graduate level public health interns supported a collaborative project between MCH and Medicaid to improve Early and Periodic Screening, Diagnostic and Treatment (EPSDT) rates and promote Bright Futures, 4th Edition. Their final report and recommendations can be found in Appendix C.

In February 2019, the Child Health Program Manager and the Youth and Young Adult Health Program Manager attended the Strengthening Families Protective Factors Framework Training. The training was sponsored by Wyoming Children's Trust Fund and facilitated by national trainers from the National Alliance of Children's Trust and Prevention Funds. The purpose of this 21-hour course was to train participants to be recognized national instructors on the five protective factors (Parental Resilience, Knowledge of Parenting, Knowledge of Child Development, Concrete Support in Times of Need, and Social Connections). Applying the five protective factors provides the MCH Unit with tangible tools to promote work that considers the social determinants of health, promote health equity, and promotes a life course approach. Another benefit of the training was connecting MCH staff with key partners from the Department of Family Services, Department of Education, UPLIFT (Wyoming's Family Voices affiliate), Align (Wyoming's provider of early childhood educator continuing education), and the University of Wyoming.

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

The MCH Unit revised its core value of engagement in December 2018 ahead of the current needs assessment process. The new value of “engagement” demonstrates a Unit commitment to ‘cultivate authentic collaboration and trust with families and community partners.’

Wyoming Parent/Family Engagement Workgroup

Meaningful parent and family partnership requires dedicated staff and resources. The MCH Unit submitted a Public Health Associate Program (PHAP) application in 2018 and 2019 to increase capacity to improve parent and family partnership. In 2018, Wyoming was selected as a site but not matched with an associate. To continue planned efforts despite not matching, the Unit leveraged an opportunity to welcome a University of Wyoming masters-level social work student intern to the Unit in the Fall of 2018 to develop a parent/family engagement vision and plan. The intern conducted foundational research on parent/family engagement, developed a stakeholder survey to better understand current requirements and activities, conducted key informant interviews, and planned a stakeholder meeting. Of the 72 stakeholders who responded to the survey, 71% (n=51) responded that their organization has parent/family/youth/young adult engagement requirements. Of those with requirements, 61% stated their organizational mission required it, 51% stated their grant/funder required it, 22% stated a law/statute required it, and 15% stated ‘other’. Forty respondents shared information about how they currently engage parents/families/youth/young adults. The student used Title V MCH Services Block Grant guidance to describe the types of activities which define parent/family engagement. See below for a breakdown of respondents’ activities.

Q3 In what areas do you currently engage parents/families/youth/young adults? (Check all that apply)

Advisory Groups (i.e. membership on governor's council, steering committee, parent/youth council) (1)		35.00%	14
Consumer Survey (i.e. customer satisfaction, parent feedback) (2)		27.50%	11
Strategic and Program Planning (3)		37.50%	15
Quality Improvement (4)		32.50%	13
Workforce Development and Training (i.e. staff trainings based on parent input, parent/youth leadership training) (5)		17.50%	7
Grant Development and Review (6)		17.50%	7
Materials Development (7)		20.00%	8
Advocacy (8)		52.50%	21
Policy Development (9)		20.00%	8
Direct Service (i.e. child welfare, home visiting) (10)		45.00%	18
Support Group (i.e. peer-to-peer, professionally facilitated) (11)		35.00%	14
Other (please specify) (12)	Responses	17.50%	7
Total Respondents: 40			

In April and June 2019, a group of over 20 engaged stakeholders met to discuss opportunities to improve and coordinate statewide parent and family engagement activities. Next steps include development of a crosswalk describing current parent/family engagement activities, development of a shared definition of parent/family engagement, and recruitment of parents to join our planning group. The vision of this workgroup is still in development but there is momentum building for the development of a statewide family advisory council. Through a partnership with the Wyoming Children’s Trust Fund, the group heard from guest speakers from the National Alliance of Children's Trust and Prevention Funds about their national parent advisory council and TA provided to other states in developing statewide councils. In June 2019, the MCH Unit accepted another social work intern who will continue these efforts in Fall 2019.

Fatherhood Engagement
A MCH Unit staff member attended a 2019 stakeholder meeting facilitated and led by The Fatherhood Initiative and hosted by the Wyoming Children's Trust Fund. The goal of the meeting was to bring together interested stakeholders to develop a fatherhood engagement strategic plan. This group of stakeholders drafted a shared mission statement, vision statement, core values, and a fatherhood engagement survey which will be distributed in the coming months. All efforts will be made to coordinate the efforts of the Wyoming Parent/Family Engagement Workgroup and the fatherhood engagement initiative.

Family Voices Partnership
The MCH Unit continues to work toward strengthening its relationship with UPLIFT, Wyoming's Family Voices affiliate. The MCH Unit supported UPLIFT's Executive Director's attendance at the 2019 Family Voices conference.

Youth Council Development
In 2019, the Youth and Young Adult Health Program released a Request for Applications to support the development of a statewide youth advisory council. 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. The contract for youth council coordination is expected to be executed by end of 2019.

Parent Leadership Training Institute
During FFY18, the MCH Unit funded Laramie County Community Partnership to conduct a Parent Leadership Training Institute (PLTI) class in Laramie County, Wyoming. Fifteen parents started the class and completed some coursework and a total of six participants graduated. Project topics addressed domestic violence, early childhood education and pre-K expansion, anti-bullying and positive peer support, CPR education access, Department of Family Services policies to support children who experience and/or witness domestic violence, and supporting families to achieve self-sufficiency. The MCH Unit does not have current plans to fund additional PLTI sites. The MCH Unit plans to engage the newly developed Wyoming Parent/Family Engagement Workgroup to determine if and how PLTI will be implemented in the future. The MCH Unit hopes to identify opportunities for improved evaluation and sustainability before supporting future cohorts.

Title V funds were used to train over 100 PLTI graduates over the past 10 years. Currently, there is no frequent communication with our graduates and no formal way to connect graduates with opportunities to use their leadership skills. A survey released in 2018 to all graduates only yielded 15 responses. The MCH Unit hopes a future MCH intern will develop a searchable inventory of trained parent leaders 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. The goal is to match parents with both MCH opportunities as well as opportunities to lend expertise to other Wyoming agencies and organizations.

Parent Partner Project
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 to assist other parents of CSHCN. 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. Parent Partners are paid $15.00 per hour for a total of up to 16 hours per week. In addition A

Parent Partner statewide coordinator position has been added. This position will be filled by a current Parent Partner and will allow for a Wyoming specific point of contact. This position will support identifying providers' offices to incorporate new Parent Partners and will also identify and try new Parent Partners.

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

The State Systems Development Initiative (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 MCH Epidemiology staff who gather and analyze the necessary data to complete the block grant reporting. This support includes development of Evidence-Based Strategy Measures (ESMs) and data gathering efforts for 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 data linkage between Wyoming birth and death certificates, as well as Wyoming death certificates for women of reproductive age to births - enhancing our ability to monitor infant and maternal mortality.
- Creation of linkages between birth certificates and hospital discharge data as well as birth certificates and Medicaid claims.
- Creation of “real time” access to reports, focused on newly developed linkages.
- 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 certificate (and eventually birth certificates) - increasing accuracy and decreasing burden and time for providers to complete certificates.

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 Market Decisions, LLC.
- 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

Wyoming's public health system is mixed (centralized and decentralized), with four independently run county health departments and the remaining 19 counties utilizing both state and county staff. The MCH Unit works closely with both state and county staff in all 23 counties to assure access to home visiting and care coordination services for CSHCN, high risk pregnant women, and high risk infants. Assuring access to these services is especially important in rural and frontier communities with limited providers. Ten counties have no obstetricians/gynecologists and 12 counties have no pediatrician. Limited access to both primary care and specialty providers means that many families seek care across state lines. This makes the health care delivery system in Wyoming unique and challenging.

Both MCH and PHN participate in the Wyoming Home Visiting Network (WYHVN). This network of committed stakeholders promotes a system of high quality home visiting from pregnancy through age three as a core early childhood service available to all Wyoming families. Key stakeholders include Early Head Start, 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.

CSH 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.

Through a partnership between the MCH Unit, Parents as Teachers National Center (PATNC), and other key early childhood system partners, efforts are underway to map the early childhood system. The MCH Unit participated in the development of a Request for Proposals (RFP) for MIECHV needs assessment activities to include a systems map. The RFP guidance includes instructions for the proposer to consider the needs and services for CYSHCN in completion of the needs assessment and map. The MCH Unit will be significantly involved in the completion of the MIECHV needs assessment, as will PATNC in the completion of the Title V needs assessment.

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. Results confirmed that Wyoming is the only state without a level III/IV maternal or neonatal care hospital. This means that many pregnant women, children, and families must seek care out of state. Over ten percent of births occur outside of Wyoming. There is limited data available to determine the reason for delivering outside of the state. There are plans to repeat LOCATe statewide using a revised tool once it is released. The act of completing the assessment has significantly increased 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 (WYPQC) and in 2018, a WYPQC Coordinator contract was executed. 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 PHD and Healthcare Financing (Medicaid) meet monthly to discuss ongoing and new collaboration opportunities. The MCH Unit routinely provides updates to the 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 the use of effective family planning
- Promote preventive and quality care for children and adolescents
- New: Prevent maternal mortality

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 worked with MCH, Medicaid and other key stakeholders to develop a plan to implement Bright Futures, 4th Edition during Summer 2018. 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 can be viewed in Appendix C. In 2019, the MCH Unit will reconvene interested stakeholders to prioritize and implement the students' recommendations. The first step is to form a Bright Futures Implementation Task Force. So far, the MCH Unit has commitment from Wyoming Medicaid, WYhealth, and the Immunizations Unit to participate.

Health insurance coverage for children in Wyoming is an emerging concern. The MCH Unit promotes enrollment in Medicaid 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 reducing barriers to the use of long-acting reversible contraception (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 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 in hospital settings and from encounter fees in rural health clinics, federally qualified health centers, and Indian Health Services clinics. See Women/Maternal Health Domain Annual Report for more details on current efforts to change Medicaid policy related to LARC reimbursement.

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."

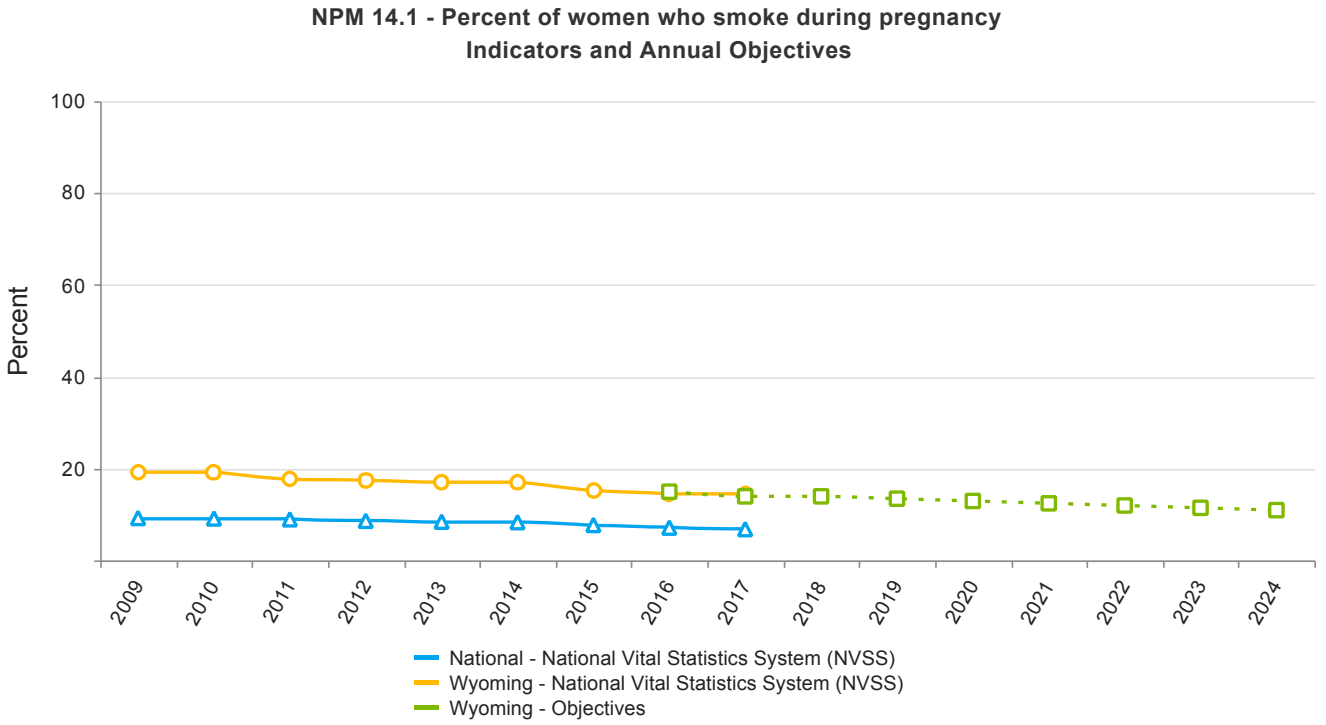
III.E.2.c State Action Plan Narrative by Domain

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	Data Not Available or Not Reportable	NPM 14.1
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2017	8.7 %	NPM 14.1
NOM 5 - Percent of preterm births (<37 weeks)	NVSS-2017	8.9 %	NPM 14.1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2017	26.8 %	NPM 14.1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2016	4.3	NPM 14.1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2016	5.0	NPM 14.1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2016	3.2	NPM 14.1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2016	1.8	NPM 14.1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2016	135.4	NPM 14.1
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2016	Data Not Available or Not Reportable	NPM 14.1
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2016_2017	90.3 %	NPM 14.1

National Performance Measures



Federally Available Data			
Data Source: National Vital Statistics System (NVSS)			
	2016	**2017**	**2018**
Annual Objective	15	14	14
Annual Indicator	15.2	14.6	14.4
Numerator	1,148	1,043	968
Denominator	7,540	7,152	6,735
Data Source	NVSS	NVSS	NVSS
Data Source Year	2015	2016	2017

State Provided Data			
	2016	2017	2018
Annual Objective	15	14	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						
	2019	2020	2021	2022	2023	2024
Annual Objective	13.5	13.0	12.5	12.0	11.5	11.0

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**	**2024**
Annual Objective	25.0	30.0	30.0	35.0	35.0	40.0

ESM 14.1.2 - # of providers trained on SCRIPT implementation

Measure Status:						Active
Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	7.0	7.0	8.0	10.0	10.0	10.0

State Performance Measures

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

Measure Status:					Active	
Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	66.0	68.0	70.0	71.0	72.0	73.0

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 Wyoming Quitline with 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.

Improve LARC reimbursement policies in RHC, FQHC, and Hospitals.

Strategies

Provide technical assistance to Wyoming hospitals implementing IPP LARC protocols.

Develop an IPP LARC toolkit

Complete a cost analysis on LARC usage versus unintended pregnancy in Wyoming.

Change Medicaid policies related to LARC reimbursement in hospitals (IPP LARC) and RHCs, FQHC, and IHS (Global LARC).

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

Priority Need

Prevent Infant Mortality

Objectives

Improve perinatal outcomes.

Strategies

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

Offer provider training on safe prescribing to reduce opioid use/misuse in pregnancy and postpartum periods

Annual Report Fiscal Year 2018: This section provides a summary of Federal Fiscal Year 2018 (FFY18) activities, accomplishments, and challenges related to National Performance Measures (NPMs) and State Performance Measures (SPMs) (2016-2020) for the Women/Maternal Health Domain.

Priority	Performance Measure	ESM (if applicable)
Improve Access to and Promote Use of Effective Family Planning	**SPM 6: Use of most/moderately effective contraception by postpartum women**	N/A

In spring 2015, the MCH Unit selected Improve Access to and Promote Use of Effective Family Planning as one of its 2016-2020 priorities. There is no available NPM for this priority. Healthcare access in a rural and frontier state can be challenging, and this is especially true for family planning services. Contraception choices can be limited when the nearest family planning clinic is hours away, and some clinics may not be equipped to offer a full range of contraceptive options. Access to effective family planning not only decreases unintended pregnancy rates, but helps women attain healthy birth spacing, delay pregnancy when desired, and promotes the well-being and autonomy of women. Wyoming women face a number of barriers to widespread family planning access. Long-acting reversible contraception (LARCs) such as intrauterine devices (IUDs) and implants are the most effective form of birth control available, but are often not accessible or offered to women as a contraceptive choice. According to program partners, stakeholders, and current work in the state, the bundling system for payments in federally qualified healthcare centers (FQHCs), Rural Health Clinics (RHCs), IHS, and hospitals is the primary barrier to accessing LARCs. The current reimbursement structure disincentivizes providers to offer LARCs due to little or no reimbursement for the procedure or the device.

The Wyoming Pregnancy Risk Assessment Monitoring Survey (PRAMS) aggregate data from 2012 - 2015 show that 31.2% of live births in Wyoming were the result of unintended pregnancies and 15.8% of women indicated that they were not sure what they wanted.

Strategy 1: Provide technical assistance to Wyoming hospitals implementing immediate post-partum (IPP) LARC protocols

The WIHP, MCH Epidemiology Program, Wyoming Medicaid, and a provider champion participated in the Association of State and Territorial Health Officials (ASTHO) Learning Community on Increasing Access to Contraception from 2016 to 2018. During that time, the Wyoming team partnered with a local hospital to pilot a project aimed at reducing barriers to IPP LARC insertions, with the support of a local physician champion and hospital leadership. This project helped identify primary barriers to implementation in a hospital setting in Wyoming. These barriers include hospital stocking, Medicaid reimbursement for device outside of the bundle, and provider uptake. Although many barriers must be addressed to reduce barriers to LARC use, the reimbursement challenges were greatest. At least one provider in the pilot hospital successfully billed Medicaid for IPP LARC; however, the workaround was not sustainable and not a possibility for all providers.

Strategy 2: Develop IPP LARC Toolkit

Efforts to unbundle LARC in hospital settings are on hold as DRG (Diagnosis Related Grouper) implementation continues. Wyoming Medicaid requests that the project team delay efforts to unbundle IPP LARC until at least 9-12 months after the DRG goes live. In the meanwhile, the project team will focus on reimbursement of LARCs as part of

the postpartum, outpatient global fee.

Strategy 3: Complete a cost analysis on LARC versus unintended pregnancy in Wyoming; Strategy 4: Change Medicaid policies related to LARC reimbursement in hospitals, RHCs, FQHCs, and IHS.

In order to further focus efforts on the reimbursement challenges of LARC, the WIHP applied for a State-Level Initiatives to Expand Access to LARC grant funding opportunity offered by the National Institute for Reproductive Health. WDH received a $25,000 grant to refocus LARC work in the state in early 2019. This grant opportunity will fund a cost analysis on the use of LARCs versus the cost of an unintended pregnancy in Wyoming. The cost analysis will be used to demonstrate the need for unbundling the cost of LARC devices in FQHCs, RHCs and hospital settings under both public and private insurance. Due to the barriers in the hospital setting, WDH will focus its efforts with Wyoming Medicaid to unbundle the LARC device and procedure fee in FQHCs and RHCs first. This will improve contraceptive access in the states most rural and frontier locations. The MCH Unit has partnered with the Wyoming Primary Care Association (WYPCA) and Wyoming Medicaid on this project, and has obtained the support of the WYPCA as a project partner and grant subrecipient.

The SPM for this strategy--the percentage of women aged 15-44 at risk of unintended pregnancy that is provided a most effective (i.e. sterilization, implants, intrauterine devices or systems (IUD/IUD)) or moderately effective (i.e., injectables, oral pills, patch, ring, or diaphragm) contraceptive method-- was adopted in FFY19 and will be reported in 2020. The MCH Epidemiology Program will also track other contraceptive care measures adopted by the National Quality Forum, as appropriate.

Priority	Performance Measure	ESM (if applicable)
Prevent Infant Mortality	**NPM 14.1: Percent of women who smoke during pregnancy**	• ESM 14.1.1: # of pregnant women referred to the Wyoming Quitline services from Healthy Baby Home Visitation • ESM 14.1.2: # of providers trained on SCRIPT implementation

The WIHP seeks to prevent infant mortality through reducing the percentage of women who smoke during pregnancy. Smoking during pregnancy has been linked to numerous health problems for the unborn infant, including placental issues, low birth weight, increased risk of premature birth, birth defects, and spontaneous abortion.

Strategy 1: Train health care providers in Smoking Cessation and Reduction in Pregnancy Treatment (SCRIPT) Program

The WIHP partnered with March of Dimes in April of 2017 to attend the 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 provided SCRIPT training at the Wyoming Public Health Association annual conference in September of 2018 on SCRIPT implementation, and eight public health providers, including six public health nurses (PHN), were trained on SCRIPT implementation. As of May

2019, Sweetwater County Public Health has plans in place to implement SCRIPT in their home visitation program, and data on this effort will be collected through the Healthy Baby Home Visitation program through the new PHN electronic health record, WebChart, that was implemented in late 2018. Currently, no MCH staff are trained in SCRIPT. This strategy will be continued after new staff receive training.

Strategy 2: Promote the Wyoming Quitline with pregnant and postpartum women, with a focus on women served through the Healthy Baby Home Visitation Program.

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 requires PHNs to ask about smoking status at every home visit and refer smoking clients to the Wyoming Quitline. The WIHP continues to promote the Wyoming Quitline through distribution of marketing materials in PHN home visiting and PHN offices.

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. The ESM for this strategy was adopted in FFY19 and will measure the success of the partnership between the MCH Unit, PHN, and Tobacco Prevention Program in getting women who smoke during pregnancy to enroll in the Quitline services. During FFY18, 18 pregnant women were referred to the WY Quitline.

(Inactivated) Strategy: Work with tribal tobacco program to build capacity to implement strategies for smoking cessation during pregnancy

In mid-2017, the WIHPM executed a contract with a licensed clinical psychologist to offer life-history training to healthcare and social service providers on the Wind River Reservation, specifically staff from the White Buffalo Recovery Center. Training topics were to include qualitative interviewing and coding techniques. By increasing capacity to conduct focus groups (and life history interviews), the program expected to learn more about circumstances surrounding smoking (and other risky health behaviors such as substance use) among pregnant and postpartum women use that information to better target information and interventions related to smoking cessation in pregnancy. In FFY18, due to staff turnover at White Buffalo Recovery Center and other barriers, the training was postponed indefinitely. When a new WIHPM begins in Summer 2019, this strategy will be reviewed further to identify if other strategies may be employed with tribal partners to reduce smoking among Native women.

Priority	Performance Measure	ESM (if applicable)
Prevent Infant Mortality	**N/A**	**N/A**

Strategy 1: Support hospitals in implementation of AIM safety bundles (e.g. hypertension, opioids use during pregnancy, low-risk Cesarean delivery)

The WIHP maintains an ongoing partnership with the Utah Department of Health related to their Alliance for Innovation in Maternal Health (AIM) ECHO series. Six Wyoming hospitals participated in Utah's Severe Hypertension in Pregnancy safety bundle ECHO starting in 2017. This partnership resulted from review of LOCATe results and identified opportunities to improve maternal emergency protocols and drills. Currently, Wyoming is not an AIM state and therefore cannot directly participate in AIM work. The requirements for states to participate as an AIM state are to have established both a maternal mortality review committee and a perinatal quality collaborative. The partnership

with Utah allows Wyoming hospitals to participate in AIM despite Wyoming not currently meeting eligibility criteria. Participating hospitals completed pre/post assessments and were permitted to register as AIM facilities and upload data into the AIM portal, thus contributing to data capacity on maternal safety in the hospital setting. Sessions for this safety bundle wrapped up in mid-2018, but plans are in place to offer refresher sessions in 2019. Wyoming facilities will be invited to participate in an in-person close-out meeting.

In late 2018, the WIHP released a survey to Wyoming hospitals to assess interest in future ECHO sessions and to help inform Utah's choice on their next ECHO topic. Eleven Wyoming hospitals responded. Wyoming survey results indicated an interest in the Support After a Severe Maternal Event safety bundle and Obstetric Care for Women with Opioid Use Disorder safety bundle. Utah selected the Obstetric Care for Women with Opioid Use Disorder safety bundle based on feedback from both Wyoming and Utah hospitals. The WIHPM will continue to partner with the Utah Department of Health to develop the ECHO session content and schedule. The WIHP anticipates increased participation from Wyoming hospitals due to increased hospital engagement in the Wyoming Perinatal Quality Collaborative (WYPQC).

New FFY19/20 Strategy: Offer provider training on safe prescribing to reduce opioid use/misuse in pregnancy and postpartum periods

In early FFY19, the WIHP, in partnership with the WDH Public Health Preparedness and Response Unit and their Cooperative Agreement for Emergency Response: Public Health Crisis Response funding, started work on a training for healthcare providers related to safe prescribing of opioids during pregnancy and postpartum. The training will be offered in Summer/Fall 2019 and will help providers meet a new legislative requirement of receiving three continuing medical education (CME) hours on safe prescribing every two years. The WIHP worked with partners at tertiary care facilities in Colorado to identify potential trainers who will be Dr. Kaylin Klie from Colorado Children's Hospital, Dr. Lesley Brooks from the Northern Colorado Health Alliance, and Dr. Ryan Jackman, an Addiction Medicine Specialist from St. Mary's Family Medicine. The WIHP will continue to work with the Wyoming Medical Society, American College of Obstetricians and Gynecologists (ACOG) and other physicians groups to engage providers who serve pregnant women in Wyoming, to ensure the training reaches a wide audience. It will also be broadcast virtually for remote attendance, and will offer continuing medical education for live attendees.

Through the same partnership with the WDH Public Health Preparedness and Response Unit and their Cooperative Agreement for Emergency Response: Public Health Crisis Response funding, the WIHP will release a Request for Application (RFA) to Wyoming hospitals to implement quality improvement projects that respond to the rising incidence of opioid use in pregnancy and postpartum and neonatal abstinence syndrome. This grant will support Wyoming hospitals in implementation of quality-improvement strategies or projects that prioritize one of the following project options:

1. **Obstetric Care for Women with Opioid Use Disorder Patient Safety Bundle** developed by the Alliance for Innovation in Maternal Safety (AIM)
    a. **Overview:** This project is being offered by the Utah Department of Health in conjunction with the University of Utah and the Utah Perinatal Quality Collaborative. Wyoming hospitals are invited to participate. For more information, visit safehealthcareforeverywoman.org.
    b. **Requirements:**
        1. Twelve-month commitment to attend AIM Project ECHO sessions. Sessions are offered bi-weekly, and funded hospitals must commit to attending no less than 75% of offered sessions. ECHO sessions will be offered using Zoom video conferencing software. Anticipated start date of this ECHO series will Fall 2019.

2. Execution of a required data-use agreement between the awarded hospital and AIM. Hospitals must report all required project data.
3. Attendance at *optional* in-person launch meeting (Fall 2019) and project wrap-up meeting, both of which will take place in Salt Lake City, Utah.
4. Required project updates and summary reports provided to the WYPQC, including updates at quarterly WYPQC meetings.

2. **Colorado Substance Exposed Newborns (CHoSEN) Hospital Learning Collaborative**
   a. **Overview:** This project is offered through a partnership with the Children's Hospital of Colorado, Illuminate Colorado, and the Colorado Perinatal Care Quality Collaborative. For more information, visit https://www.illuminatecolorado.org/sen.
   b. **Requirements:**
      1. Development of a project aim and selection of key drivers.
      2. Implementation of a comprehensive quality improvement project.
      3. Execution of a required data-use agreement between the awarded hospital and CHoSEN. Hospitals must report all required data into the RedCAP system.
      4. Attendance at *optional* in-person CHoSEN summit in Fall 2019.
      5. Required project updates and summary reports provided to the WYPQC, including updates at quarterly WYPQC meetings.

Additional WIHP Activities:

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 and Level IV facilities. 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.

Maternal Mortality Review

In FFY18, stakeholders engaged in the development of a WYPQC identified maternal mortality as a topic of interest. Specifically, several group members (including past Wyoming ACOG Chair) expressed an interest in supporting the development of a maternal mortality review committee. The MCH Epidemiology Assignee provided multiple presentations to interested stakeholders on current maternal mortality and morbidity data and TA and support was provided by the Centers for Disease Control and Prevention's (CDC) Division of Reproductive Health.

Over the past year, the MCH Epidemiology Assignee closely evaluated Wyoming's maternal mortality data, including evaluating the use of the pregnancy check box and developing a plan for case finding. The MCH Epi Assignee is a member of a CDC-led case finding workgroup. Wyoming now identifies cases through linkage of birth and fetal death certificates to mortality data, rather than just the pregnancy check box. This change has improved the quality of data that are submitted to CDC's Pregnancy Mortality Surveillance System. Data linkages are planned to further complement case finding.

In 2018, the topic of maternal mortality received significant national attention leading to the passing of the Preventing Maternal Deaths Act of 2018 which provides for establishing and supporting maternal mortality review committees (MMRCs) to review pregnancy-related and pregnancy-associated deaths. In March 2019, the CDC released a funding opportunity for existing MMRCs. Wyoming currently does not have a MMRC. The lack of in-state specialists, lack of needed legal protections for committee members, and small numbers provides a challenge for starting an independent MMRC at this time. While not an impossibility long-term, it is not a feasible option at this time for

Wyoming to start a separate MMRC. For that reason, Wyoming did not apply for the funding separately. Instead, partners at the Utah Department of Health generously offered to include Wyoming in their application for CDC MMRC funding and include a budget to support Wyoming efforts. This partnership will significantly increase Wyoming capacity to prevent maternal mortality and allow nearly immediate review of Wyoming deaths as part of the longstanding Utah Perinatal Mortality Review Program.

Women/Maternal Health - Application Year

Application Federal Fiscal Year 2020: 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.

Priority	Performance Measure	ESM (if applicable)
Improve Access to and Promote Use of Effective Family Planning	**SPM 6: Use of most/moderately effective contraception by postpartum women**	N/A

The WIHP will impact SPM 6: Use of most/moderately effective contraception by postpartum women -- by implementing the following selected strategies:

1. Complete a cost-analysis on LARCs and unintended pregnancy. The cost-analysis will be completed by Health Management Associates, Inc., a vendor recommended by the National Institute for Reproductive Health. The cost analysis will focus on costs and reimbursement structures under Wyoming Medicaid to demonstrate the need for unbundling of LARC devices under current Medicaid policy. The goal of the analysis is to provide justification for policy change at the state level that will allow for FQHCs, RHCs and hospitals to bill for the insertion of LARC devices, including the cost of the device itself, outside of the current reimbursement structures to which each is bound. The analysis will also consider the costs associated with LARC insertion and removal under private payers. This work can potentially demonstrate the need for policy change under the primary private payers in Wyoming, as needed and depending on reimbursement policies that are currently in place.
2. Change Medicaid policies related to LARC reimbursement in hospitals (IPP LARC) and RHCs, FQHCs, and IHS/Tribal Health clinics (Global LARC). Success of this strategy will be measured through the following:
    a. # of Medicaid policies implemented that reduce barriers to offering most/moderately effective forms of contraception (e.g. LARC)
    b. % of RHCs, FQHCs and IHS/Tribal Health clinics who serve women of reproductive age who are billing Medicaid (i.e. have at least one paid claim) for LARC
3. Conduct outreach about LARC reimbursement policy change. Assess training needs related to insertion and removal, availability of LARCs, and patient-centered contraceptive counseling. Additional outreach strategies will be designed and implemented by the WYPCA to communicate with consumers about LARC availability and coverage.

Wyoming's participation in ASTHO Increasing Access to Contraception learning collaborative, and the funding received from the National Institute for Reproductive Health, will continue to inform work to increase access to LARCs in a variety of settings 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. The WIHP 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, WYPCA, Title X, PHN, OB/GYN providers, and hospitals.

In addition, the WIHP, YAHAP, and MCH Unit Manager will meet monthly with Wyoming's Title X grantee, Wyoming Health Council, to continue to improve Title V/Title X partnership. A new Title X Director began in June 2019 and will be invited to participate in family planning work convened through Title V programs. The WIHP will also participate in a monthly family planning workgroup comprised of PHN staff to further coordinate and streamline statewide family planning efforts.

Priority	Performance Measure	ESM (if applicable)
Prevent Infant Mortality	**NPM 14: A) Percent of women who smoke during pregnancy B) Percent of children who live in households where someone smokes**	• ESM 14.1.1: # of pregnant women referred to the Wyoming Quitline services from Healthy Baby Home Visitation • ESM 14.1.2: # of providers trained on SCRIPT implementation

Beginning in FFY20, 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. Continue to work with the Healthy Baby Home Visitation Program to promote evidence-based smoking cessation programs as measured by the following:
    a. # of pregnant women referred to the Wyoming Quitline services from Healthy Baby Home Visitation
    b. # of postpartum women referred to the Wyoming Quitline services from Healthy Baby Home Visitation
2. Promote training on and implementation of SCRIPT in home visitation settings (including but not limited to Healthy Baby Home Visitation, Early Head Start, Parents as Teachers) as measured by the following:
    a. # of counties implementing SCRIPT in Healthy Baby Home Visitation Program.
    b. # of individuals trained in SCRIPT (by home visitation program)

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.

Wyoming Perinatal Quality Collaborative (WYPQC)

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

Opioid Safe Prescribing Training

The WIHP will continue to work with the Wyoming Medical Society, ACOG and other physicians groups to engage providers who serve pregnant women in Wyoming, to ensure the training reaches a wide audience. It will also be broadcast virtually for remote attendance, and will include CMEs for live attendees.

Opioid Hospital Grants

Provide funding to Wyoming hospitals to implement projects that respond to the rising incidence of opioid use in pregnancy and postpartum, and with it the increase in substance-exposed newborns seen in the labor and delivery environment.

Maternal Mortality Review

The WIHPM, MCH Unit Manager, and MCH Epidemiology Assignee will work closely with the Utah Department of Health to develop a process for reviewing Wyoming maternal deaths as part of the Utah Perinatal Mortality Review Program. Notice of funding awards is expected in August 2019.

The proposed draft process includes:

- Wyoming MCH Epidemiologists conducts case identification activities.
- WIHP contracts with abstractor who will request records based on case identification.
- Contracted Wyoming abstractor abstracts records.
- Contracted Wyoming abstractor enters case information into Maternal Mortality Review Information Application (MMRIA)
- Deidentified case summary automatically generated in MMRIA and reviewed by Utah MMRC. Up to four Wyoming representatives will attend reviews twice a year to review Wyoming deaths.
- Utah MMRC develops recommendations using committee decision form and sends Wyoming recommendations to the Maternal Mortality Subcommittee of the WYPQC for review/prioritization.
- WYPQC Maternal Mortality Subcommittee disseminates approved/prioritized recommendations to WYPQC and other partners for action.
- WYPQC acts on recommendations

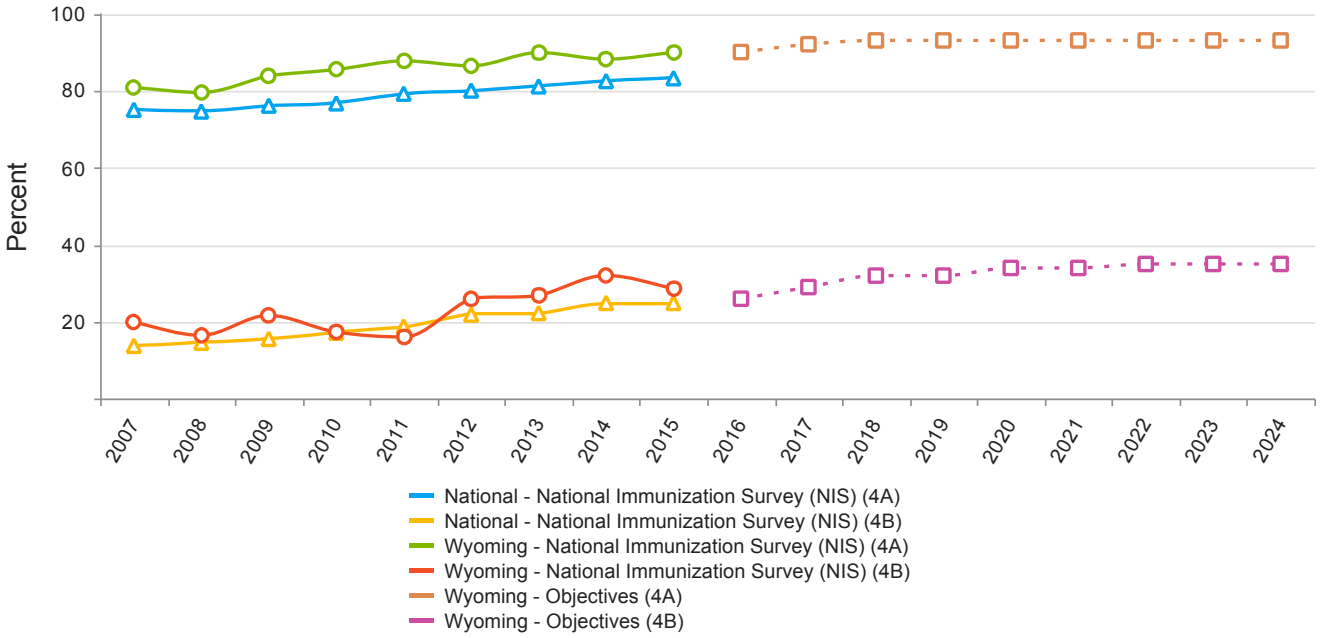
Perinatal/Infant Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2016	5.0	NPM 4
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2016	1.8	NPM 4
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2016	Data Not Available or 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 Indicators and Annual Objectives



NPM 4A - Percent of infants who are ever breastfed

Federally Available Data			
Data Source: National Immunization Survey (NIS)			
	2016	**2017**	**2018**
Annual Objective	90	92	93
Annual Indicator	89.7	88.3	90.0
Numerator	5,817	5,853	6,269
Denominator	6,486	6,628	6,963
Data Source	NIS	NIS	NIS
Data Source Year	2013	2014	2015

State Provided Data			
	2016	2017	2018
Annual Objective	90	92	93
Annual Indicator	91	90.7	
Numerator			
Denominator			
Data Source	PRAMS	PRAMS	
Data Source Year	2014	2016	
Provisional or Final ?	Final	Final	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
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**	**2018**
Annual Objective	26	29	32
Annual Indicator	27.0	32.0	28.8
Numerator	1,693	2,049	1,959
Denominator	6,263	6,412	6,790
Data Source	NIS	NIS	NIS
Data Source Year	2013	2014	2015

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	32.0	34.0	34.0	35.0	35.0	35.0

Evidence-Based or –Informed Strategy Measures

ESM 4.4 - Number of Hospitals Participating in the Wyoming 5-Steps to Breastfeeding Success Program

Measure Status:	Active	
State Provided Data		
	2017	**2018**
Annual Objective	4	4
Annual Indicator	4	4
Numerator		
Denominator		
Data Source	Women and Infant Program	Women and Infant Health Program
Data Source Year	2017	2018
Provisional or Final ?	Final	Final

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	0.0	4.0	4.0	4.0	4.0	4.0

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**	**2024**
Annual Objective	100.0	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**	**2024**
Annual Objective	90.0	90.0	95.0	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	2018
Annual Objective		54	70
Annual Indicator	51.9	68	80.6
Numerator	42	68	50
Denominator	81	100	62
Data Source	Wyoming Vital Statistics Services	Wyoming Vital Statistics Services	Wyoming Vital Statistics Services
Data Source Year	2015	2016	2017
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	80.0	80.0	81.0	81.0	82.0	82.0

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 trained Certified Lactation Counselor (CLC)

Promote breastfeeding within the Healthy Baby Home Visitation Program.

Award mini-grants and provide ongoing technical assistance to hospitals participating in the Wyoming 5-Steps to Breastfeeding Success Project.

Develop a hospital recognition program for Wyoming 5-Steps to Breastfeeding Success.

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 - Number of Hospitals Participating in the 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) results.

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

Develop a Wyoming Perinatal Quality Collaborative.

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.

State Action Plan Table (Wyoming) - Perinatal/Infant Health - Entry 4

Priority Need

Prevent Infant Mortality

Objectives

Reduce infant mortality in Wyoming communities through implementation of Fetal and Infant Morality Review.

Strategies

Implement FIMR in pilot community.

Develop FIMR toolkit for use in additional communities.

Annual Report Fiscal Year 2018: This section provides a summary of Federal Fiscal Year 2018 (FFY18) activities, accomplishments, and challenges related to National Performance Measures (NPMs) and State Performance Measures (SPMs) (2016-2020) for the **Perinatal/Infant Health Domain**.

Priority	Performance Measure	ESM (if applicable)
Improve Breastfeeding Duration	**NPM 4: A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months**	• ESM 4.4: # of hospitals participating in the Wyoming 5-Steps to Breastfeeding Success program • ESM 4.6: Percent of hospitals demonstrating an increase in at least one step from baseline based on hospital self-reported assessment • ESM 4.7: Percent of counties that have at least one public health nurse trained as a Certified Lactation Consultant (CLC)

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. 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.

Strategy 1: Ensure each county has one nurse who is a trained Certified Lactation Counselor (CLC);
Strategy 2: Promote breastfeeding within the Healthy Baby Home Visitation Program

To ensure that mothers and their infants served by PHNs through home visitation, family planning clinics, or other MCH-related services have access to breastfeeding support, the Women and Infant Health Program Manager (WIHPM) provides financial support to train public health nurses as CLCs. The goal is to have a CLC-trained nurse in all counties. In FFY18, 96% of counties (22/23) had a CLC-trained nurse. CLC-trained nurses are able to provide breastfeeding and human lactation support. Support includes assessing the latching and feeding process, providing corrective interventions, counseling mothers, understanding and applying knowledge of milk production. This effort supports new mothers through the challenges and uncertainty around breastfeeding, and helps to increase the number of new mothers that are able to breastfeed successfully. Where possible, the WIPHM partners with the Women, Infants, and Children (WIC) program to coordinate in-state CLC trainings so that both WIC and PHN staff may benefit.

Through the ongoing collaboration between Wyoming PHN and MCH, breastfeeding practices and support are also

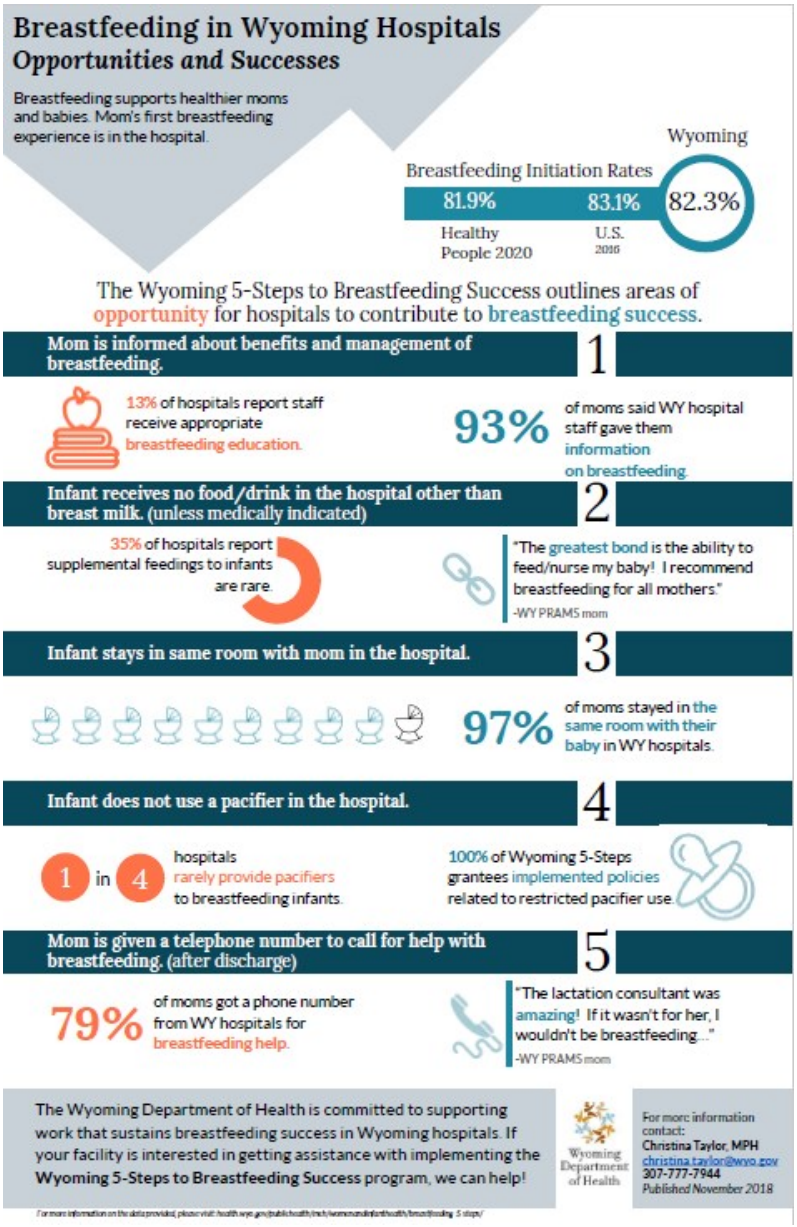
tracked within the Healthy Baby Home Visitation (HBHV) program. The HBHV Program is delivered by public health nurses in all 23 counties in Wyoming to pregnant and postpartum mothers and their families. Through a contract with MCH, each county is required to ensure all PHNs delivering MCH services receive annual breastfeeding training. Each county is also responsible for providing breastfeeding education/support/referrals as part of the home visiting curriculum and for collecting data on initiation and duration of breastfeeding. Data on the PHN breastfeeding support provided by PHNs and HBHV client breastfeeding outcomes are reviewed quarterly by the MCH Consultant for PHN to encourage ongoing quality improvement.

Strategy 3: Award mini-grants and provide ongoing technical assistance to hospitals participating in the Wyoming 5-Steps to Breastfeeding Success Project and work with the Wyoming Hospital Association (WHA) to develop hospital recognition program; Strategy 4: Develop a hospital recognition program for Wyoming 5-Steps to Breastfeeding Success

Wyoming has historically had a very high rate of breastfeeding initiation and 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 WIHPM partnered with WIC and the Wyoming Chronic Disease Prevention Program (CDPP) to develop the program, the Request for Applications (RFP), and review/select grant recipients. Four hospitals applied. All received funding due to leveraged resources from a grant from the Association for State and Territorial Health Officials' (ASTHO) Learning Community to Improve State Health Agency Capacity for Breastfeeding Promotion and Support and Title V funding. All funded hospitals participated in required technical assistance calls with the WDH, and 100% of grantees reported an improvement from baseline on a hospital self-assessment.

Due to ongoing success in breastfeeding rates statewide and limited resources, the WIHP did not release a second RFA in 2018. However, the WIHP continues to promote the Wyoming 5-Steps to Breastfeeding Success program and offers technical assistance to hospitals interested in improving breastfeeding practices. In FFY19, the WIHP will seek consultation from the Wyoming Perinatal Quality Collaborative (WYPQC) and its partners (including the WHA and the Wyoming Business Coalition on Health) to determine the feasibility and value of launching a hospital recognition program for the Wyoming 5-Steps to Breastfeeding Success.

In 2018, the WIHP and MCH Epidemiology Program participated in the Association of Maternal and Child Health Programs (AMCHP) Data Communications E-Learning Collaborative. The Wyoming team used data from the Center for Disease Control and Prevention's (CDC) Maternity Practices in Infant Nutrition and Care (mPINC) Survey and Pregnancy Risk Assessment Monitoring System (PRAMS) to develop Wyoming 5-Steps to Breastfeeding Success posters including hospital-specific data on progress related to each of the steps in the grant program. AMCHP provided technical assistance and consultation on this project. The Wyoming team developed and distributed posters for all Wyoming hospitals in order to promote continued awareness of evidence-based steps to improving breastfeeding initiation and duration rates in the hospital setting. The image below shows the Wyoming statewide poster.



Additional Strategies:

From 2017-2019, the WIHP worked closely with the Wyoming WIC Unit to draft a breastfeeding at work policy to support working parents employed by the WDH and to promote increased breastfeeding duration. Approximately 35% of the WDH workforce is made up of women of childbearing age, and this policy has the potential to positively impact a large portion of new mothers in the state, as well as to model positive breastfeeding support practices to the larger community and other organizations. The WIHPM and WIC Breastfeeding Consultant modeled the draft policy after other state health departments that have demonstrated success in breastfeeding support among their staff. The policy allows parents to bring their infant to work for up to 6 months after birth. It also better outlines WDH accommodations that have been put in place to support the expression of breastmilk in the workplace, including the provision of hospital-grade pumps and compatible pump kits by MCH, access to lactation rooms in state offices, and

information on Fair Labor Standards Act (FLSA) policies that protect breastfeeding parents. The policy remains a priority for MCH and continues to be promoted among WDH leadership. While it has not been officially adopted within the WDH, there are plans in place to review the policy with the new WDH director in 2019.

Priority	Performance Measure	ESM (if applicable)
Reduce Infant Mortality	**SPM (NPM 3): Percent of VLBW infants born in a hospital with a Level III+ NICU**	N/A

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.

Strategy 1: Distribute facility specific reports on Levels of Care Assessment Tool (LOCATe) results.

The MCH Unit and MCH Epidemiology Program, with support from CDC and ACOG, piloted LOCATe in early FFY16 to determine levels of care for Wyoming hospitals. Wyoming lacks a formal system to designate or define neonatal or maternal levels of care. Interested hospitals received a draft LOCATe report and met with MCH Epidemiology Assignee to discuss their assessments. The MCH Epidemiology assignee linked LOCATe data with hospital discharge data to examine pregnancy complications and the existence of maternal emergency hospital protocols and drills. These results prompted Wyoming to partner with the Utah Department of Health on their Extension for Community Healthcare Outcomes (ECHO) Project to implement patient safety bundles for maternal hypertensive emergencies. Six Wyoming hospitals participated in the ECHO project in FFY17/18.

Another success related to risk appropriate perinatal care includes efforts by two of Wyoming's largest hospitals to sign alliance agreements with a neighboring state children's hospital to ensure a formal process for consultation and transport. Based on LOCATe results, another hospital educated new providers on what type of patients the hospital is capable of caring for. Wyoming facilities are currently focused on providing the best care within their level and launching initiatives to improve the quality of care for mothers and infants.

In 2018, the MCH Epidemiology Assignee partnered with the CDC to pilot outcome and performance measures for the maternal levels of care. These results were presented at the 2018 MCH Epidemiology Conference.

Strategy 2: Support hospitals in implementation of AIM safety bundles (e.g. hypertension, opioids use during pregnancy, low-risk Cesarean delivery)

See Women/Maternal Health Domain for more information.

Strategy 3: Develop a Wyoming Perinatal Quality Collaborative (WYPQC)

In December 2017, a group of engaged perinatal health stakeholders voted to formally establish the WYPQC. The CDC defines a perinatal quality collaborative as a state network working to improve the quality of care for mothers

and babies, with members identifying health care processes that need to be improved through evidence based practices as quickly as possible. Membership includes stakeholders such as WHA and several hospitals across the state, in-state and out-of-state providers, Wyoming Medicaid, Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN), March of Dimes, the Wyoming Business Coalition on Health, public and private payers, community-based organizations, and members of both the Colorado and Utah PQCs.

In June 2018, the WIHP hosted a day-long strategic planning meeting to formalize the WYPQC vision, mission, and core principles. The CDC and the National Network of Perinatal Quality Collaboratives (NNPQC) both provided key subject matter expertise for this meeting. Emily Osteen Johnson, a Public Health Advisor from the CDC's Division of Reproductive Health, provided an overview presentation on PQCs, including structure and potential projects. The CDC MCH Epidemiology Assignee presented an overview of Wyoming's perinatal epidemiology. Dr. Ed Donovan, a founder of the Ohio PQC and a consultant for the Colorado PQC, attended through funding from the NNPQC, and presented on best practices in PQC development. Through this meeting, the WYPQC established a vision, mission and core principles for the group, which are outlined below:

Wyoming Perinatal Quality Collaborative

Vision: Optimal perinatal health outcomes for all Wyoming moms and babies.

Mission: The Wyoming Perinatal Quality Collaborative (WYPQC) exists to improve health outcomes for Wyoming moms and babies through collaborative, data-driven quality improvement work.

***Core Principles*:** The WYPQC will accomplish this through work that prioritizes:

- Increased access to high-quality, culturally appropriate care
- Ongoing education and training on safe and effective perinatal care
- Family engagement and advocacy

In June 2018, the WYPQC voted to contract with a coordinator to lead the work of the group. The WIHP release a RFA for coordination of the WYPQC in late 2018, and awarded a contract in April of 2019. Brenda Burnett, RN, MSN, PCMH CCE, of Brenda Burnett Clinical Consulting LLC, is the current WYPQC Coordinator and brings a wealth of clinical expertise in perinatal issues, as well as project management and quality improvement experience. Brenda will facilitate the WYPQC through meetings and project planning, coordinate communication and activities, develop toolkits and outreach materials for projects, and ensure ongoing engagement and recruitment of project partners and stakeholders. Brenda will identify and research emerging perinatal health issues, and will assure communication of these issues to the larger group. In 2018, the WIHP released a call for nominations for WYPQC leadership roles (including Co-Chair). At the writing of this report, the WYPQC Co-Chair role remains vacant. Filling key leadership will be a key task of the WYPQC Coordinator in 2019.

The WYPQC continues to poll membership regarding areas of interest and emerging needs through ongoing discussions and surveys. In 2018, the group identified maternal mortality as a topic of interest. Specifically, several group members expressed an interest in supporting the development of a maternal mortality review committee. A maternal mortality subcommittee of the WYPQC is in development and will guide future Wyoming maternal mortality prevention efforts. *See Women/Maternal Health Domain Annual Report for more information on activities related to maternal mortality.* The WYPQC membership also demonstrated interest in continued partnership with the Utah ECHO project.

Additional Strategies:

Implement Fetal and Infant Mortality Review (FIMR) in pilot community

The WIHP continued to support the Fetal Infant Mortality Review (FIMR) pilot project in Fremont County Wyoming through 2018, in collaboration with providers and community members on the Wind River Indian Reservation. The Fremont County Case Review Team (CRT) reviewed 100% of Fremont County fetal and infant deaths from 2016. The CRT utilized the results of those reviews to make recommendations for action. Preconception health was a chosen focus and included promoting management of chronic conditions before and during pregnancy and client centered contraceptive counseling.

Through County Health Rankings funding offered by the Robert Wood Johnson Foundation, the WIHP funded two trainings on preconception health for providers in the Wind River Family and Community Health Care Clinic during 2018. Dr. Christine Dehlendorf from University of California at San Francisco provided a training on patient-centered contraceptive counseling, which was customized to reflect cultural considerations and past trauma for Native American populations. Dr. Lisa Callegari of the University of Washington provided a training on preconception health and chronic disease management before and during pregnancy. Both trainings were well received, and reached over 10 providers who serve Native women. A post-training evaluation was conducted for Dr. Callegari's training, and 8 providers responded. 100% of respondents reported that they learned something useful that will change the way they address pre-pregnancy/preconception health in their practice. During early 2019, a CAT subgroup worked with the clinic to develop a culturally appropriate way for providers to discuss reproductive life planning. During the spring of 2019, a DNP student from the University of Wyoming worked to develop a template for the EHR and incorporate reproductive planning into well woman visits. The project is ongoing, and results of the template pilot are expected during the summer of 2019. The CRT aims to begin reviewing cases in summer/fall of 2019 after breaking to plan the intervention.

In FFY18/19, the WIHPM, MCH Unit Manager, and MCH Epidemiology Assignee brainstormed options for FIMR expansion in Wyoming. Considerations include resources, staff capacity, local level interest, data support capacity, legal authority and protections, and opportunities to coordinate efforts with other death reviews.

Promote the MCH Unit's *Maternal High Risk (MHR) and Newborn Intensive Care (NBIC) Programs.*

The MHR and NBIC programs provide care coordination services and limited gap-filling financial assistance for eligible high-risk pregnant women and high-risk infants 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. The goal is to increase program referrals through increased engagement and outreach by the WYPQC.

Improve Newborn Screening Timeliness and Quality

Timely newborn screening (NBS) 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 FFY18, the Wyoming NBS Program continued participation in NewSTEPs 360 (Newborn Screening Technical Assistance and Evaluation Program), a national project providing technical assistance and access to data to improve NBS timeliness. NewSTEPs 360 is an extension of the national CoIIN focused on improving NBS timeliness. In 2018, the project team from Wyoming and Colorado focused on hospital quality improvement efforts and data quality improvements within the Colorado Department of Public Health and Environment Laboratory (CDPHE), the lab that processes Wyoming's specimens. Previous work under this grant

program helped Wyoming to develop newborn screening report cards using quality measures collected for the NewSTEPs project. Report cards outline key timeliness measures and highlight successes and opportunities for improvement. The report also includes outliers to show hospitals instances of extreme delays.

Throughout 2018, the Wyoming NBS Coordinator developed a site visit plan for Wyoming hospitals. The Wyoming NBS Coordinator and MCH Epidemiology Program reviewed hospital data to identify hospitals for site visits. Four hospitals participated in site visits. The Wyoming NBS Coordinator developed a process flow diagram to discuss with each hospital to identify areas where a simple change in how a screen was handled in the hospital setting could greatly improve timeliness measures. Each hospital walked the Wyoming NBS Coordinator through the life cycle of a newborn screen. Opportunities for improvement were discussed and documented and the Wyoming NBS Coordinator provided recommendations after each site visit.

The NBS program worked with MCH Epidemiology to create a newborn screening dashboard using Tableau data visualization software. The dashboard can pull data directly from the feed from CDPHE and present it in an easy-to-use format that allows hospitals to see their standings and compare their data to that of other hospitals in the state. A data quality issue was identified in the CDPHE system during the course of this project leading to a suspension of work. When data quality is improved, the project will restart.

In May 2018, an issue was identified with specimens from Cheyenne Regional Medical Center (CRMC) reaching the CDPHE laboratory in an untimely manner. The Wyoming NBS Coordinator met with the contracted courier to address concerns, and the courier has 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 Wyoming NBS 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 CDPHE. This tracking system ensures we maintain timely transport of specimens from our birthing hospitals to CDPHE.

Other WIHP Activities

Healthy Baby Home Visitation Program

The WIHPM participates in the Wyoming Home Visiting Network (WYHVN) and in 2018 was nominated to Chair the network. The WYHVN was formed under the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) grant program, which is administered by Parents as Teachers (PAT), as a way to ensure cross-model collaboration and systems-building work for home visiting in Wyoming. The group has grown and evolved, and continues to meet quarterly to ensure ongoing coordination of home visiting services. As Chair, the WIHPM has led the group towards the promotion and growth of the early childhood system in Wyoming, to ensure better coordination and resource-referral for Wyoming families. The group has committed to improving cross-model referrals statewide, and to promoting the available home visiting models in each county through marketing and outreach. The WYHVN also worked in early 2019 to coordinate with PAT to support the MIECHV needs assessment process, and to ensure that the product of the needs assessment under this grant program reflects the needs of the entire home visiting system in Wyoming.

Perinatal/Infant Health - Application Year

Application Year Plan (FFY20): 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.

Priority	Performance Measure	ESM (if applicable)
Improve Breastfeeding Duration	**NPM 4: A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months**	• ESM 4.4: # of hospitals participating in the Wyoming 5-Steps to Breastfeeding Success program • ESM 4.6: Percent of hospitals demonstrating an increase in at least one step from baseline based on hospital self-reported assessment • ESM 4.7: Percent of counties that have at least one public health nurse trained as a Certified Lactation Consultant (CLC)

In FFY20, 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. Work with WHA and the WDH Public Information Officer to develop hospital recognition program based on the Wyoming 5-Steps to Breastfeeding Success.
    a. # of applications received for recognition
    b. # of hospitals awarded recognition
2. Continue to work with PHN to ensure all counties have a CLC-trained MCH nurse
    a. % of counties that have a CLC-trained nurse on staff

The WIHPM will also continue to pursue implementation of the internal WDH breastfeeding policy, and will pursue additional policies to support the WDH workforce, as appropriate.

Priority	Performance Measure	ESM (if applicable)
Reduce Infant Mortality	**SPM (NPM 3): Percent of VLBW infants born in a hospital with a Level III+ NICU**	N/A

Currently, infant mortality prevention efforts are guided by the WYPQC. In FFY20, we plan to impact NPM 3 (selected as a SPM in Wyoming)--percent of VLBW infants born in a hospital with a Level III+ NICU-- by implementing the following selected strategies:

- Support the continued growth of the WYPQC
    - # of engaged stakeholders participating in the WYPQC development process
    - # of quality improvement projects implemented under the guidance of the WYPQC
- Continue to support Wyoming hospital participation in Utah ECHO projects
    - # of hospitals participating in ECHO sessions
    - Improvement from baseline assessment for participating facilities

The MCH Unit will continue to support the MHR and 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.

Other Work

FIMR

In FFY20, the WIHP will consider expanding FIMR efforts beyond Fremont County. The program will compile lessons learned from pilot implementation in Fremont County to update the FIMR implementation toolkit reviewed by WDH leadership and used to launch FIMR in Fremont County in 2014. The WIHPM and MCH Epidemiology Assignee will finalize the toolkit and develop/communicate a vision for FIMR expansion considering available resources, staff capacity, data support capacity, legal authority and protections, and interest from local level partners. The WIHP will work closely with the Injury and Violence Prevention Program (IVPP) to align death review efforts. Currently, the IVPP program is developing a plan to support local implementation of Child Death Reviews and is researching other death review options (e.g. suicide). All efforts will be made to assure cross-model collaboration and statewide dissemination of best practices related to death review implementation.

Opioid Response

The WIHP, in partnership with the WDH Public Health Preparedness and Response Unit and their Cooperative Agreement for Emergency Response: Public Health Crisis Response funding, started work on a training for healthcare providers related to safe prescribing of opioids during pregnancy and postpartum. The training, which will meet an upcoming legislative requirement for Wyoming providers to take 3 CME hours of safe prescribing training every two years, will be offered in summer 2019. The WIHP worked with partners at tertiary care facilities in Wyoming to identify potential trainers, and has engaged Dr. Kaylin Klie from Colorado Children's Hospital, Dr. Lesley Brooks from the Northern Colorado Health Alliance, and Dr. Ryan Jackman, an Addiction Medicine Specialist from St Mary's Family Medicine. The WIHP will continue to work with the Wyoming Medical Society, ACOG and other physicians groups to engage providers who serve pregnant women in Wyoming, to ensure the training reaches a wide audience. It will also be broadcast virtually for remote attendance, and will include CMEs for live attendees.

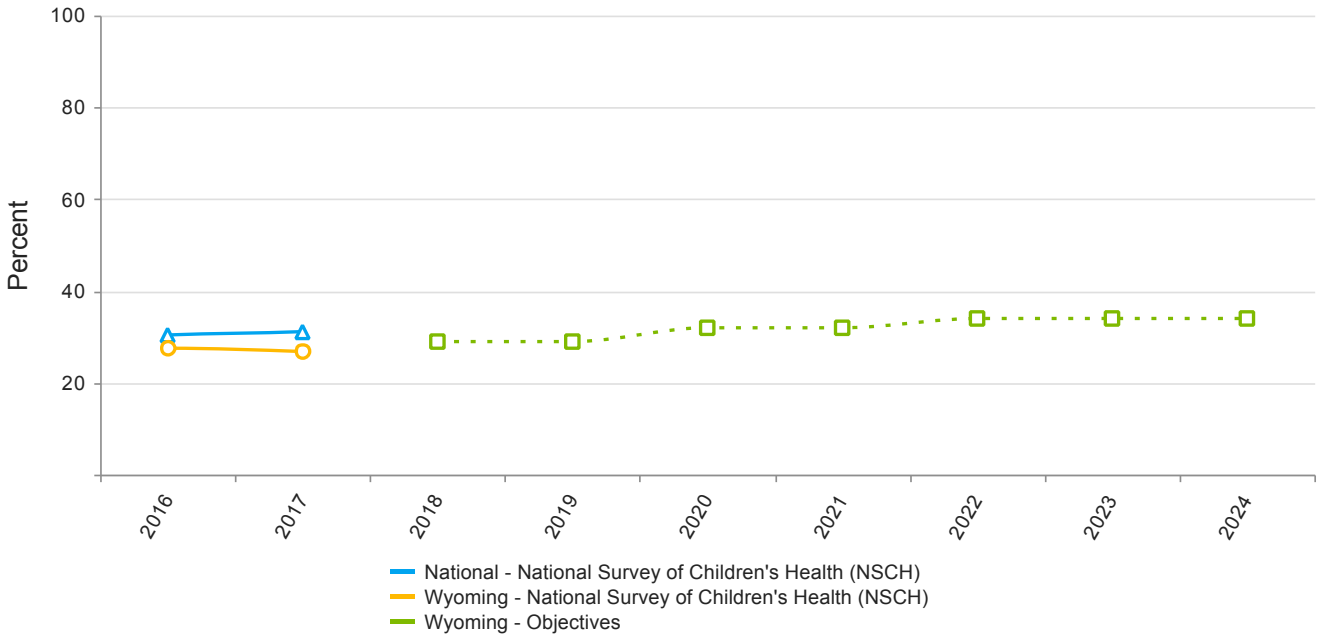
Child Health

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 or Not Reportable	NPM 6
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2016_2017	90.3 %	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
Indicators and Annual Objectives



Federally Available Data			
Data Source: National Survey of Children's Health (NSCH)			
	2016	**2017**	**2018**
Annual Objective			29
Annual Indicator		27.6	27.0
Numerator		4,900	4,651
Denominator		17,751	17,226
Data Source		NSCH	NSCH
Data Source Year		2016	2016_2017

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						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	29.0	32.0	32.0	34.0	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	2018
Annual Objective	30	45
Annual Indicator	39	49
Numerator		
Denominator		
Data Source	HMG Reports	HMG Reports
Data Source Year	2017	2018
Provisional or Final ?	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	60.0	0.0	0.0	0.0	0.0	0.0

ESM 6.5 - Total number of referrals received by HMG

Measure Status:	Inactive - Duplicate ESM with 6.3. Definition unclear.

State Provided Data		
	2017	2018
Annual Objective	20	25
Annual Indicator	13	0
Numerator		
Denominator		
Data Source	HMG Program Records	HMG Program Records
Data Source Year	2017	2018
Provisional or Final ?	Final	Provisional

ESM 6.6 - Number of referrals from HMG to community resources resulting in services

Measure Status:	Active

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	50.0	0.0	0.0	0.0	0.0	0.0

ESM 6.7 - Number of providers trained on Bright Futures

Measure Status:	Active

Annual Objectives					
	2020	2021	2022	2023	2024
Annual Objective	10.0	10.0	10.0	10.0	10.0

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	2018
Annual Objective		20	30
Annual Indicator	25.3	32.2	13
Numerator	22	28	11
Denominator	86,903	86,855	84,348
Data Source	Wyoming Hospital Discharge Data	Wyoming Hospital Discharge Data	Wyoming Hospital Discharge Data
Data Source Year	FY 2015	CY 2016	CY17
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	30.0	29.0	29.0	28.0	28.0	27.0

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	2024
Annual Objective	32.0	34.0	35.0	36.0	38.0	40.0

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

Pilot Help Me Grow model in two counties (inactive as of June 30, 2019)

Provide Ages and Stages training to Wyoming providers.

Increase the availability and quality of vision screening training (inactive as of October 1, 2018)

Promote lead screening.

Train providers on Bright Futures recommendations.

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	Inactive
ESM 6.6 - Number of referrals from HMG to community resources resulting in services	Active
ESM 6.7 - Number of providers trained on Bright Futures	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).* (*The program will also track NPM 7.1 and 7.2 informally though no official SPM will be added.)

Strategies

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

Support Safe Kids Wyoming (inactive as of October 1, 2018)

Annual Report Fiscal Year 2018: This section provides a summary of Federal Fiscal Year 2018 (FFY18) activities, accomplishments, and challenges related to National Performance Measures (NPMs) and State Performance Measures (SPMs) (2016-2020) for the Child Health Domain.

Priority	Performance Measure	ESM (if applicable)
Promote 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))**	• ESM 6.3: 211 Referrals to HMG • ESM 6.6: # referrals from HMG to community resources resulting in services • ESM 6.7: # of providers trained on Bright Futures

Developmental surveillance, screening, and observations are important in all aspects of a 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 months, 18 months, and 2.5-year visits. Additionally, the AAP recommends developmental screening any time concerns are identified.

In FFY18, the Child Health Program (CHP) continued to support two methods to increase developmental screening: (1) implementation of Help Me Grow (HMG) in two pilot communities and (2) training on and distribution of the Ages and Stages Questionnaire (ASQ) screening tool.

Strategy 1: Pilot HMG model in two counties (inactive as of June 30, 2019)

In 2015, the national HMG model was selected to support a system-level approach to improving access to existing developmental resources and services for children through age eight, including children with special health care needs. The WDH contracted with Wyoming 211 in October 2016 to act as the centralized telephone access point for HMG. Wyoming 211 began a limited regional pilot focusing specifically on Albany and Laramie counties.

The HMG model is divided into three main areas: (1) building the infrastructure, (2) building the system; and (3) sustaining the system. During FFY18, Wyoming implementation of HMG remained in the infrastructure building phase. Fidelity assessment results showed progress in the area of developing a centralized telephone access system (at systems-building phase). Wyoming saw less significant progress in areas related to community outreach and data collection.

Four cooperative and interdependent core components characterize the HMG system model. They include centralized access point, family and community outreach, child health care provider outreach, and data collection and analysis.

Centralized telephone access is a key component of the HMG model as well as a critical component of the model for Wyoming's implementation. The frontier nature of the State requires innovative and virtual supports to link children and families to needed resources. HMG received referrals in two main ways. Referrals came through direct contact with HMG (ESM 6.5) by phone, mail, walk-in or word of mouth or as a referral from the 211 call center (ESM 6.3).

Unfortunately, the number of unique contacts referred to HMG remained limited throughout the pilot. Anecdotally, we understand this may be due to the fact that the difference between HMG and 211 was difficult to understand for many stakeholders and consumers.

The HMG system relies upon strong child health care provider outreach to establish buy-in for HMG as a method for linking children and families to needed services and resources. The HMG Coordinator attempted to establish relationships with providers in both communities but outreach remained a challenge throughout the pilot project. Another clear challenge to effective outreach was turnover at both Wyoming 211 and the MCH Unit, leading to significant gaps in implementation and delayed training on the HMG model. The HMG program experienced turnover at the HMG Care Coordinator position four times between 2016 and 2019. In addition, the CHP position turned over once in 2018 and the Wyoming 211 Executive Director position changed three times. Fortunately, through key staffing changes, the key funders of the Wyoming HMG pilot remained consistent and represented the MCH Unit, Wyoming Children's Trust Fund, Wyoming Head Start Collaboration Office (Department of Workforce Services) and Wyoming Early Intervention and Education Program (Part C).

In 2018, Wyoming 211 upgraded their data system to improve data collection and reporting. Additionally, the CHP and HMG staff worked to better define the measures being collected in order to match measures with program performance and outcomes. This new data system combined with refined measures has allowed for more accurate data collection and usage. However, the numbers reported show low uptake of HMG.

As the three-year pilot neared its end, the MCH Unit met with key stakeholders as well as Wyoming 211/HMG staff to discuss progress and challenges. While current Wyoming 211 staff dedicated considerable time and effort learning the HMG model and attempting to reset, the long-term challenges outweighed the current success of the model. Identified challenges included:

- Confusion over the difference between HMG and Wyoming 211;
- Limited stakeholder understanding on how HMG fits within a complex early childhood system;
- Concern for duplication of efforts between HMG and other community services such as home visitation, early intervention, etc;
- Community push-back in pilot communities (i.e. lack of stakeholder support and buy-in); and
- Limited data on impact/value of HMG pilot project in Laramie and Albany counties.

In 2019, the MCH Unit and partner funding agencies decided to end the HMG pilot in Laramie and Albany counties effective June 30, 2019 instead of continuing the program in the final year of the Title V five-year cycle. The CHP will use FFY20 to convene key statewide stakeholders within the Wyoming early childhood system to include the WDH, Wyoming Department of Workforce Services, Wyoming Department of Family Services, Wyoming Department of Education, University of Wyoming, Wyoming Children's Trust Fund, and Wyoming Kids First to define the early childhood system, identify duplicate and complementary services, and identify gaps in available services. The MCH Unit recently requested technical assistance from the MCH Workforce Development Center to accomplish this work.

Strategy 2: Provide ASQ Training and Tools to Wyoming providers

Historically, the CHP provided ASQ training and resources to a wide range of partners including day care providers, child development center staff, providers, PHNs, and home visiting staff. The program identified challenges collecting data on usage of the ASQ from a diverse group of partners due to the absence of any shared or central data system. The CHP maintains little to no direct control over most sites utilizing the ASQ tool and therefore, cannot accurately report on distribution or use. The ASQ is, however, utilized by PHN in their home-visiting programs and the CHP has better access to PHN's data system. Therefore, the CHP elected to only measure the usage of the

ASQ by PHNs.

The CHP maintains a commitment to providing training and support of the ASQ tool to community providers and partners. The MCH Unit does not currently have any staff certified to train on the ASQ tool but can rely on trained partners as needed. In September of 2018, the CHP partnered with HMG staff and the Wyoming Children's Trust Fund to provide ASQ training at the Wyoming Public Health Association (WPHA) annual conference. WPHA conference attendees were child care providers, child healthcare providers, and public health nurses. Additionally, the CHP and the Wyoming Children's Trust Fund supported the training of staff at the University of Wyoming Family Medicine Residency Clinic in Casper, Wyoming. The CHP provided ASQ kits and the Wyoming Children's Trust Fund provided the training needed to administer the ASQ.

Strategy 3: Increase the availability and quality of vision screening training (inactive as of October 1, 2018)

In 2018, the University of Wyoming's Wyoming Institute for Disabilities (WIND), a University Center for Excellence in Developmental Disabilities, completed a multi-year project which developed a comprehensive child vision screening training program to support the Wyoming Vision Collaborative. Through this joint relationship, a well-established high-quality virtual learning environment was created to support the long-term training and support of child vision screeners across Wyoming.

Strategy 4: Promote lead screening

In Fall 2018, the Wyoming Department of Environmental Quality (DEQ) applied for and received a Water Infrastructure Improvements for the Nation Act (WIIN Act) Grant: Lead Testing in School and Child Care Program Drinking Water. The grant creates a voluntary program to assist with testing for lead in drinking water at schools and child care programs. WDH staff (including State Health Officer and representatives from Wyoming Public Health Laboratory, MCH Unit, Wyoming Medicaid, WIC, and PHN) will partner with DEQ, schools, and child care centers to support this grant initiative, as needed. In addition, WDH representatives formed a workgroup to discuss strategies to improve lead screening and surveillance data, community and provider education, and public health response to lead exposure. Next steps include recruiting provider champions to support this initiative.

Strategy 5: Train providers on Bright Futures Recommendations

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. 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 worked with MCH, Medicaid and other key stakeholders to develop a plan to implement Bright Futures, 4th Edition during Summer 2018. 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 Title V NPMs. They include NPM 6: Developmental Screening, NPM 10: Adolescent Well Visit, and NPM 12: Transition. The student-developed plan to implement Bright Futures can be viewed in Appendix C. In 2019, the MCH Unit will reconvene interested stakeholders to prioritize and implement the students' recommendations. The first step is to form a Bright Futures Implementation Task Force. So far, the MCH Unit has commitment from Wyoming Medicaid, WYhealth, and the Immunizations Unit to participate.

Priority	Performance Measure	ESM (if applicable)
Prevent Childhood Obesity	**SPM 5: Percent of children (6-11 years) who are physically active at least 60 minutes per day (NSCH)**	N/A

The prevention of childhood obesity was selected as a Wyoming priority for 2016-2020. Physical activity remains the key strategy to reduce childhood obesity.

In FFY18, the CHP transitioned NPM 8--percent of children (6-11 years) who are physically active at least 60 minutes per day (NSCH) into SPM 5. This change was made at the encouragement of Title V reviewers who acknowledged the MCH Unit was focusing on too many strategies with limited resources.

Strategy 1: Partner with the Wyoming Chronic Disease Program to implement evidence based prevention strategies in early childhood facilities and schools

The CHP partnered with the Wyoming Chronic Disease Prevention Program (CDPP) to support the Comprehensive School Physical Activity Program (CSPAP). During FFY18, Title V funds supported training of 118 secondary education teachers across the state. Thirty-three training participants represented schools on the Wind River Indian Reservation serving both the Northern Arapaho and Eastern Shoshone tribal nations. CSPAP reached an estimated total potential population of 3,186 Wyoming children in FY18 based upon the average class size of 27 students per Wyoming secondary education classroom.

The CHP partnered with the Wyoming Chronic Disease Prevention Program (CDPP) to support a contract with the University of Wyoming Cent$ible Nutrition Program to support training of Cent$ible Nutrition Educators (CNE). This activity was part of the Centers for Disease Control and Prevention (CDC) and Nemours Children's Health System, Let's Move initiative. The work brought together partners from the WDH, Workforce Services, Family Services, Education, and the University of Wyoming Cent$ible Nutrition Program. At the end of this 18-month project, national trainers from Nemours Children's Health System supported by CDC were able to certify 45 University of Wyoming Extension service, nutrition educators (CNE) as child obesity prevention educators. These CNE's represent all 23 Wyoming counties as well as both Tribal nations on the Wind River Indian Reservation.

Over the past several years, CDPP implemented nutrition and physical activity promotion efforts in early childhood settings. In FFY18 the CDPP received zero funding to address childhood obesity or to target children 0-18. As a result of the CDPP's loss of targeted funding to address children 0-18, the CHP adjusted strategies to fill an important gap. The CHP partnered with the Head Start State Collaboration Office to develop a Wyoming Healthy Policies Toolkit targeting early childcare centers, Head Starts, Early Head Starts, licensed childcare providers, and elementary schools. This tool kit will incorporate evidence-based policy recommendations and will be distributed soon.

Priority	Performance Measure	ESM (if applicable)
Prevent Childhood Injury	**SPM 2: Rate of hospitalization for (non-fatal) injury per 100,000 children (1-11 yrs)***	N/A

** The CHP and MCH Epidemiology Program will also track NPM 7.1 and NPM 7.2 in FFY20 due to a change in program strategy to focus on childhood injury prevention for ages 0-19. Due to it being the last year of a federal cycle, we will not add new SPMs.*

Strategy 1: Support Safe Kids Wyoming (inactive as of October 1, 2018)

In FFY18, the CHP continued to fund Safe Kids Wyoming (SKW) to focus on activities to prevent the leading causes of death and injury in Wyoming children ages 1-11 with a primary focus on child passenger safety. The CHPM, the WDH Injury and Violence Prevention Program (WIVPP) Prevention Coordinator, and MCH Injury Epidemiologist advised the work of SKW as members of the SKW Leadership Team. Activities employed by local SKW coalitions across the state to reduce child injury hospitalizations and 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 reported that 1,477 infant and child car seats were inspected across the state by 205 certified child passenger safety technicians. Additionally, SKW reported that 859 car seats were distributed to families in need.

The CHP recognized the need to adjust strategies within this priority to align with leading causes of childhood injury. Historically (in Wyoming and nationwide), SKW primarily focused on childhood injury in younger children. The focus of SKW on younger children also aligned with the 'target age group' for the CHP--ages 1-11. With new CHP leadership and recommendations from MCH Epidemiology to look more broadly at childhood injury, emerging topics of adolescent suicide and adolescent driver safety surfaced. The broadened focus requires significant collaboration between the CHP and Youth and Young Adult Health Program. Due to changing focus on this priority, the program will also track NPM 7.1 and 7.2, the rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 0-9 and 10-19, respectively; however, we have not set new SPMs nor targets for these measures due to insufficient time in this block grant cycle to see a considerable change. The needs assessment will determine how we proceed on this topic beginning in FFY21.

Strategy 2: Implement community based grants with targeted evidence-based strategies to address the major causes of childhood injury/hospitalizations in Wyoming

In order to respond to changing data needs related to injury prevention in children, the CHP shifted its funding model for this priority away from statewide SKW coordination and towards a mini-grant program to increase the amount of resources going straight to local implementation evidence-based or evidence-informed childhood injury prevention strategies. As a result, the contract to support SKW coordination was not extended for FFY19. The YAYAHP and the CHP developed and released a MCH Community Mini-Grant Program with a focus on childhood injury prevention. Nine organizations applied for funding and all were awarded. The mini-grant projects address a wide variety of injury topics from safe sleep, to prescription drug monitoring to adolescent motor vehicle safety and adolescent suicide prevention. Projects will begin Summer 2019 and continue into FFY20.

In 2018, the CHP, YAYAHP, and Injury and Violence Prevention Program joined the Child Safety Learning Collaborative (CSLC), through the Child Safety Network (CSN), to focus efforts to reduce fatal and serious injuries

among infants, children, and adolescents by building and improving partnerships and implementing and spreading best practices, especially among the most vulnerable populations. Upon review of available data and capacity, the team selected Suicide & Self-Harm Prevention (SSHP) and Motor Vehicle Traffic Safety (Child Passenger and Teen Driver/Passenger) (MVTS) as CSLC topic areas of focus for Wyoming. The YAYAHPM took lead on the SSHP topic while the CHPM leads MVTS.

The CHPM is a member of Safe States Alliance. Some of the components of active membership includes serving on the Plains to Peaks (P2P) steering team. P2P is the regional Safe States Alliance networking committee that brings together public health injury and violence prevention professionals from the rocky mountain region and the west coast. Participations allows for sharing of information and resources and professional development. The CHPM served as an abstract reviewer on infant, child, and adolescent injury topics ahead of the September 2019 conference.

Child Health - Application Year

Application Year Plan (FFY20): This section presents strategies/activities for 2016-2020 MCH priorities related to Child Health. See Five-Year State Action Plan Table for more information.

Priority	Performance Measure	ESM (if applicable)
Promote 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))**	• ESM 6.7: # of providers trained on Bright Futures

In FFY20, 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. The CHP will use FFY20 to convene key statewide stakeholders within the Wyoming early childhood system to include the WDH, Wyoming Department of Workforce Services, Wyoming Department of Family Services, Wyoming Department of Education, University of Wyoming, Wyoming Children's Trust Fund, and Wyoming Kids First to define the early childhood system, identify duplicate and complementary services, and identify gaps in available services. This effort will reduce the fragmentation within the early childhood system and strengthen system partner relationships. The MCH Unit recently requested technical assistance from the MCH Workforce Development Center to accomplish this work. The goals for this project are:

    1. Develop a shared vision for delivering high-quality services to children and families.
    2. Create a unified mission statement.
    3. Convene regularly to assess gaps and barriers.
    4. Develop common messaging.
    5. Set measurable short and intermediate strategic goals.
    6. Create a tool for evaluating success.

2. The CHP will support the work of the Wyoming Home Visiting Network and will provide technical assistance and education as needed to members of the network on developmental screening and developmental monitoring to include education on the importance of parent-completed screening tools.

3. The CHP will support the Wyoming Maternal, Infant and Early Childhood Home Visiting program (MIECHV) grantee Parents as Teachers National Center (PATNC) in the completion of a comprehensive early childhood systems map to support both the Title V and MIECHV needs assessments and five-year strategic plan.

4. The CHP will collaborate with Wyoming Medicaid and other partners to expand the education of providers on the American Academy of Pediatrics (AAP) Bright Futures guidelines (4th ed.) as part of efforts to improve access to and quality of Early and Periodic Screening, Diagnosis and Treatment (EPSDT)/well-visits.

5. The CHPM and the MCH Unit Manger will continue to participate in a multidisciplinary workgroup focused upon improving lead screening rates.

Priority	Performance Measure	ESM (if applicable)
Prevent Childhood Obesity	**SPM 5: Percent of children (6-11 years) who are physically active at least 60 minutes per day (NSCH)**	N/A

In FFY20, the CHP will continue to impact SPM 5: Percent of children (6-11 years) who are physically active at least 60 minutes per day by implementing the following strategies:

1. Work with the Head Start State Collaboration Office to distribute and promote a Wyoming Health Policies Toolkit targeting early childcare centers, Head Starts, Early Head Starts, licensed childcare providers, and elementary schools.
2. Work closely with the CDPP to identify needs, gaps, and challenges related to childhood obesity prevention as part of the MCH Needs Assessment.

Priority	Performance Measure	ESM (if applicable)
Prevent Injury in Children	**SPM 2: Rate of hospitalization for (non-fatal) injury per 100,000 children (1-11 yrs) (Wyoming Hospital Discharge Data)***	N/A

** The CHP and MCH Epidemiology Program will also track NPM 7.1 and 7.2 in FFY20 due to a change in program strategy to focus on childhood injury prevention for ages 0-19.*

The CHP plans to impact childhood injury hospitalizations by implementing the following selected strategies:

1. The CHP and YAYAHP established a community mini-grant program to address the leading causes of injury/hospitalizations in Wyoming children age 0 to 18 years. Each community selected for this mini-grant demonstrated a data-informed need to address selected injury topics. This mini-grant will support nine applicants across Wyoming in implementing or sustaining work related to child passenger safety, teen driver safety, infant safe sleep, prescription drug management programs, and adolescent suicide.

   Nine community-based applicants have been selected for this grant program. Below are the anticipated recipients and the topic selected:

   - Youth Emergency Services of Campbell County (adolescent suicide prevention)
   - Campbell County School District (adolescent suicide prevention)
   - Cheyenne Regional Medical Center (prescription drug monitoring system)
   - Cheyenne Regional Medical Center (child passenger safety, water safety)
   - Park County Wyoming (child passenger safety)
   - Johnson County Wyoming (child passenger safety, safe sleep)

- Uinta County Wyoming (safe sleep, child passenger safety, medication safety, water safety)
- JDavis Consulting (safe sleep)
- Wyoming Highway Patrol (teen driver safety)

The CHP and YAYAHP prioritized the selection of applicants who identified system or environmental level approaches and incorporated social determinants of health into the identification of need in order to positively impact their identified populations. Additionally, the MCH Unit is committed to providing technical assistance to each of the grant recipients and will support the implementation of sustainable evidence-based strategies.

2. Continue participation in the Child Safety Learning Collaborative (CSLC), through the Child Safety Network (CSN), to focus efforts to reduce fatal and serious injuries among infants, children, and adolescents. This learning collaborative allows for the MCH Unit to receive targeted technical assistance, multi-state partnership and peer support in two injury topic areas: Suicide & Self-Harm Prevention (SSHP) and Motor Vehicle Traffic Safety (Child Passenger and Teen Driver/Passenger) (MVTS). This collaborative will leverage existing partnerships between the MCH Unit, Wyoming Injury & Violence Prevention Program, the Wyoming Department of Transportation, Wyoming Students against Destructive Decisions, and PHN. This learning collaborative will also identify and strengthen new partnerships. With 76% of Wyoming considered as frontier, the MCH Unit is dependent on local partnerships in order to affect change. The learning collaborative is identifying community partners who are engaging with their communities such as the Wyoming Chapter of Students Against Destructive Decisions (SADD). SADD has a physical presence in schools across the state and is able to support the implementation of evidence-based strategies and interventions directly targeting school-aged children and adolescents. In much the same way the Wyoming Highway Patrol have resident Troopers stationed in virtually every community in Wyoming and to support the needs of their respective communities. By partnering with and supporting these community-based partners, we can expand the reach of our injury prevention strategies in a way that is relevant and responsive to community needs.

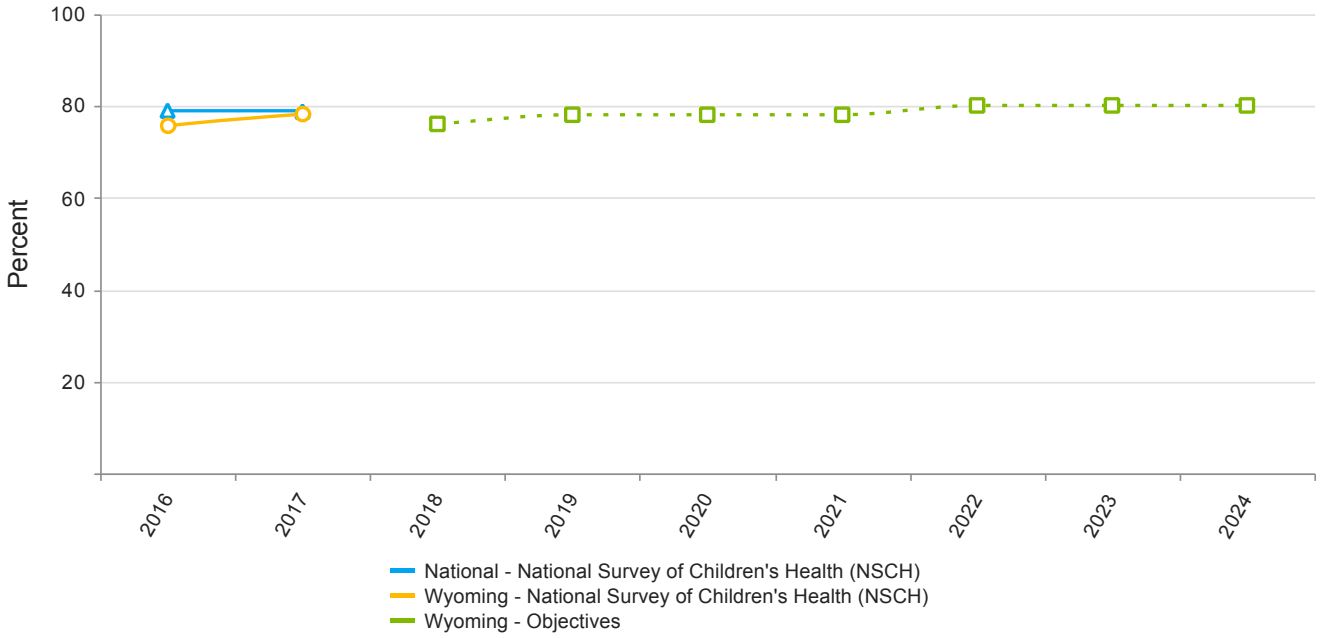
Adolescent Health

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-2017	37.4	NPM 10
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS-2015_2017	21.0	NPM 10
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2015_2017	31.1	NPM 10
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2016_2017	61.8 %	NPM 10
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2016_2017	90.3 %	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_2017	10.6 %	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	10.9 %	NPM 10
NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza	NIS-2017_2018	43.2 %	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NIS-2017	46.9 %	NPM 10
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS-2017	86.4 %	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-2017	60.7 %	NPM 10
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2017	24.6	NPM 10

National Performance Measures

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



Federally Available Data			
Data Source: National Survey of Children's Health (NSCH)			
	2016	**2017**	**2018**
Annual Objective			76
Annual Indicator		75.7	78.2
Numerator		34,569	35,814
Denominator		45,669	45,789
Data Source		NSCH	NSCH
Data Source Year		2016	2016_2017

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						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	78.0	78.0	78.0	80.0	80.0	80.0

Evidence-Based or –Informed Strategy Measures

ESM 10.2 - # QI cycles completed by participating practices

Measure Status:	Active					
Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	4.0	6.0	8.0	10.0	12.0	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	2018
Annual Objective		70	70
Annual Indicator	68.4	68.4	66.3
Numerator			
Denominator			
Data Source	Prevention Needs Assessment	Prevention Needs Assessment	Prevention Needs Assessment
Data Source Year	2016	2016	2018
Provisional or Final ?	Provisional	Provisional	Provisional

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	70.0	72.0	72.0	74.0	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.

Develop statewide youth council to ensure youth voices are included in decisions related to 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 2018: This section provides a summary of Federal Fiscal Year 2018 (FFY18) activities, accomplishments, and challenges related to National Performance Measures (NPMs) and State Performance Measures (SPMs) (2016-2020) for the Adolescent Health Domain.

Priority	Performance Measure	ESM (if applicable)
Promote Preventive and Quality Care for Adolescents	**NPM 10: Percent of adolescents with a preventive services visit in the last year (National Survey of Children's Health (NSCH))**	ESM 10.2: # QI cycles completed by participating practices

Strategy 1: Implement Adolescent Centered Environment Assessment Process in Wyoming clinics to improve adolescent friendly environment.

In 2017, Wyoming joined the Association of Maternal and Child Health Programs (AMCHP) Adolescent and Young Adult Health Collaborative Improvement and Innovation Network (AYAH CoIIN) with the Wyoming Primary Care Association (WYPCA) serving as the fiscal agent for the project. 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. Implementation of the action plan continued into FFY18 and FFY19.

The YAYAHP identified the Adolescent Centered Environment Assessment Process (ACE-AP) from the University of Michigan 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. The ACE-AP addresses the following 12 key areas of adolescent-centered care:

- Access to Care
- Adolescent Appropriate Environment
- Confidentiality
- Best Practices & Standards of Care
- Reproductive & Sexual Health
- Behavioral Health
- Nutritional Health
- Cultural Responsiveness
- Staff Attitudes & Respectful Treatment
- Adolescent Engagement & Empowerment
- Parent Engagement
- Outreach & Marketing

In late 2017, a 'clinic environment workgroup' of the Wyoming AYAH CoIIN team drafted a Request for Application (RFA) to recruit pilot clinics to implement the ACE-AP model. Wyoming Medicaid provided rates of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) visits compared to primary care visits for all Wyoming

clinics. Review of this data informed the RFA outreach and 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 Youth and Young Adult Health Program (YAYAHP) released the pilot clinic mini-grant RFA. Four clinics applied and a review committee selected all four to participate. The four participating clinics are Lander Medical Clinic, University of Wyoming Family Medicine Residency Program, Laramie Pediatrics, and Casper Children's Center. The clinics completed a baseline self-assessment of their organization's environment, policies and practices related to youth-friendly services to identify opportunities for improvement and met with the University of Michigan monthly to identify and implement quality improvement initiatives. Each clinic also received up to $1,500 to implement a change within their clinic to become more adolescent friendly (e.g. iPads for completion of adolescent screening tools, privacy screens for check-in, youth-friendly posters and materials). To assure ongoing quality improvement and evaluation, each clinic collected patient satisfaction surveys from all youth and young adults ages 10-25 years visiting their clinic. Final data for this project will be available for FFY19 reporting.

One common need identified across all four ACE-AP pilot clinics was information and guidance related to adolescent consent and confidentiality. Through the AMCHP AYAH CoIIN project, the Center for Adolescent Health and the Law developed consent and confidentiality guides for all participating CoIIN states. The guides will be released in 2019. In addition, the University of Michigan plans to summarize consent and confidentiality laws in a handout for participating clinics.

In August of 2018, the YAYAHP Manager (YAYAHPM) attended the AYAH CoIIN close out meeting in Washington, D.C. to network and collaborate with other states and partners, discuss challenges and successes, and further develop a sustainability plan with resources from AMCHP and the National Resource Center. Following the close out meeting, the Wyoming AYAH CoIIN team conducted a site visit in Cheyenne, Wyoming facilitated by the director of the State Adolescent Health Resource Center. Representatives from the MCH Unit, pilot clinics, Medicaid, Kid Care CHIP (Children's Health Insurance Program), WDH PHD, Wyoming Family Voices, Wyoming American Academy of Pediatrics, WYPCA, and WyHealth (Medicaid contractor) attended. The goal of the meeting was to take stock of current efforts, align goals, and discuss next steps.

In FFY17, a 'consumer education workgroup' of the AYAH CoIIN developed two surveys for youth and young adults and their parents/caregivers. The survey seeks to collect youth and parent views about well visits (e.g. barriers, knowledge about well visits) in order to inform future well visit promotion efforts. Data from 50 parents/caregiver surveys was used to inform program efforts, promotional campaigns, and educational materials developed to increase well-visits. The YAYAHPM plans to administer a survey to youth/young adults in Fall 2019 to further inform program efforts.

One of the key challenges of this project is maintaining engagement of a large and diverse team of stakeholders. The YAYAHPM keeps all members of the larger team engaged through frequent e-mail communication and in-person meetings as appropriate.

Strategy 2: Send well-visit reminders to Children's Special Health (CSH) Program clients

CSH program staff continue to send enrolled clients (and their families) reminders about the importance of attending annual well visits. A requirement of the CSH program is that clients have a primary care provider in addition to the specialists needed to care for the child or adolescent's special health need(s). This aligns with medical home recommendations. State and local staff provide ongoing care coordination for enrolled clients and their families and work to identify a local primary care provider in cases where a family may not have one or needs a new provider.

Strategy 3: Develop statewide youth council to ensure youth voices are included in decisions related to program development, implementation, and evaluation.

The YAYAHP seeks to promote youth voice in the development of strategies and products, and development of a statewide youth council will bring youth voices and experience together with health programs, promoting success, increased youth engagement, and quality improvement. In Fall 2018, YAYAHPM partnered with an MCH Unit intern to research best practices related to youth engagement and review previous WDH plans to launch a statewide youth council. The YAYAHPM developed a framework for the youth council and released an RFA in 2019. The key deliverables included:

- Establish, coordinate, and facilitate statewide youth council
- Recruit members across the state
- Create supportive guidelines and documents for council (ie. application, agreements/expectations, code of conduct, council description/informational letter)
- Work with youth to provide feedback on WDH program materials and implementation as "outlined" by the YAYAHPM
- Work with YAYAHPM to provide training on public health, social determinants of health, and the social ecological model
- Promote youth involvement in relevant topics (ie. youth suicide, bullying, eating disorders, vaping, etc)
- Plan and create youth council agendas and materials
- Attend and facilitate council meetings (encourage and promote youth facilitation and involvement)
- Manage all youth council communication to include drafting e-mails to be distributed to council members on updates, clarifications, upcoming meetings and events, and data reminders-can be in conjunction with council members
- Work with YAYAHPM to provide positive youth development training for youth and adults working with youth
- Regularly communicate with youth and young adults to ensure ongoing collaboration and information sharing on best practices and emerging issues related to youth and young adults (12-24) in Wyoming and other states
- Provide leadership/professional development/social opportunities for youth
- Coordinate ongoing recruitment to promote sustainability
- Manage member leadership roles/responsibilities (ie social media, secretary, chair, etc.)
- Share volunteer opportunities
- Coordinate reimbursements for youth council members

A review team is currently reviewing applications. A contract for youth council activities will be in place before FFY20 begins.

Priority	Performance Measure	ESM (if applicable)
Promote Preventive and Quality Care for Adolescents	**NPM 12: Percent of adolescents with special health care needs who received services necessary to make transitions to adult health care (NSCH)**	ESM 12.4: # of parent or youth completed transition readiness assessments completed by PHN in CSH program

See CSHCN Annual Report.

Priority	Performance Measure	ESM (if applicable)
Promote Healthy and Safe Relationships for Adolescents	**SPM: Percent of high schoolers reporting 0 occasions of alcohol use in past 30 days (Prevention Needs Assessment (PNA))**	**N/A**

The “Promote Healthy and Safe Relationships” 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 2016, 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 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. Program staff held multiple exploratory calls with the University of Washington between Fall 2017 and early 2018 about possible implementation in Wyoming. In addition, the YAYAHPM worked to inform all stakeholders about the framework as well as gain momentum for applying this framework. Due to staff turnover, lack of stakeholder buy-in, and sustainability concerns, plans were suspended in Spring 2018. The most significant barrier of CTC implementation was the requirement that local implementing agency staff dedicate at least .5 FTE to the CTC model. Local infrastructure and project funding was insufficient to meet this requirement.

In Fall 2018, the decision was made to use the Collective Impact Model to address this state priority instead of CTC. Collective Impact is the commitment of a group of individuals from different sectors to a common agenda for solving a specific problem, using a structured form of collaboration. It 1) establishes shared agendas and shared measurement, 2) fosters mutually reinforcing activities, 3) encourages continuous communication, and 4) has a strong backbone. The new YAYAHPM attended trainings/conferences on collective impact, protective factors, and adverse childhood experiences (ACES) to build capacity to increase protective factors as a strategy for promoting healthy and safe relationships in communities.

The following strategies related to this priority are funded with Title V, Rape Prevention and Education (RPE) Program and Preventive Health and Health Services (PHHS) Block Grant funds.

Strategy 1: Support Rape Prevention and Education (RPE) Program pilot communities to implement primary sexual assault prevention strategies using a collective impact model.

The YAYAHPM is the RPE Project Director, and the MCH Epidemiology Program provides evaluation and data support for the RPE program. 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 target audience for this work is adolescents ages 12-24. Historically, three pilot communities were funded through this grant to conduct primary prevention in their local communities with a shared risk and protective factors approach. In Fall 2018, the decision was made to fund two pilot communities, as the third community successfully completed a community-level

strategy, partnering with the local chamber of commerce, reaching 10,000 people. Some examples of programming implemented in the pilot communities 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. By leveraging Title V and RPE funds, we expect to see a broader impact on youth and young adult health outcomes.

Strategy 2: Build statewide capacity for sexual violence prevention among youth and young adults through the Wyoming Sexual Violence Prevention Council (WSVPC).

The YAYAHPM and MCH/Injury Epidemiologist serve as steering committee members of the WSVPC. The council was developed to increase effectiveness of violence prevention efforts statewide. The WSVPC underwent strategic planning including a revision of the vision, mission and core values. In addition, three workgroups of this committee were identified in addition to the Steering Committee. They include the Policy and Legislation work group; the Education, Training and Outreach 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. With a focus on community/societal level strategies, FFY18 brought about a slight shift to the work of the council. The council is currently clarifying goals and strategies that support the collective impact framework in Wyoming sexual violence prevention work.

Strategy 3: Implement comprehensive sexual education curriculum which includes content on reducing risky behaviors (e.g. alcohol use).

The YAYAHPM is the Wyoming Personal Responsibility Education Program (WyPREP) Project Director and 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 FFY18, contracts with nine organizations were active; six school districts, two youth in out of home care facilities, and Wyoming Institute for Disabilities. 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. Starting in the 2017-2018 school year to present, WyPREP reached over 800 Wyoming youth. The YAYAHP partners with the MCH Epidemiology Program 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 2017-2018 school year to present, over 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 months following the program.

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 Epidemiology, 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 was two pronged in nature and looked to evaluate both fidelity to the model of WyPREP programming and the impacts of the program within the local

communities where it is implemented. Based on evaluation findings, there have been several program improvements. Site visits have been implemented to monitor fidelity and provide feedback to facilitators. The WyPREP has improved fidelity monitoring by ensuring all facilitators are trained by WDH staff trainers. Training opportunities have been made available and refresher trainings continue to be offered to troubleshoot issues and provide reporting information/updates. WDH WyPREP staff are also available to provide technical assistance throughout the year.

Strategy 4: Develop statewide youth council to ensure youth voices are included in decisions related to program development, implementation, and evaluation.

See Strategy 3 for Promote Preventive and Quality Care for Adolescents priority above.

Other YAYAHP Activities:

YAYAHP Partnership Development

New in her role, the YAYAHPM worked to develop/build partnerships with many youth serving organizations, other WDH programs, and within other agencies to increase the effectiveness of YAYAH programming. Partnerships include:

- Wyoming Equality
- Wyoming Primary Care Association
- Strong Families Strong Wyoming
- Wyoming Health Council
- Boys and Girls Clubs of Cheyenne
- Students Against Destructive Decisions (SADD)
- Wyoming Children's Trust Fund
- Wyoming Department of Education
- Behavioral Health Division (WDH)

Wyoming College Consortium

In FFY17, 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 Epidemiology 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 Epidemiology and six institutions from across the State.

In FFY2017, 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 Unit to fill in gaps for monitoring the health of young adults in Wyoming regarding safe and healthy relationship.

From FFY18 to present, the YAYAHP and the WCADVSA have worked to ensure primary sexual violence prevention

information is shared with all institutions of higher learning and technical assistance is provided. In August 2019, a joint meeting will be held for pilot communities, campus consortium members, and council members to encourage the collective impact model and identify specific strategies to implement that impact the community/societal level.

Emerging Topic: Youth Suicide Prevention

The YAYAHP, Child Health Program, and Injury and Violence Prevention Program (WIVPP) joined the Child Safety Learning Collaborative (CSLC), through the Child Safety Network (CSN), to focus efforts to reduce fatal and serious injuries among infants, children, and adolescents by building and improving partnerships and implementing and spreading best practices, especially among the most vulnerable populations. Upon review of available data and capacity, the team selected Suicide & Self-Harm Prevention (SSHP) and Motor Vehicle Traffic Safety (Child Passenger and Teen Driver/Passenger) (MVTS) as CSLC topic areas of focus for Wyoming. The YAYAHPM took lead on the SSHP topic while the Child Health Program Manager leads MVTS.

The YAYAHP also partnered with the WIVPP to apply for the Garrett Lee Smith State/Tribal Youth Suicide Prevention and Early Intervention Grant Program. The purpose of the program is to support states and tribes with implementing youth suicide prevention and early intervention strategies in schools, educational institutions, juvenile justice systems, substance use programs, mental health programs, foster care systems, and other child and youth-serving organizations. It is expected that this program will: (1) increase the number of youth-serving organizations who are able to identify and refer youth at risk of suicide; (2) increase the capacity of clinical service providers to assess, manage, and treat youth at risk of suicide; and (3) improve the continuity of care and follow-up of youth identified to be at risk for suicide, including those who have been discharged from emergency department and inpatient psychiatric units.

Adolescent Health - Application Year

Application Year Plan (FFY20): 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	Performance Measure	ESM (if applicable)
Promote Preventive and Quality Care for Adolescents	**NPM 10: Percent of adolescents with a preventive services visit in the last year (National Survey of Children's Health (NSCH))**	ESM 10.2: # QI cycles completed by participating practices

In FFY20, the YAYAHP will implement the following strategies to address NPM10 within the Promote Preventive and Quality Care for Adolescents priority:

1. The YAYAHP will continue to work with statewide stakeholders 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. The YAYAHP will complete Request for Application (RFA) process and selection for clinics and will extend the contract with the University of Michigan for the new cohort of up to four clinics to implement the (ACE)-AP model. The University of Michigan will provide technical assistance on youth friendliness and the incorporation of elements of Bright Futures into practice within selected clinics. Work will be measured by ESM 10.2: # QI cycles completed by participating practices. A QI cycle is defined as the 18 month period of the ACE assessment process on one identified topic.
3. The YAYAHP will increase youth engagement and promote youth voice in the development of strategies and products by contracting out for the State of Wyoming Youth Council Coordinator position.
4. The YAYAHP will continue to promote enhanced provider engagement. A new partnership with the Wyoming Immunizations Unit will support this strategy.

Priority	Performance Measure	ESM (if applicable)
Promote Preventive and Quality Care for Adolescents	**NPM 12: Percent of adolescents with special health care needs who received services necessary to make transitions to adult health care (NSCH)**	ESM 12.4: # of parent or youth completed transition readiness assessments completed by PHN in CSH program

See CSHCN Application.

Priority	Performance Measure	ESM (if applicable)
Promote Healthy and Safe Relationships for Adolescents	**SPM: Percent of high schoolers reporting 0 occasions of alcohol use in past 30 days (Prevention Needs Assessment (PNA))**	N/A

In FFY20, the YAYAHP will implement the following strategies to address SPM4 within the Promote Health and Safe Relationships for Adolescents priority:

1. Complete Request for Application (RFA) process and selection for RPE Program to support community/societal level work;
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 increase the number of communities implementing WyPREP curriculum and provide technical assistance and support;
4. Continue efforts to integrate messages about healthy sexuality and sexual violence prevention. This will be done by integrating affirmative consent training with WyPREP facilitator trainings and implementing strategies that support healthy sexuality and sexual violence prevention.
5. Continue quality improvement on WyPREP program evaluation;
6. Continue to build/improve relationships with stakeholders to engage youth; and
7. Contract with entity to coordinate statewide youth council.

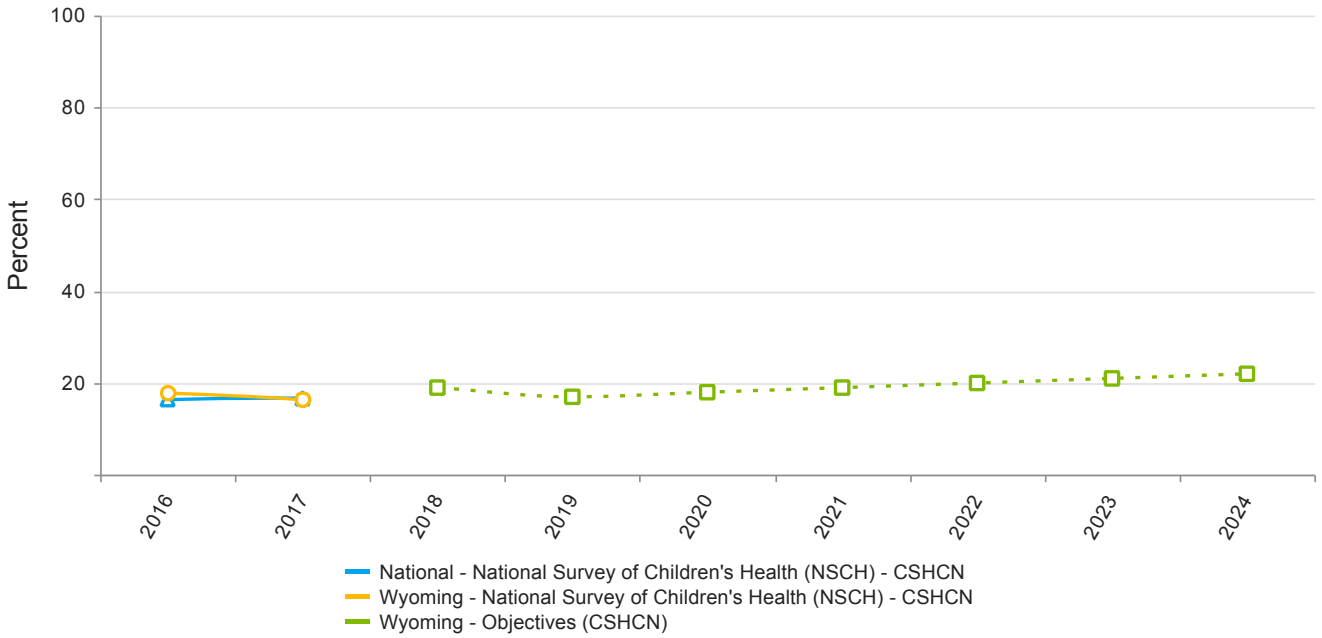
Children with Special Health Care Needs

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_2017	16.6 %	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
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**	**2018**
Annual Objective			19
Annual Indicator		17.9	16.5
Numerator		2,073	2,119
Denominator		11,609	12,855
Data Source		NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017

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						
	2019	2020	2021	2022	2023	2024
Annual Objective	17.0	18.0	19.0	20.0	21.0	22.0

Evidence-Based or –Informed Strategy Measures

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**	**2024**
Annual Objective	45.0	47.0	49.0	51.0	53.0	55.0

State Performance Measures

SPM 7 - Percent of children with and without special health care needs having a medical home

Measure Status:	Active				
Annual Objectives					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	45.0	46.0	47.0	48.0	49.0

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

SPM

SPM 7 - Percent of children with and without special health care needs having a medical home

Objectives

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

Strategies

Support the Parent Partner Project in health care settings.

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

Improve access to genetic services.

Strategies

Provide in person and telehealth services for ongoing genetic clinics.

Annual Report Fiscal Year 2018: This section provides a summary of Federal Fiscal Year 2018 (FFY18) activities, accomplishments, and challenges related to National Performance Measures (NPMs) and State Performance Measures (SPMs) (2016-2020) for the Children with Special Health Care Needs (CSHCN) Domain. 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 efforts within this Domain.

Priority	Performance Measure	ESM (if applicable)
Promote Preventive and Quality Care for Children and Adolescents	**SPM 7 (formerly NPM 11): Percent of children with and without special health care needs having a medical home (NSCH)**	N/A

Strategy 1: Support the Parent Partner Project in health care settings

The Wyoming Parent Partner Program (PPP) began in Wyoming approximately seven 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 that has a child with special health care needs. These parents, called Parent Partners, are on staff approximately 16 hours a week when the provider is seeing CSHCN clients. The Parent Partner works as a peer mentor to support the families and provide many of the elements of patient centered medical home. Parent Partners are paid $15/hour. Beginning in SFY 2020, one Parent Partner will also serve as a statewide coordinator at $20/hour. In addition, at least one Parent Partner will provide services virtually.

The Child Health Program Manager (CHPM) tracks the number of unique families served by the Wyoming PPP. During FFY2018, the PPP served 189 unique families and unique 233 children. Parent Partners serve clinics in Cheyenne, Casper, Riverton, and the F.E. Warren Air Force Base (Cheyenne, Wyoming).

Strategy 2: Provide in-person and telehealth services for ongoing genetics clinics

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 previous model held up to 25 in-person clinics throughout the state. In 2017, the MCH Unit convened stakeholders from PHN, Rural and Frontier Health Unit, 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. 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).

The first two telehealth genetics clinics launched in early 2018 in two Wyoming locations, Casper (Natrona County) and Cheyenne (Laramie County); communities selected for their high volume of patient referrals and central locations in the state. While initial visits will always be in person, Wyoming families will now be able to obtain follow-up genetic services via telehealth. Additionally, under the new model, the WDH anticipates an annual cost savings of close to 75%.

An evaluation of the new program was launched in early 2018, including both quantitative and qualitative data

collection. A complete report about the results of this evaluation is available upon request. A summary of key findings follows.

Phase 1, the quantitative portion of the evaluation, asked three key questions: 1) Who are we currently serving? 2) What would happen if there were no Wyoming genetic clinics? 3) Is telemedicine an acceptable option for patients and providers?

As of December 31, 2018 Wyoming Genetic Program enrolled 69 clients with services provided to 63 individuals. Of these, 24 patients had a telehealth visit.

Clients enrolled in the program (n=69) averaged 10 years of age, with a range from birth to 45 years. The majority (74%) were enrolled in Wyoming Medicaid. Sixty-six percent (66%) resided in medically underserved areas and 70% of parents, caregivers, or adult patients reported educational levels of high school graduation or less. Over 60% reported that they had to take time off work or school for the appointment. Patient services were split between two sites; Laramie County (Cheyenne) with 58% of the patients and Natrona County (Casper) with 42% of the patients. Most patients (85%) had not tried to get genetic services elsewhere. Denver or Salt Lake City were most often cited as options for genetic services however both require long waits, with Denver scheduling approximately 18 months out.

All patients (whether they received an in-person visits or telehealth visit) completed a post-visit survey. Those receiving telehealth services (n=24) felt that telegenetics made it easier for them or their child to receive services and that telemedicine was more convenient than traveling out-of-state. All were satisfied with the quality of services received and said their questions were answered. It was the first time that most families had used telemedicine.

Phase 2 and Phase 3 of the evaluation interviewed front-line providers (front desk clerks, public health nurses, consulting physicians) about their experience with the Wyoming Genetics Telehealth program. While patient satisfaction, travel times, and barriers to services were important for program coordinators to understand, so too was the acceptability of telehealth to providers. Questions included how telehealth fit into their current role, whether the training that they received had been adequate, the future of telehealth in Wyoming, and suggestions for improvement of the program.

Results proved informative. Assets included excellent relationships between both public health nursing teams and the consulting providers, longer appointments for families using telehealth, and the utilization of equipment already in place at the two clinic sites. Challenges included working with families who lived outside the county, particularly in the area of medical record acquisition prior to the visit and resource referral following the visit. The public health nursing team from Natrona County (Casper) experienced greater challenges in this area because most of the individuals scheduled at their clinic were not from their county. Laramie County (Cheyenne) had established relationships with most of their patients, resulting in fewer appointment cancellations and more complete acquisition of needed medical records at the front end. For all patients, transportation in our rural and frontier state continues to be a barrier to care.

Action steps for the Wyoming Genetics Clinic include marketing the program to local providers and providing more information for families about what a telehealth visit entails. Finally, a cluster of families residing in Fremont County (in and near the Wind River Indian Reservation) was identified and to meet their needs, a third genetic clinic site will launch in mid-2019 in Riverton, Wyoming. It is anticipated that more Wyoming residents will begin to seek and receive care with the opening of this new clinic site

Additional Strategies:

Medical Home Promotion for CSH clients
Public Health Nurses (PHNs) educate Children's Special Health (CSH) program clients and 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, state and local care coordinators (CSH staff and public health nurses) 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.

Wyoming Primary Care Association Patient-Centered Medical Home Summit
The CHPM served as a panelist at the Wyoming Primary Care Association's Patient-Centered Medical Home (PCMH) summit in January 2019. This was the second year that the MCH Unit presented on the importance of medical home for the CSH population. At this summit, the CHPM presented to Wyoming medical providers on the value of adopting PCMH as a standard of care and the importance of aligning with the American Academy of Pediatrics (AAP) Bright Futures Guidelines, 4th Edition.

Promotion of Telehealth Services
In addition to promoting 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 a partnership between the 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 May 2019, 372 Zoom licenses were issued through the Wyoming Telehealth Network (WyTN). This includes 30 PHN offices and 19 Women, Infants & Children (WIC) offices.

Priority	Performance Measure	ESM (if applicable)
Promote Preventive and Quality Care for Children and Adolescents	**NPM 12: Percent adolescents with and without special health care needs who received services necessary to make transitions to adult health care (NSCH)**	ESM 12.4 - # of completed parent or youth completed transition readiness assessments submitted by PHN to the CSH Program

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. The majority (82%) of Wyoming parents of adolescents **with** special health care needs reported that their child *did not* get the services necessary to transition to adult care.

Strategy 1: Train Children's Special Health nurses on how to conduct a transition readiness assessment

During Summer 2018, the CSH Program provided virtual training series for PHNs and Tribal MCH Nurses. The trainings provided information about programs, services, and resources available to families with children with special health care needs. Topics covered include Medicaid/Kid Care CHIP (State Children's Health Insurance Program) eligibility, travel assistance, Developmental Disabilities Waiver, UPLIFT (Wyoming's Family Voices affiliate), SSI, WYhealth (Case Management Program for Wyoming Medicaid), Wyoming 211, Help Me Grow,

Children's Mental Health Waiver, Early Intervention and Education program (Part B and Part C), Parent Information Center (PIC), and health care transition for young adults. All trainings included a follow-up survey to better understand the utility of the information provided. In addition, all trainings were recorded and made available on a website accessible to all PHNs. CSH staff also made trainings available to Tribal MCH nurses serving CSH clients on Wind River Indian Reservation. Nurses in at least three counties requested additional CSH orientation/training following the web series. A CSH Benefits and Eligibility Specialist implemented in-person training with new nurses as a result of this request.

Transition from pediatric to adult health care for youth with and without special health care needs was identified as a priority for the YAYAHP and CSH Program. Both programs partnered to develop a training on adolescent transition for PHNs and Tribal MCH Nurses who provide CSH care coordination services to children and youth with special health care needs. The training was offered in September 2018 and recorded for ongoing use for current and new nurses.

The training reviewed definitions of health care transition, health care transition data, best practices, and how to implement newly developed tools and resources. The tools were developed by the YAYAHP and CSH program staff using Got Transition resources.

Strategy 2: Distribute Wyoming modified 'Got Transition' materials to families of youth with special health care needs served through the CSH Program

With 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) and the review of the *Got Transition* materials by the CSH staff, the CSH Program and partners developed a Wyoming specific transition toolkit for PHNs to use with youth and parent/caregiver enrolled in the CSH Program. The toolkit, which includes Transition Readiness Assessments for parents/caregivers and youth, is designed to identify and respond to gaps in knowledge about health care transition and guide annual discussions with youth and parent/caregiver starting when the client turns age 14. A fact sheet containing transition issues and community contacts is also sent to CSH clients turning 18 and at age 19 and is part of the health care transition discussion the PHN has with the youth and parent/caregiver during their annual renewal.

In February 2019, the MCH Unit and MCH Epidemiology Program formally launched the implementation of health care transition assessments for youth and young adults as part of the CSH annual renewals with a strong emphasis on quality improvement. Preliminary evaluation results show that parents and youth alike appreciate learning about the importance of health care transition. Parents were also pleased and, at times surprised, when they learned that their children wanted to be involved in future health care discussions and decision-making. Finally, PHNs interviewed to-date report that discussion about health care transition adds an interesting dimension to the annual clinical visit.

Response to the CSH Transition initiative has been positive. Adrienne Tatman, RN, CLC (Sheridan County Public Health) reported "*My client's mother thought the health care transition was very helpful and a great way to help her daughter become her own advocate. During our meeting, my client actively took part in developing her care plan. The family also expressed that their eldest would have benefited from this transition assistance and expressed gratitude it is now part of the CSH experience*".

Another public health nurse, Lori Bickford, RN, BSN, MS (Weston County Public Health) said "*I witnessed a young teenage girl become excited about gaining independence in making her own appointments. The parent was very supportive and eager to help her learn how to do this on her own. As the nurse completing this paperwork for the*

first time, I felt like it was a seamless process and stimulated meaningful conversation between myself, the client and her parent."

Currently, the CSH Program continues to provide limited gap-filling financial assistance and care coordination services to CYSHCN and their families and to work on improving health care transition for Wyoming families of children and youth with special health care needs. The program actively served 634 CSH clients during the past fiscal year.

Other CSH Program Activities

The MCH Units' overall priority of supporting continuous quality improvement of our care coordination services provided to our children with special health care needs clients and families served on our Children's Special Health (CSH) program. Internal chart audits are being conducted to ensure uniform compliance is happening and learn ways to improve.

In 2018, program staff updated the CSH program brochure to better inform our clients and providers of the benefits of enrollment in our Children's Special Health (CSH) program. Programs highlighted in our brochure include CSH (children with special health care needs), Maternal High Risk, Newborn Intensive Care and Genetics Clinic services.

The MCH Unit collaborates with Wyoming Medicaid to offer emergency travel assistance to alleviate barriers to receiving care with out-of-state specialists.

CSH Benefits and Eligibility Specialists (BES) each maintain a desk manual. In late 2017, CSH staff began developing a comprehensive desk manual for all staff to promote uniform adherence to procedures and for succession planning. Caseload of the CSH program is distributed amongst three BES. The purpose of the desk manual is to have standards documented for how caseloads are worked similarly. The desk manual will be complete by Fall 2019.

Children with Special Health Care Needs - Application Year

Application Year Plan (FFY20): 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	Performance Measure	ESM (if applicable)
Promote Preventive and Quality Care for Children and Adolescents	**SPM 7 (formerly NPM 11): Percent of children with and without special health care needs having a medical home (NSCH)**	N/A

Due to the changes in the Block Grant guidance and Wyoming MCH's capacity, National Performance Measure (NPM) 11 was discontinued in FFY19. However, due to ongoing work, a SPM for medical home was added (now SPM 7). Priorities and selected measures will reset in 2021 following the required needs assessment.

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:

1. Continue to contract with the Wyoming Parent Partner Program (PPP) to provide peer support to families of CSHCN within a medical home as measured by:
    a. # of unique families served through the PPP
2. Continue to provide genetic clinics services as measured by:
    a. # of clients served
3. Evaluate telegenetics services as measured by:
    a. Demographics of clients served\
    b. Client barriers accessing genetic services
    c. Acceptability of telegenetic services

Priority	Performance Measure	ESM (if applicable)
Promote Preventive and Quality Care for Children and Adolescents	**NPM 12: Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care (NSCH)**	ESM 12.4 - # of completed parent or youth completed transition readiness assessments submitted by PHN to CSH Program

In FFY20, the YAYAHP will partner with CSH Program and MCH Epidemiology Program staff to implement the following strategies to address NPM12 within the Promote Preventive and Quality Care for Adolescents priority:

1. PHN will continue to use the Transition Toolkits as part of the new health care transition initiative, which includes a flow chart of how visits should be conducted, assessment forms to include a Plan of Care document, talking points for clients and families, a resource list, and other useful documents as part of PHN

CSH (Children's Special Health) annual renewal.

2. The CSH Program will continue to send reminders to enrolled clients to attend their annual well-visit and complete the transition readiness assessment. The FAQ document, *The Adolescent and Young Adult Well-Visit: A Guide for Families*, is also included with the appointment letters for clients ages 11-18.
    a. Work will be measured by ESM 12.4: # of parent or youth completed transition readiness assessments completed by PHN in CSH program.
3. CSH staff will collaborate with other MCH staff to develop a tool to assess parent and youth impressions of the health care transition tools provided by the PHN. CSH staff will receive technical assistance, as necessary, from organizations such as *Got Transition* on the applicability of their evidence-based and evidence-informed resources to Wyoming populations and the development of a Transition Policy.
4. The YAYAHP will extend its contract with the University of Michigan to work with up to four more clinics within the state to implement techniques that assess knowledge and readiness of transition and encourage/support the transition process. An 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

Excerpts from the draft FY2020 application and FY2018 annual report were made available to the public via the MCH Unit website on July 3, 2019. The MCH Unit Manager sent a link to the draft report and a public input survey to a list of PLTI graduates who previously stated they would be interested in receiving communication from the MCH Unit. A separate e-mail was sent to individuals (n=37) who replied to a 2018 MCH Collaboration Survey stating their interest in reviewing future Title V reports.

The public input survey asked for general feedback on the contents of the annual report and application as well as specific feedback on each Title V population domain report and application, about services/activities they were not aware of but that were covered in the report, about 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.

As of September 15, 2019, the MCH Unit received only two survey responses. The low response may be partly due to the fact that no incentives (e.g. gift cards) were offered for public input this year as they were in years past. This was due to updated state procedures discouraging use of gift cards. Another possible reason is the length of the input survey; the MCH Unit Manager will revise prior to resending.

Despite a very low survey response rate, the MCH Unit received informal feedback from a handful of stakeholders who reviewed the report and incorporated feedback. The final report will be accessible on the website in September and any additional feedback received will be incorporated into next year’s annual report and application.

III.G. Technical Assistance

The MCH Unit met and discussed potential technical assistance (TA) needs. They include:

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

  The CSH program in Wyoming has not changed for many years despite reductions in staff/budget 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 but implements few systems-level strategies. The MCH Unit requests TA in the form of cross-state mentorship so that the Wyoming CSH team can learn from another rural/frontier state familiar with our challenges and capacity.

  Due to an inadequate and dated CSH data system, current programmatic efforts lack evaluation and ongoing quality assurance. The MCH Unit requests TA related to establishing effective data systems to track program eligibility *and* evaluate care coordination services. Efforts to identify a system have been slow but have included researching a WDH system for waiver services and WebChart Electronic Health Record, a system adopted by PHN in October 2018. Lastly, the CSH Program received some TA from the National Center for Care Coordination Technical Assistance and would like to revisit options in the next fiscal year.

  In 2014, the CSH Program Manager position was repurposed to establish a Youth and Young Adult Health Program, leaving a leadership gap in CSH. Currently, the Title V Director assumes the CYSHCN Director responsibilities and supervision of CSH program staff is divided amongst three separate supervisors. The MCH Unit requests TA related to succession planning and training of new CSH staff as two key positions are expected to become vacant due to retirements within the next year.

  Lastly, while the CSH Program recently launched a virtual training series for all PHNs and Tribal MCH Nurses delivering CSH services, there remains a gap in available training on care coordination services for CSHCN. The MCH Unit requests TA related to care coordination training. Previous options suggested for care coordination training by the National Center for Care Coordination Technical Assistance required a level of capacity that the MCH Unit could not provide.

- **Provider Engagement**

  All MCH programs prioritize provider engagement in the promotion of 2016-2020 priorities. Unlike other states, Wyoming does not have active professional associations such as the American Academy of Pediatrics (AAP) or the American College of Obstetricians and Gynecologists (ACOG). In some cases, it is difficult for us to identify who are Wyoming Chapter leads are for associations. We request TA on engaging provider groups in rural/frontier states.

- **Evidence-Based Home Visitation Models for Rural/Frontier States**

  The MCH Unit provides over one million dollars a year in State General Funds (and Title V match/MOE funds) to local PHN offices to deliver MCH services including home visitation services. Currently, the Healthy Baby Home Visitation Program offers two models: 1) Best Beginnings, a research informed model based on the Partners for a Healthy Baby curriculum developed by Florida State University (available in all 23 counties); and 2) Nurse Family Partnership, an evidence-based home visitation model (available in 4 counties). Best Beginnings is well-liked due to its flexibility; however, it is not evidence-based and program evaluation efforts

have been difficult due to inconsistency in model implementation. Nurse Family Partnership is well-respected as an evidence-based model but implementation in a rural/frontier state has seen challenges over the past twenty years, leading to a reduction of the number of implementing counties from over 20 to just four as of July 1, 2019. The MCH Unit requests support in researching evidence-based home visitation models suitable for rural/frontier communities and/or support in adapting current models for effective implementation in rural/frontier communities. This research will be conducted in partnership between the MCH Unit and PHN's MCH Coordinators.

- **Early Childhood Systems Mapping (*TA request in process*)**

  The Wyoming early childhood system is fragmented. There is no shared vision for early childhood system improvements and many current activities are siloed. This leads to duplication of efforts as well as undetermined gaps in services and systems to support the MCH population. In 2019, the MCH Unit submitted an application to the MCH Workforce Development Center to build MCH capacity to convene Wyoming early childhood system partners to prepare for future early childhood systems mapping processes. Within the past six months, the Wyoming Title V program and the Wyoming Maternal, Infant, and Early Childhood Home Visiting (MIECHV) grantee have improved partnership. Specifically, both programs have identified areas of mutual interest including the desire/need to develop an early childhood systems map. The MIECHV grantee has agreed to use MIECHV Needs Assessment funds to support this work. As this mutual effort was discussed with statewide partners, we learned that another statewide early childhood partner, Wyoming Kids First, also planned to dedicate time and resources to mapping the early childhood system. Efforts are underway to coordinate completion of one comprehensive systems map and support from the MCH Workforce Development Center will be useful in this work. Specifically, TA will be helpful in responding to needs identified through the mapping exercise and designing a strategic plan that considers all partners within the system.

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 - Appendix A_2021-2025 MCH Needs Assessment Charter_Approved Draft.pdf

Supporting Document #02 - Appendix B_2018 Wyoming MCH Unit Collaboration Survey.pdf

Supporting Document #03 - Appendix C_ Bright Futures 4th Edition Guidelines_ Recommendations for Implementation_Wyoming.pdf

Supporting Document #04 - Appendix D_MCH Unit Healthstat Documents 2018.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - PHD Org Chart_January-March 2019 wo 03-06-19 (1).pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Wyoming

	FY 20 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	$ 400,000	(36.3%)
B. Children with Special Health Care Needs	$ 385,000	(35%)
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)	$ 830,000	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 1,825,591	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 550,000	
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)	$ 1,877,176	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 5,352,767	

OTHER FEDERAL FUNDS	FY 20 Application Budgeted
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Temporary Assistance for Needy Families (TANF)	$ 1,177,341
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 121,774
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 228,074
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 99,987
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 250,000

	FY 18 Annual Report Budgeted		FY 18 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 1,125,000		$ 1,083,689	
A. Preventive and Primary Care for Children	$ 360,000	(32%)	$ 383,021	(35.3%)
B. Children with Special Health Care Needs	$ 440,000	(39.1%)	$ 432,698	(39.9%)
C. Title V Administrative Costs	$ 45,000	(4%)	$ 36,583	(3.4%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 845,000		$ 852,302	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 1,825,591		$ 1,948,353	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0		$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 550,000		$ 427,238	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0		$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 2,375,591		$ 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)	$ 3,500,591		$ 3,459,280	
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)	$ 1,600,234		$ 1,559,910	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 5,100,825		$ 5,019,190	

OTHER FEDERAL FUNDS	FY 18 Annual Report Budgeted	FY 18 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Temporary Assistance for Needy Families (TANF)	$ 1,177,341	$ 1,124,927
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 97,644	$ 128,422
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 130,249	$ 114,554
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 195,000	$ 192,007

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children**
	Fiscal Year:	**2020**
	Column Name:	**Application Budgeted**
	Field Note: Programs/services within the Child Health and Young and Young Adult Health Program including salary for CHPM and partial salary for YAYAHPM. Example projects to be funded include: youth council coordination, adolescent well-visit promotion, EPSDT/Bright Futures promotion (in partnership with Medicaid, Immunizations, etc.). See CH and AH application narratives and State Action Plan.	
2.	**Field Name:**	**2. Subtotal of Lines 1A-C**
	Fiscal Year:	**2020**
	Column Name:	**Application Budgeted**
	Field Note: A budget phase 'FAM' includes expenditures related to the Women/Maternal and Perinatal/Infant domains managed by the Women and Infant Health Program.	
3.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs**
	Fiscal Year:	**2020**
	Column Name:	**Application Budgeted**
	Field Note: Programs/services within the Children's Special Health Program including salaries for 3 CSH Benefits and Eligibility Specialists. Example projects to be funded include: Genetics clinics (including telehealth), adolescent transition efforts, and care coordination training. See CSHCN application narratives and State Action Plan.	
4.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2020**
	Column Name:	**Application Budgeted**
	Field Note: State funds pay for MCH/MCH Epidemiology Program salaries; supplies; printing; travel to national conferences (including required Title V meeting); strategic planning consultation support.	
5.	**Field Name:**	**5. OTHER FUNDS**
	Fiscal Year:	**2020**
	Column Name:	**Application Budgeted**

	Field Note: Trust and Agency Account for Newborn Screening.	
6.	**Field Name:**	**1.FEDERAL ALLOCATION**
	Fiscal Year:	**2018**
	Column Name:	**Annual Report Expended**
	Field Note: Total federal award: $1,083,689. Expenditures match award.	
7.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children:**
	Fiscal Year:	**2018**
	Column Name:	**Annual Report Expended**
	Field Note: Includes expenditures related to CHP salary, Safe Kids, University of Michigan Adolescent Health Initiative, Help Me Grow (national support and local implementation), Strengthening Families Protective Factors Framework training, vision screening collaborative, physical activity promotion (WAPHERD), sponsorship for community and pediatric conference, support for development of Healthy Policies Toolkit for early care settings (child obesity prevention), and travel related to CHP.	
8.	**Field Name:**	**2. Subtotal of Lines 1A-C**
	Fiscal Year:	**2018**
	Column Name:	**Annual Report Expended**
	Field Note: The Unit tracks an additional federal Title V funding phase to capture the balance of Title V funding each year. These funds are used for pregnant women, infants, and other populations. The expenditures for FFY18 = $229,990.	
9.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs:**
	Fiscal Year:	**2018**
	Column Name:	**Annual Report Expended**
	Field Note: Expenditures related to CSH program salaries (including through May, June and July (partial) CSH Benefits and Eligibility Specialist salaries), genetics clinics, PLTI (local implementation, training, travel), support for Family Voices conference, Parent Partner Project, and supplies related to CSH activities (e.g. transition toolkits).	
10.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2018**
	Column Name:	**Annual Report Expended**

	Field Note: Less than 10% of total Title V award.	
11.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2018**
	Column Name:	**Annual Report Expended**
	Field Note: SGF from MCH and MCH Epidemiology phases: $1,718,612.92 SGF from Immunization phase: $229,740.23	
12.	**Field Name:**	**5. OTHER FUNDS**
	Fiscal Year:	**2018**
	Column Name:	**Annual Report Expended**
	Field Note: Trust and Agency Account for Newborn Screening. Less than previous years due to SGF being used to pay for a portion of newborn screening services during reporting year.	
13.	**Field Name:**	**7. TOTAL STATE MATCH**
	Fiscal Year:	**2018**
	Column Name:	**Annual Report Expended**
	Field Note: Match/MOE made.	
14.	**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:	**2020**
	Column Name:	**Application Budgeted**
	Field Note: Estimate based on current funding.	
15.	**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:	**2020**
	Column Name:	**Application Budgeted**

	Field Note: From balance sheet RAPEPREVED GFY19.	
16.	**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:	**2020**
	Column Name:	**Application Budgeted**
	Field Note: From Balance Sheet H18MC5825 FFSD8	
17.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)**
	Fiscal Year:	**2020**
	Column Name:	**Application Budgeted**
	Field Note: From Unit 534 Balance Sheet, FFPRE6/7 estimate.	
18.	**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:	**2018**
	Column Name:	**Annual Report Expended**
	Field Note: Expenditures from OT17MFH, OTTAN8.	
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:	**2018**
	Column Name:	**Annual Report Expended**
	Field Note: FFSSD7.	
20.	**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:	**2018**
	Column Name:	**Annual Report Expended**

	Field Note: FFPRM7 expenditures. 12-month period. 4/1/2017 - 3/31/2018. Data Source: Balance Sheet.	
21.	**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:	**2018**
	Column Name:	**Annual Report Expended**
	Field Note: FFSVP7. 12 months. 2/1/2017 - 1/31/2018. This is the data available for 12 months of expenditure reporting.	

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	FY 20 Application Budgeted	FY 18 Annual Report Expended
1. Pregnant Women	$ 110,000	$ 50,462
2. Infants < 1 year	$ 110,000	$ 88,530
3. Children 1 through 21 Years	$ 400,000	$ 383,021
4. CSHCN	$ 385,000	$ 432,698
5. All Others	$ 50,000	$ 92,395
Federal Total of Individuals Served	$ 1,055,000	$ 1,047,106

IB. Non-Federal MCH Block Grant	FY 20 Application Budgeted	FY 18 Annual Report Expended
1. Pregnant Women	$ 150,000	$ 128,363
2. Infants < 1 year	$ 1,400,000	$ 1,515,258
3. Children 1 through 21 Years	$ 125,000	$ 91,850
4. CSHCN	$ 250,000	$ 174,005
5. All Others	$ 450,591	$ 466,115
Non-Federal Total of Individuals Served	$ 2,375,591	$ 2,375,591
Federal State MCH Block Grant Partnership Total	$ 3,430,591	$ 3,422,697

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:	**2018**
	Column Name:	**Annual Report Expended**
	Field Note: Partial salary for Women and Infant Health Program Manager Limited PQC costs including PQC coordinator contract (50% of expenditures supporting 'pregnant women' and 50% supporting 'infants'); Wyoming Hospital Association outreach booth for PQC. Supplies	
2.	**Field Name:**	**IA. Federal MCH Block Grant, 2. Infant < 1 Year**
	Fiscal Year:	**2018**
	Column Name:	**Annual Report Expended**
	Field Note: Partial salary for Women and Infant Health Program Manager Limited PQC costs including PQC coordinator contract (50% of expenditures supporting 'pregnant women' and 50% supporting 'infants'); Wyoming Hospital Association booth for PQC and NBS. Supplies	
3.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1 through 21 years**
	Fiscal Year:	**2018**
	Column Name:	**Annual Report Expended**
	Field Note: A phase is set up (FFVEN) to capture all expenses related to the child and adolescent population. These expenses include CHP salary, Safe Kids, University of Michigan Adolescent Health Initiative, Help Me Grow (national support and local implementation), Strengthening Families Protective Factors Framework training, vision screening collaborative, physical activity promotion (WAPHERD), sponsorship for community and pediatric conference, support for Healthy Policies Toolkit (childhood obesity prevention), and travel related to CHP.	
4.	**Field Name:**	**IA. Federal MCH Block Grant, 4. CSHCN**
	Fiscal Year:	**2018**
	Column Name:	**Annual Report Expended**
	Field Note: A phase is set up (FFCSH) to capture all expenses related to the CSHCN population. These expenses include CSH program salaries, genetics clinics, PLTI (local implementation, training, travel), support for Family Voices conference, Parent Partner Project, and supplies related to CSH activities (e.g. transition toolkits).	
5.	**Field Name:**	**IA. Federal MCH Block Grant, 5. All Others**

	Fiscal Year:	**2018**
	Column Name:	**Annual Report Expended**
	Field Note: Partial salary for Youth and Young Adult Health Program Manager A portion of Help Me Grow costs due to parent education/outreach activities Community event registration Supplies	
6.	**Field Name:**	**IB. Non-Federal MCH Block Grant, 1. Pregnant Women**
	Fiscal Year:	**2018**
	Column Name:	**Annual Report Expended**
	Field Note: Home Visiting Services for pregnant women (8% of time spent on prenatal services x Total Expenditures for Home Visiting/MCH/CSH Services) MCH/MCH Epi supplies (20% of Total Supplies) MCH/MCH Epi salaries (20% of Total Salaries)	
7.	**Field Name:**	**IB. Non-Federal MCH Block Grant, 2. Infant < 1 Year**
	Fiscal Year:	**2018**
	Column Name:	**Annual Report Expended**
	Field Note: Home Visiting Services for infants (30% of time spent on infant home visitation services x Total Expenditures for Home Visiting/MCH/CSH Services) MCH/MCH Epi supplies (20% of Total Supplies) MCH/MCH Epi salaries (20% of Total Salaries) Newborn Screening funding (SGF and NBS Trust and Agency Account) Immunizations (Prevnar)	
8.	**Field Name:**	**IB. Non-Federal MCH Block Grant, 3. Children 1 through 21 years**
	Fiscal Year:	**2018**
	Column Name:	**Annual Report Expended**
	Field Note: Home Visiting Services for children, ages 1-up; (4% of time spent on services for children ages 1-up x Total Expenditures for Home Visiting/MCH/CSH Services) MCH/MCH Epi supplies (20% of Total Supplies) MCH/MCH Epi salaries (20% of Total Salaries)	
9.	**Field Name:**	**IB. Non-Federal MCH Block Grant, 4. CSHCN**
	Fiscal Year:	**2018**

	Column Name:	**Annual Report Expended**
	Field Note: CSH care coordination services provided by PHN (13% of time spent on CSH services x Total Expenditures for Home Visiting/MCH/CSH Services) MCH/MCH Epi supplies (20% of Total Supplies) MCH/MCH Epi salaries (20% of Total Salaries)	
10.	**Field Name:**	**IB. Non-Federal MCH Block Grant, 5. All Others**
	Fiscal Year:	**2018**
	Column Name:	**Annual Report Expended**
	Field Note: Home Visiting Services for mothers/parents (45% of time spent on services for parents/mothers x Total Expenditures for Home Visiting/MCH/CSH Services) MCH/MCH Epi supplies (20% of Total Supplies) MCH/MCH Epi salaries (20% of Total Salaries)	

Data Alerts: None

Form 3b
Budget and Expenditure Details by Types of Services

State: Wyoming

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY 20 Application Budgeted	FY 18 Annual Report Expended
1. Direct Services	$ 60,000	$ 71,000
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	$ 60,000	$ 71,000
2. Enabling Services	$ 260,000	$ 226,037
3. Public Health Services and Systems	$ 780,000	$ 786,652
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		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Other		
Speciality Clinics		$ 71,000
Direct Services Line 4 Expended Total		$ 71,000
Federal Total	$ 1,100,000	$ 1,083,689

IIB. Non-Federal MCH Block Grant	FY 20 Application Budgeted	FY 18 Annual Report Expended
1. Direct Services	$ 70,591	$ 0
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	$ 70,591	$ 0
2. Enabling Services	$ 705,000	$ 638,990
3. Public Health Services and Systems	$ 1,600,000	$ 1,736,601
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		$ 0
Physician/Office Services		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Direct Services Line 4 Expended Total		$ 0
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:	**2018**
	Column Name:	**Annual Report Expended**
	Field Note: Genetics Services provided by University of Utah.	
2.	**Field Name:**	**IIA. Federal MCH Block Grant, 1. C. Services for CSHCN**
	Fiscal Year:	**2018**
	Column Name:	**Annual Report Expended**
	Field Note: Genetics services provided by University of Utah between April 2018 - June 2019.	
3.	**Field Name:**	**IIA. Federal MCH Block Grant, 2. Enabling Services**
	Fiscal Year:	**2018**
	Column Name:	**Annual Report Expended**
	Field Note: Includes the following enabling expenditures: Safe Kids Wyoming Help Me Grow (serving both children and other) Parent Partner Project	
4.	**Field Name:**	**IIA. Federal MCH Block Grant, 3. Public Health Services and Systems**
	Fiscal Year:	**2018**
	Column Name:	**Annual Report Expended**
	Field Note: Includes salary support (capacity/infrastructure) for CSH Benefits and Eligibility Specialists, Women and Infant Health Program Manager, Child Heatlh Program Manager, .5FTE Youth and Young Adult Health Program Manager, and partial salary support for MCH/PRAMS Epidemiologist and MCH/Injury Epidemiologist. A small portion of funds support infrastructure in the new Injury and Violence Prevention Program. Additional expenditures include PLTI support, support for Family Voices WY (travel to conference), supplies/travel, conference support (perinatal conference, community/pediatric conference), University of Michigan technical assistance for ACE-AP project, Help Me Grow membership fee, Protective Factors training, and trainings provided by Wyoming Vision Collaborative.	
5.	**Field Name:**	**IIB. Non-Federal MCH Block Grant, 1. Direct Services**

	Fiscal Year:	**2018**
	Column Name:	**Annual Report Expended**
	Field Note: Report for direct expenditures for the CSH Program not yet available due to a new fiscal reporting system launched during FFY18. Only CSH expenditures are impacted because they are processed by the Medicaid Fiscal Agent (due to the fact that the CSH program provides gap-filling financial assistance for eligible providers who provide eligible services and pays at the Medicaid rate). The MCH Unit Manager and new fiscal manager will develop a method for reporting these direct expenditures prior to final submission of the block grant.	
6.	**Field Name:**	**IIB. Non-Federal MCH Block Grant, 2. Enabling Services**
	Fiscal Year:	**2018**
	Column Name:	**Annual Report Expended**
	Field Note: Review of Public Health Nursing time and task tracking system revealed that 70% of time (for all counties) was spent on enabling services (e.g. home visits/care coordination visits). 70% x Total expenditures	
7.	**Field Name:**	**IIB. Non-Federal MCH Block Grant, 3. Public Health Services and Systems**
	Fiscal Year:	**2018**
	Column Name:	**Annual Report Expended**
	Field Note: Review of Public Health Nursing time and task tracking system revealed that 30% of time (for all counties) was spent on systems services (e.g. community events, fairs) 30% x Total expenditures In addition, the following expenditures are considered at the systems level: MCH/MCH Epi salary (capacity) Newborn Screening expenditures Immunizations (Prevnar) expenditures MCH/MCH Epi supplies (infrastructure)	
8.	**Field Name:**	**IIA. - Other - Speciality Clinics**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: Genetics services provided by University of Utah.	

Form 4
Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: Wyoming

Total Births by Occurrence: 5,990 **Data Source Year: 2018**

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	5,872 (98.0%)	4	4	4 (100.0%)

Program Name(s)				
3-Hydroxy-3-Methyglutaric Aciduria	3-Methylcrotonyl-Coa Carboxylase Deficiency	Argininosuccinic Aciduria	Biotinidase Deficiency	Carnitine Uptake Defect/Carnitine Transport Defect
Citrullinemia, Type I	Classic Galactosemia	Classic Phenylketonuria	Congenital Adrenal Hyperplasia	Critical Congenital Heart Disease
Cystic Fibrosis	Glutaric Acidemia Type I	Homocystinuria	Isovaleric Acidemia	Long-Chain L-3 Hydroxyacyl-Coa Dehydrogenase Deficiency
Maple Syrup Urine Disease	Medium-Chain Acyl-Coa Dehydrogenase Deficiency	Methylmalonic Acidemia (Cobalamin Disorders)	Methylmalonic Acidemia (Methylmalonyl-Coa Mutase)	Primary Congenital Hypothyroidism
Propionic Acidemia	S, ßeta-Thalassemia	S,C Disease	S,S Disease (Sickle Cell Anemia)	Severe Combined Immunodeficiences
ß-Ketothiolase Deficiency	Trifunctional Protein Deficiency	Tyrosinemia, Type I	Very Long-Chain Acyl-Coa Dehydrogenase Deficiency	

2. Other Newborn Screening Tests

None

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

Wyoming does not currently conduct long term follow-up activities. However, through contracts with specialists for metabolic, endocrine, hemoglopinopathies, and SCID, WY does assure short-term follow up. Starting July 1, 2019, the Colorado Department of Public Health and Environment began providing follow-up services (short-term) for WY babies in addition to the laboratory services they have provided for WY for over 20 years.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

1.	**Field Name:**	**Total Births by Occurrence**
	Fiscal Year:	**2018**
	Column Name:	**Total Births by Occurrence Notes**
	Field Note: Wyoming Vital Statistics Services, 2018.	
2.	**Field Name:**	**Core RUSP Conditions - Receiving At Least One Screen**
	Fiscal Year:	**2018**
	Column Name:	**Core RUSP Conditions**
	Field Note: Provided by WY Newborn Screening Coordinator.	
3.	**Field Name:**	**Core RUSP Conditions - Positive Screen**
	Fiscal Year:	**2018**
	Column Name:	**Core RUSP Conditions**
	Field Note: Congenital adrenal hyperplasia Cystic Fibrosis Medium-chain acyl-CoA dehydrogenase deficiency	

Data Alerts: None

Form 5
Count of Individuals Served by Title V & Total Percentage of Populations Served by Title V

State: Wyoming

Annual Report Year 2018

Form 5a – Count of Individuals Served by Title V
(Direct & Enabling Services Only)

		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	1,135	33.0	0.0	59.2	7.8	0.0
2. Infants < 1 Year of Age	1,990	34.3	0.0	57.9	7.8	0.0
3. Children 1 through 21 Years of Age	1,117	64.1	2.5	24.6	5.0	3.8
3a. Children with Special Health Care Needs	775	78.9	3.5	9.1	3.2	5.3
4. Others	2,736	9.0	0.0	79.0	12.0	0.0
Total	6,978					

Form 5b – Total Percentage of Populations Served by Title V
(Direct, Enabling, and Public Health Services and Systems)

Populations Served by Title V	Reference Data	Used Reference Data?	Denominator	Total % Served	Form 5b Count (Calculated)	Form 5a Count
1. Pregnant Women	6,903	No	6,551	100	6,551	1,135
2. Infants < 1 Year of Age	6,272	No	7,479	100	7,479	1,990
3. Children 1 through 21 Years of Age	158,275	Yes	158,275	21	33,238	1,117
3a. Children with Special Health Care Needs	33,000	Yes	33,000	23	7,590	775
4. Others	413,561	Yes	413,561	7	28,949	2,736

Form Notes for Form 5:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2018**
	Field Note: Wyoming Title V serves pregnant women through the maternal high risk program (17) and through home visiting services (1118). 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 the reference data for Wyoming coverage of pregnant women. Home Visiting data from PHNI system from October 1, 2017 - September 30, 2018.	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2018**
	Field Note: Wyoming Title V serves infants through the Newborn Intensive Care Program (68) and postpartum home visitation (1922). Insurance coverage for NBIC is based on programmatic information. Coverage for infants in home visiting services is based on the reference data for Wyoming infants. Home Visiting data from PHNI system from October 1, 2017 - September 30, 2018.	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2018**
	Field Note: Wyoming Title V serves children through genetic clinics (43) and family home visitation services (299). Coverage information for genetics forms from programmatic data, Estimates for primary coverage type for home visitation services are based on Wyoming coverage for children. This also includes services for eligible-CSH program clients (542) and Parent Partner (233). Home Visiting data from PHNI system from October 1, 2017 - September 30, 2018.	
4.	**Field Name:**	**Children with Special Health Care Needs**
	Fiscal Year:	**2018**
	Field Note: Wyoming Title V serves Children with Special Health Care Needs through the Children's Special Health Program (542) and the Parent Partner Program (233). Insurance coverage for CSHCN comes from programmatic data. Estimates for primary coverage type for the Parent Partner Program are based on Wyoming insurance coverage for children.	
5.	**Field Name:**	**Others**

	Fiscal Year:	**2018**

Field Note:
Wyoming Title V serves parents through home visiting services both when their children are between 0-1 (2280) and when their children are 1-older (267) and through the Parent Partner Program (189). Estimation for coverage type for home services are based on the Wyoming reference data for adults aged 22 and older.

Home Visiting data from PHNI system from October 1, 2017 - September 30, 2018.

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women**
	Fiscal Year:	**2018**

Field Note:
Title V activities reach all pregnant women in the state. Women are reached through the following example activities:
Home Visitation Services (all 23 counties); legislation offers to all pregnant women.
Infrastructure building for maternal mortality review and perinatal quality collaborative
TA to hospitals to become breastfeeding friendly.
Hospital participation in the AIM Initiative to reduce maternal morbidity (4 hospitals)
Infrastructure building for immediate postpartum long acting reversible contraception and other LARC coverage

2.	**Field Name:**	**InfantsLess Than One Year**
	Fiscal Year:	**2018**

Field Note:
Title V activities reach all infants in the state. Infants are reached through the following example activities:
Home Visiting Services (all 23 counties); legislation offers to all families
Newborn Screening (Other Funds & Title V funding leveraged)
Fetal and Infant Mortality Review (FIMR) (1 county)
TA for hospitals to become breastfeeding friendly
Infrastructure/systems building through Help Me Grow

3.	**Field Name:**	**Children 1 Through 21 Years of Age**
	Fiscal Year:	**2018**

	Field Note: Title V activities reach children ages 1-21 years through the following programs: Home Visitation Services provided in all 23 counties Safe Kids Parent Partner Program Genetics clinics Promotion of developmental screening (ASQ) through PHN Help Me Grow Vision Screening Education RPE program Adolescent Centered Environment TA from University of Michigan for four pilot clinics PREP CSPAP training for schools	
4.	**Field Name:**	**Children With Special Health Care Needs**
	Fiscal Year:	**2018**
	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 using the following formula: [95B 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:	**2018**
	Field Note: PLTI Laramie County. PLTI is a systems-level effort to improve parent engagement to make community changes. Population Estimate, Laramie County, 18-up: 26,427. Before submission in September, we will attempt to adjust numerator to better reflect reach of the PLTI program (e.g. calculating population estimate for 21 and up to match reference data).	

Data Alerts: None

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Wyoming

Annual Report Year 2018

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	6,551	5,127	54	847	221	42	33	153	74
Title V Served	1,135	0	0	0	0	0	0	0	1,135
Eligible for Title XIX	2,059	1,364	26	402	160	13	9	64	21
2. Total Infants in State	7,479	5,834	190	1,121	240	94	0	0	0
Title V Served	1,990	0	0	0	0	0	0	0	1,990
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:	**2018**
	Column Name:	**Total**
	Field Note: 2018 Vital Statistics Services	
2.	**Field Name:**	**1. Title V Served**
	Fiscal Year:	**2018**
	Column Name:	**Total**
	Field Note: This field represents the number of women that were served through Healthy Baby Home Visitation and the Maternal and High Risk program. Data on race and ethnicity are not reliably collected.	
3.	**Field Name:**	**1. Eligible for Title XIX**
	Fiscal Year:	**2018**
	Column Name:	**Total**
	Field Note: Data are from the 2018 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:	**2018**
	Column Name:	**Total**
	Field Note: CDC Wonder 2018	
5.	**Field Name:**	**2. Title V Served**
	Fiscal Year:	**2018**
	Column Name:	**Total**
	Field Note: This represents the number of infants served through the Newborn Intensive Care Programs and the Best Beginning Home Visiting Program. Data on race and ethnicity are not reliably collected.	
6.	**Field Name:**	**2. Eligible for Title XIX**

Fiscal Year:	**2018**
Column Name:	**Total**

Field Note:
Currently we do not collect this information. Wyoming Title V will explore different ways this could be collected for the next Block Grant.

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: Wyoming

A. State MCH Toll-Free Telephone Lines	2020 Application Year	2018 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 Child Health Toll Free Line	Maternal and Child Health Toll Free Line
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"		93

B. Other Appropriate Methods	2020 Application Year	2018 Annual Report Year
1. Other Toll-Free "Hotline" Names	n/a	n/a
2. Number of Calls on Other Toll-Free "Hotlines"		0
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		13,951
5. State Title V Social Media Websites	n/a	n/a
6. Number of Hits to the State Title V Program Social Media Websites		0

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
Address 1	6101 Yellowstone Road
Address 2	Suite 420
City/State/Zip	Cheyenne / WY / 82002
Telephone	(307) 777-6326
Extension	
Email	danielle.marks@wyo.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Danielle Marks
Title	Maternal and Child Health Unit Manager
Address 1	6101 Yellowstone Road
Address 2	Suite 420
City/State/Zip	Cheyenne / WY / 82002
Telephone	(307) 777-6326
Extension	
Email	danielle.marks@wyo.gov

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 2020

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 10
National Outcome Measures (NOMs)

State: Wyoming

Form Notes for Form 10 NPMs, NOMs, SPMs, SOMs, and ESMs.

The program also plans to track NPM 7.1 and 7.2 in FFY20 due to a change in program strategy to focus on childhood injury prevention of all ages 0-19.

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
2017	78.1 %	0.5 %	5,317	6,808
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% points or >1.2 times the estimate, 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

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2018
Annual Indicator	2.7
Numerator	
Denominator	
Data Source	Pregnancy Mortality Surveillance System (PMSS)
Data Source Year	2010-2014

NOM 3 - Notes:

This rate should be interpreted with caution due to small numbers and potentially incomplete data. We have recently strengthened our case finding methods through linkage with birth/fetal.

Pregnancy-related mortality ratio (PRMR) from PMSS.

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
2017	8.7 %	0.3 %	600	6,903
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% points or >1.2 times the estimate, 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
2017	8.9 %	0.3 %	616	6,903
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	9.0 %	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% points or >1.2 times the estimate, 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
2017	26.8 %	0.5 %	1,852	6,903
2016	25.4 %	0.5 %	1,878	7,385
2015	25.6 %	0.5 %	1,988	7,764
2014	25.5 %	0.5 %	1,965	7,691
2013	25.4 %	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% points or >1.2 times the estimate, 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
2017/Q2-2018/Q1	2.0 %			
2017/Q1-2017/Q4	2.0 %			
2016/Q4-2017/Q3	2.0 %			
2016/Q3-2017/Q2	1.0 %			
2016/Q2-2017/Q1	1.0 %			
2016/Q1-2016/Q4	2.0 %			
2015/Q4-2016/Q3	3.0 %			
2015/Q3-2016/Q2	4.0 %			
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
2016	4.3	0.8	32	7,398
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	6.4	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
2016	5.0	0.8	37	7,386
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	5.5	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
2016	3.2	0.7	24	7,386
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
2016	1.8	0.5	13	7,386
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
2016	135.4	42.8	10	7,386
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
2016	NR	NR	NR	NR
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
2017	8.1 %	1.4 %	543	6,749
2016	7.2 %	1.3 %	518	7,186
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 confidence interval width >20% points or >1.2 times the estimate 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
2016	5.5	0.9	36	6,531
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)

Federally available Data (FAD) for this measure is not available/reportable.

NOM 12 - Notes:

None

Data Alerts: None

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

Federally available Data (FAD) for this measure is not available/reportable.

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_2017	10.4 %	1.2 %	13,726	132,184
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
2017	19.0	5.3	13	68,410
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	22.5	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
2017	37.4	7.1	28	74,890
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
2015_2017	21.0	4.4	23	109,363
2014_2016	20.7	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
2015_2017	31.1	5.3	34	109,363
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_2017	20.1 %	1.5 %	28,038	139,423
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_2017	16.6 %	3.3 %	4,649	28,038
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_2017	2.3 %	0.7 %	2,613	114,917
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_2017	8.7 %	1.2 %	9,965	114,254
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_2017	61.8 %	5.1 %	9,863	15,959
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_2017	90.3 %	1.2 %	125,626	139,055
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	10.9 %	0.8 %	2,738	25,064
2013	10.7 %	0.7 %	2,542	23,672
2011	11.2 %	0.7 %	2,781	24,933
2009	9.8 %	0.6 %	2,453	25,130
2007	9.2 %	0.7 %	2,389	25,975
2005	8.3 %	0.6 %	2,182	26,363

Legends:

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate 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_2017	10.6 %	2.0 %	6,074	57,147
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
2017	9.9 %	1.6 %	13,677	137,883
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 >20% points, >1.2 times the estimate, or that is inestimable 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
2017	72.0 %	3.3 %	7,175	9,964
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
2017_2018	43.2 %	2.0 %	56,061	129,852
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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	46.9 %	3.2 %	17,261	36,772
2016	43.4 %	3.1 %	15,672	36,083
2015	42.2 %	3.4 %	15,198	36,011

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
2017	86.4 %	2.3 %	31,758	36,772
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
2017	60.7 %	3.1 %	22,323	36,772
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 or that are inestimable 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
2017	24.6	1.2	424	17,250
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	39.4	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
2017	12.7 %	1.8 %	849	6,660
2016	11.4 %	1.5 %	803	7,055
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% points or >1.2 times the estimate 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_2017	3.1 %	0.7 %	4,317	138,227
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 10
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**	**2018**
Annual Objective	90	92	93
Annual Indicator	89.7	88.3	90.0
Numerator	5,817	5,853	6,269
Denominator	6,486	6,628	6,963
Data Source	NIS	NIS	NIS
Data Source Year	2013	2014	2015

State Provided Data			
	2016	**2017**	**2018**
Annual Objective	90	92	93
Annual Indicator	91	90.7	
Numerator			
Denominator			
Data Source	PRAMS	PRAMS	
Data Source Year	2014	2016	
Provisional or Final ?	Final	Final	

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	93.0	93.0	93.0	93.0	93.0	93.0

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data			
Data Source: National Immunization Survey (NIS)			
	2016	**2017**	**2018**
Annual Objective	26	29	32
Annual Indicator	27.0	32.0	28.8
Numerator	1,693	2,049	1,959
Denominator	6,263	6,412	6,790
Data Source	NIS	NIS	NIS
Data Source Year	2013	2014	2015

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	32.0	34.0	34.0	35.0	35.0	35.0

Field Level Notes for Form 10 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**	**2018**
Annual Objective			29
Annual Indicator		27.6	27.0
Numerator		4,900	4,651
Denominator		17,751	17,226
Data Source		NSCH	NSCH
Data Source Year		2016	2016_2017

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						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	29.0	32.0	32.0	34.0	34.0	34.0

Field Level Notes for Form 10 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**	**2018**
Annual Objective			76
Annual Indicator		75.7	78.2
Numerator		34,569	35,814
Denominator		45,669	45,789
Data Source		NSCH	NSCH
Data Source Year		2016	2016_2017

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						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	78.0	78.0	78.0	80.0	80.0	80.0

Field Level Notes for Form 10 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**	**2018**
Annual Objective			19
Annual Indicator		17.9	16.5
Numerator		2,073	2,119
Denominator		11,609	12,855
Data Source		NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017

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						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	17.0	18.0	19.0	20.0	21.0	22.0

Field Level Notes for Form 10 NPMs:

None

NPM 14.1 - Percent of women who smoke during pregnancy

Federally Available Data			
Data Source: National Vital Statistics System (NVSS)			
	2016	**2017**	**2018**
Annual Objective	15	14	14
Annual Indicator	15.2	14.6	14.4
Numerator	1,148	1,043	968
Denominator	7,540	7,152	6,735
Data Source	NVSS	NVSS	NVSS
Data Source Year	2015	2016	2017

State Provided Data			
	2016	**2017**	**2018**
Annual Objective	15	14	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						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	13.5	13.0	12.5	12.0	11.5	11.0

Field Level Notes for Form 10 NPMs:

None

Form 10
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	2018
Annual Objective		54	70
Annual Indicator	51.9	68	80.6
Numerator	42	68	50
Denominator	81	100	62
Data Source	Wyoming Vital Statistics Services	Wyoming Vital Statistics Services	Wyoming Vital Statistics Services
Data Source Year	2015	2016	2017
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	80.0	80.0	81.0	81.0	82.0	82.0

Field Level Notes for Form 10 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.	
3.	**Field Name:**	**2018**
	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	2018
Annual Objective		20	30
Annual Indicator	25.3	32.2	13
Numerator	22	28	11
Denominator	86,903	86,855	84,348
Data Source	Wyoming Hospital Discharge Data	Wyoming Hospital Discharge Data	Wyoming Hospital Discharge Data
Data Source Year	FY 2015	CY 2016	CY17
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	30.0	29.0	29.0	28.0	28.0	27.0

Field Level Notes for Form 10 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.	
2.	**Field Name:**	**2018**
	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 4 - Percentage of teens reporting 0 occasions of alcohol use in the past 30 days

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		70	70
Annual Indicator	68.4	68.4	66.3
Numerator			
Denominator			
Data Source	Prevention Needs Assessment	Prevention Needs Assessment	Prevention Needs Assessment
Data Source Year	2016	2016	2018
Provisional or Final ?	Provisional	Provisional	Provisional

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	70.0	72.0	72.0	74.0	74.0	74.0

Field Level Notes for Form 10 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.	
3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Restricted to 10th and 12th grades, ‘zero occasions’ From the 2018 Prevention Needs Assessment	

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**	**2024**
Annual Objective	32.0	34.0	35.0	36.0	38.0	40.0

Field Level Notes for Form 10 SPMs:

None

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

Measure Status:					Active	
Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	66.0	68.0	70.0	71.0	72.0	73.0

Field Level Notes for Form 10 SPMs:

None

SPM 7 - Percent of children with and without special health care needs having a medical home

Measure Status:	Active				
Annual Objectives					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	45.0	46.0	47.0	48.0	49.0

Field Level Notes for Form 10 SPMs:

None

Form 10
Evidence-Based or –Informed Strategy Measures (ESMs)

State: Wyoming

ESM 4.4 - Number of Hospitals Participating in the Wyoming 5-Steps to Breastfeeding Success Program

Measure Status:	Active

State Provided Data		
	2017	2018
Annual Objective	4	4
Annual Indicator	4	4
Numerator		
Denominator		
Data Source	Women and Infant Program	Women and Infant Health Program
Data Source Year	2017	2018
Provisional or Final ?	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	0.0	4.0	4.0	4.0	4.0	4.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Four hospitals applied for and received funding to improve their breastfeeding practices.	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

	Field Note: During FFY18, the four hospitals counted in FFY17 continued work to improve their 5-Steps implementation (through June 30, 2018). The Women and Infant Health Program will consider more sustainable ways to promote breastfeeding practices in hospitals to include a possible hospital recognition program. The ESM will be revised in 2021 if breastfeeding duration promotion remains a Title V priority at that time.	
3.	**Field Name:**	**2019**
	Column Name:	**Annual Objective**
	Field Note: In FFY19, the Women and Infant Health Program focused heavily on building infrastructure for the Wyoming Perinatal Quality Collaborative. Therefore, additional mini-grants were not offered. The WYPQC may promote the 5-Steps program in FFY20 through mini-grants or establishing a hospital recognition program.	
4.	**Field Name:**	**2020**
	Column Name:	**Annual Objective**
	Field Note: The goal is to engage up to 4 hospitals in promoting breastfeeding practices through mini-grants or a non-funded hospital recognition program. The WIHPM and WYPQC will work collaboratively on this ESM.	
5.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**
	Field Note: Continuation of this ESM depends on result of Title V priority selection. Targets will be updated as appropriate beginning in 2021.	
6.	**Field Name:**	**2022**
	Column Name:	**Annual Objective**
	Field Note: Continuation of this ESM depends on result of Title V priority selection. Targets will be updated as appropriate beginning in 2021.	
7.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**
	Field Note: Continuation of this ESM depends on result of Title V priority selection. Targets will be updated as appropriate beginning in 2021.	
8.	**Field Name:**	**2024**
	Column Name:	**Annual Objective**

Field Note:
Continuation of this ESM depends on result of Title V priority selection. Targets will be updated as appropriate beginning in 2021.

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**	**2024**
Annual Objective	100.0	100.0	100.0	100.0	100.0	100.0

Field Level Notes for Form 10 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**	**2024**
Annual Objective	90.0	90.0	95.0	95.0	95.0	95.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**Annual Objective**
	Field Note: Goal is to have at least 21 of 23 counties trained.	
2.	**Field Name:**	**2020**
	Column Name:	**Annual Objective**
	Field Note: Goal is to have at least 21 of 23 counties trained.	
3.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**
	Field Note: ESM continuation will depend on selection of Title V priorities.	
4.	**Field Name:**	**2022**
	Column Name:	**Annual Objective**
	Field Note: ESM continuation will depend on selection of Title V priorities.	
5.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**
	Field Note: ESM continuation will depend on selection of Title V priorities.	
6.	**Field Name:**	**2024**
	Column Name:	**Annual Objective**
	Field Note: ESM continuation will depend on selection of Title V priorities.	

ESM 6.3 - 211 Referrals to Help Me Grow

Measure Status:	Active

State Provided Data		
	2017	2018
Annual Objective	30	45
Annual Indicator	39	49
Numerator		
Denominator		
Data Source	HMG Reports	HMG Reports
Data Source Year	2017	2018
Provisional or Final ?	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	60.0	0.0	0.0	0.0	0.0	0.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Missing data for Q1 FFY18 due to contractor turnover.	
2.	**Field Name:**	**2020**
	Column Name:	**Annual Objective**
	Field Note: The Help Me Grow program ended on June 30, 2019.	
3.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**
	Field Note: The Help Me Grow program ended on June 30, 2019.	
4.	**Field Name:**	**2022**
	Column Name:	**Annual Objective**
	Field Note: The Help Me Grow program ended on June 30, 2019.	
5.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**
	Field Note: The Help Me Grow program ended on June 30, 2019.	
6.	**Field Name:**	**2024**
	Column Name:	**Annual Objective**
	Field Note: The Help Me Grow program ended on June 30, 2019.	

ESM 6.5 - Total number of referrals received by HMG

Measure Status:	Inactive - Duplicate ESM with 6.3. Definition unclear.	
State Provided Data		
	2017	**2018**
Annual Objective	20	25
Annual Indicator	13	0
Numerator		
Denominator		
Data Source	HMG Program Records	HMG Program Records
Data Source Year	2017	2018
Provisional or Final ?	Final	Provisional

Field Level Notes for Form 10 ESMs:

None

ESM 6.6 - Number of referrals from HMG to community resources resulting in services

Measure Status:						Active
Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	50.0	0.0	0.0	0.0	0.0	0.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**Annual Objective**
	Field Note: The Help Me Grow program ended on June 30, 2019.	
2.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**
	Field Note: The Help Me Grow program ended on June 30, 2019.	
3.	**Field Name:**	**2022**
	Column Name:	**Annual Objective**
	Field Note: The Help Me Grow program ended on June 30, 2019.	
4.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**
	Field Note: The Help Me Grow program ended on June 30, 2019.	
5.	**Field Name:**	**2024**
	Column Name:	**Annual Objective**
	Field Note: The Help Me Grow program ended on June 30, 2019.	

ESM 6.7 - Number of providers trained on Bright Futures

Measure Status:	Active				
Annual Objectives					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	10.0	10.0	10.0	10.0	10.0

Field Level Notes for Form 10 ESMs:

None

ESM 10.2 - # QI cycles completed by participating practices

Measure Status:	Active

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	4.0	6.0	8.0	10.0	12.0	0.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2024**
	Column Name:	**Annual Objective**

Field Note:
With the potential for 4 clinics participating to implement at most 3 cycles, there objectives can not exceed 12.

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**	**2024**
Annual Objective	45.0	47.0	49.0	51.0	53.0	55.0

Field Level Notes for Form 10 ESMs:

None

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**	**2024**
Annual Objective	25.0	30.0	30.0	35.0	35.0	40.0

Field Level Notes for Form 10 ESMs:

None

ESM 14.1.2 - # of providers trained on SCRIPT implementation

Measure Status:	Active

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	7.0	7.0	8.0	10.0	10.0	10.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**Annual Objective**

Field Note:
Not expected to meet target due to staff turn over.

Form 10
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 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.

SPM 7 - Percent of children with and without special health care needs having a medical home
Population Domain(s) – Children with Special Health Care Needs

Measure Status:	Active
Goal:	Increase the percent of children with and without special health care needs having a medical home
Definition:	**Numerator:** Number of children with and without special health care needs, ages 0 through 17, who meet the criteria for having a medical home (personal doctor or nurse, usual source for care, and family-centered care; referrals or care coordination if needed) **Denominator:** Number of children, ages 0 through 17 **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	Identical to Maternal, Infant, and Child Health (MICH) Objectives 30.1: Increase the proportion of children who have access to a medical home, (Baseline: 57.5%, Target: 63.3%) and 30.2: Increase the proportion of children with special health care needs who have access to a medical home. (Baseline: 49.8%, Target: 54.8%) Related to Objective Maternal, Infant, and Child Health (MICH) Objective 31: Increase the proportion of children with special health care needs who receive their care in family-centered, comprehensive, coordinated systems. (Baseline: 20.4% for children aged 0-11, Target: 22.4%; Baseline: 13.8% for children aged 12 through 17, Target 15.2%)
Data Sources and Data Issues:	National Survey of Children's Health (NSCH)
Significance:	The American Academy of Pediatrics (AAP) specifies seven qualities essential to medical home care, which include accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective. Providing comprehensive and coordinated care to children in a medical home is the standard of pediatric practice. Research indicates that children with a stable and continuous source of health care are more likely to receive appropriate preventive care, are less likely to be hospitalized for preventable conditions, and are more likely to be diagnosed early for chronic or disabling conditions. The Maternal and Child Health Bureau uses the AAP definition of medical home. www.medicalhomeinfo.aap.org

Form 10
State Outcome Measure (SOM) Detail Sheets

State: Wyoming

No State Outcome Measures were created by the State.

Form 10
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: Wyoming

ESM 4.4 - Number of Hospitals Participating in the 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 or Hospital Recognition 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 4.6 - 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 participating in 5 Steps program **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 6.5 - 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:	Inactive - Duplicate ESM with 6.3. Definition unclear.
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 referrals from HMG to community resources resulting in services
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 connections made between local services and families by HMG.
Definition:	**Numerator:** Number of referrals from HMG that result in a connection to services **Denominator:** N/A **Unit Type:** Count **Unit Number:** 500
Data Sources and Data Issues:	211 System
Significance:	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.

ESM 6.7 - Number of providers trained on Bright Futures
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 provider training on Bright Futures
Definition:	**Numerator:** Number of providers trained on Bright Futures **Denominator:** N/A **Unit Type:** Count **Unit Number:** 100
Data Sources and Data Issues:	Internal program report
Significance:	The primary goal of Bright Futures implementation is to support primary care practices (medical homes) in providing well-child and adolescent care according to Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents. Settings for Bright Futures implementation include private practices, hospital-based or hospital-affiliated clinics, resident continuity clinics, school-based health centers, public health clinics, community health centers, Indian Health Service clinics, and other primary care facilities. A complementary goal is to provide home visitors, public health nurses, early child care and education professionals (including Head Start), school nurses, and nutritionists with an understanding of Bright Futures materials so that they can align their health promotion efforts with the recommendations in the Bright Futures Guidelines. This objective will ensure that patients receive information and support that is consistent from family and youth perspectives.

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 (A QI cycle is defined as the eighteen month period of the ACE assessment process on one identified topic) **Denominator:** N/A **Unit Type:** Count **Unit Number:** 100
Data Sources and Data Issues:	University of Michigan and Program Data
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 12.4 - # 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
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
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
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