

**Maternal and Child
Health Services Title V
Block Grant**

Wyoming

**FY 2021 Application/
FY 2019 Annual Report**

Created on 8/25/2020
at 9:53 AM

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I. General Requirements

I.A. Letter of Transmittal

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

Maternal and Child Health (MCH) in Wyoming: Overview, Role, Funding, and Partnerships

The MCH Services Title V Block Grant is managed by the MCH Unit (WY MCH) within the Community Health Section (CHS) and Public Health Division (PHD) of the Wyoming Department of Health (WDH). Structurally, WY MCH's programs are divided according to the population domains they serve: women and infants, children, youth and young adults, and children and youth with special health care needs (CYSHCN). WY MCH's mission 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.

WY MCH receives approximately \$1.2 million in federal Title V funding annually and employs nine full-time staff, who are supported by one CDC-assigned and three WDH MCH epidemiologists. 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 and frontier state with 23 counties. The Wind River Indian Reservation (WRIR), located near the center of the state in Fremont County, is home to two federally recognized tribes, the Eastern Shoshone and Northern Arapaho. 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.

WY MCH works closely with both state and county staff in all 23 counties to ensure access to community-level MCH services including genetics clinics in three counties, home visiting in all counties, and care coordination services for CYSHCN, high-risk pregnant women, and high-risk infants in all counties. Other notable partnerships include the MCH Epidemiology Program, other programs and divisions within WDH (including the Rural and Frontier Health, Healthcare Financing, the Behavioral Health Division, Substance Abuse Prevention, Tobacco Prevention, Injury and Violence Prevention, Chronic Disease Prevention, Immunizations, Public Health Nursing (PHN) and WIC), other State agencies (including Department of Education, Department of Family Services, and Department of Workforce Services), the University of Wyoming, the partner who administers the Title X grant, and the partner who administers the federal Maternal, Infant, Early Childhood Home Visiting grant.

WY MCH and PHN jointly receive Temporary Assistance for Needy Families (TANF) funding from the Wyoming Department of Family Services to implement the PHN Infant Home Visitation Program. WY MCH also oversees \$2,375,591 in state and other funds (i.e. newborn screening program fees) required to meet 1989 maintenance of effort. A majority of state funds allocated to WY MCH support delivery of home visitation and CYSHCN care coordination services by PHN in all 23 Wyoming counties.

WY MCH 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), Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM), and Pregnancy Risk Assessment Monitoring System (PRAMS). WY MCH does not manage Wyoming's Title X and Maternal Infant Early Childhood Home Visiting (MIECHV) grants; however, MCH staff partner closely with the grantees.

FFY19 Priorities, Strategies, and Performance

WY MCH's selected 2016-2020 priorities are listed below, along with key examples of related strategies and performance around these priorities for FFY19.

1 - Improve access to and promote use of effective family planning

WY MCH completed a cost analysis on LARC versus unintended pregnancy, changed Medicaid policies related to LARC reimbursement in federally qualified health centers and rural health clinics, and began development of an immediate postpartum LARC toolkit. In 2018, 66.4% of women responding to the Wyoming PRAMS survey reported using a most or moderately effective form of birth control following the birth of their child; no comparison data is available from previous years as this was a new measure.

2 - Prevent infant mortality

WY MCH developed the Wyoming Perinatal Quality Collaborative (WYPCQ) and contracted with a WYPCQ coordinator, completed a pilot Fetal Infant Mortality Review project in Fremont County and the Wind River Indian Reservation, supported hospitals using AIM safety bundles, distributed LOCATe results to hospitals, promoted the Wyoming Quitline, and trained providers around smoking cessation and

safe opioid prescribing. In 2018, 13.4% of Wyoming women reported smoking during pregnancy, down from 14.4% the previous year (NVSS).

3 - Improve breastfeeding duration

WY MCH promoted breastfeeding in the PHN Healthy Baby Home Visitation Program, ensured each county has a nurse CLC, awarded mini-grants to hospitals for breastfeeding work, and helped to improve internal workplace accommodations to support lactating moms returning to work at WDH or conducting business in WDH offices. Of hospitals receiving mini-grants, 100% reported an increase in at least one step from baseline based on hospital self-reported assessment. Wyoming exceeded the HP2020 Goal of 25.5% of children who are breastfed exclusively through 6 months with 31.4% of children reported as being exclusively through 6 months (National Immunization Survey, 2016).

4 - Promote preventive and quality care for children and adolescents

WY MCH trained providers in Ages and Stages Questionnaire, promoted lead screening, developed Bright Futures Implementation Task Force infrastructure, piloted Help Me Grow, developed a statewide youth council, mailed well visit reminders for children enrolled in the WY CSH program, provided telehealth genetics services, implemented an adolescent-centered environment assessment process, supported the Parent Partner Project, and developed a transition toolkit. Between January 1, 2019 and September 30, 2019, 49 CSH clients between the ages of 14 and 19 completed transition readiness assessments and received transition education/guidance from PHNs. In 2016-2017, 78.2% of adolescents ages 12-17 had a preventive medical visit in the past year (NSCH), which exceeded the HP2020 goal of 75.6%; data between 2016-2017 and 2018 are not comparable due to changes in the NSCH.

5 - Reduce and prevent childhood obesity

WY MCH implemented evidence-based prevention strategies in early childhood facilities and schools in partnership with the Wyoming Chronic Disease Prevention Program. A Wyoming Healthy Policies Toolkit was distributed to all 633 licensed childcare providers within Wyoming as well as all 249 public elementary schools. In 2017-2018, 30.2% of children, ages 6 through 11, were physically active at least 60 minutes per day (NSCH). In 2016-2017, 27.3% of children, ages 6 through 11, were physically active at least 60 minutes per day (NSCH).

6 - Prevent injury in children

WY MCH implemented seven community-based grants with targeted evidence-based strategies to address the major causes of childhood injury/hospitalizations. In 2017, the rate of hospitalization for non-fatal injuries for children ages 0-9 in Wyoming was 119.9 per 100,000 children. In 2016 this rate was 88.0 per 100,000 children ages 0 through 9 (HCUP-SID), however, this was not a significant difference.

7 - Promote healthy and safe relationships in adolescents

WY MCH built statewide capacity for sexual violence prevention, implemented sexual education curriculum including content on reducing risky behaviors, developed a statewide youth council, and completed an RFP process and community selection for Rape Prevention and Education pilot communities to implement strategies using the Collective Impact Model. In 2018, 66.3% of teens reported zero occasions of alcohol use in the past 30 days on the Wyoming Prevention Needs Survey, down from 68.4% in 2016. The Prevention Needs Assessment survey is only conducted every other year, and the next year of available data will be for 2020.

FFY21-FFY25 Needs Assessment Process

WY MCH based its needs assessment on the six-step Peterson and Alexander Needs Assessment Process and the John M. Bryson strategic planning process. The stages were: start-up planning, operational planning, data, needs analysis, program and policy development, and resource allocation, spanning November 2018 - August 2020. WY MCH utilized qualitative and quantitative data from WDH's State Health Assessment, the MCH partner survey, and data from the National Survey of Children's Health, Vital Statistics Services, and PRAMS, in consultation with the MCH Epidemiology Program, in the development of NOM and NPM data dashboards. WY MCH involved a steering committee made up of WDH, government, and community members in early decisions, and it involved MCH stakeholder Priority Action Teams to identify priorities and strategies. Other tools included feasibility assessments and activity prioritization tools. A public input survey following initial strategy selection provided further community feedback to refine plans specific to communities.

Wyoming's identified population needs are outlined below, along with measures and strategies.

FFY21-FFY25 Proposed Priorities and FFY21 Proposed Strategies

WY MCH's seven priorities for FFY21-FFY25, along with key examples of related strategies and performance measures, are listed below.

1 - Promote healthy and safe children

Key strategies will include providing TA and education, expanding provider/parent education on Bright Futures guidelines, continuing participation in multi-disciplinary lead screening workgroup, and increasing the distribution, promotion, and use of the Wyoming Healthy Policies Toolkit. Measures will include the percent of children ages 2-4 and adolescents ages 10-17 who are obese, and the number of children receiving at least one EPSDT visit as noted within CMS 416 report, along with ESMs around Bright Futures and the Wyoming Healthy Policies Toolkit.

2 - Improve systems of care for CYSHCN

Key strategies will include conducting gap analysis of Wyoming CSH, training internal staff on National Standards for Systems of Care (NSSC), compiling a Wyoming CSH systems map incorporating the NSSC Alignment Tool, developing a CSH Advisory Council, continuing PHN use of transition toolkit, continuing mailing reminders about well visits and transition readiness assessments, and developing a tool to assess parent/youth impressions of transition tools. Measures will include the percent of children with and without special health care needs having a medical home, the percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care, and ESMs around NSSC, advisory council membership and projects, completed youth transition readiness assessments, and gaps identified by the systems map that CSH is actively working to fill.

3 - Prevent maternal mortality

Key strategies will include developing a culturally appropriate well woman visit communication campaign, conducting a gap analysis and map of mental health infrastructure for women of reproductive age, and standing up a joint Utah-Wyoming Maternal Mortality Review Committee. Measures will include the percent of women ages 18-44 with a preventive medical visit in the past year and ESMs around use of the My 307 Wellness App by women of reproductive age.

4 - Prevent Infant Mortality

Key strategies will include identifying disparities in safe sleep practices and providing education/resources to providers and PHNs to promote safe sleep practices using an equity lens, as well as developing a training module on smoking cessation screening and referral best practices. Measures will include the percent of infants placed to sleep on their backs, on a separate approved sleep surface, and without soft objects or loose bedding, and an ESM around safe sleep practices of PRAMS moms who have had a home visit, as well as the percent of women who smoke during pregnancy and the percent of children ages 0-17 who live in households where someone smokes.

5 - Prevent Adolescent Motor Vehicle Mortality

Key strategies will include convening partners and providers to develop Bright Futures Task Force and facilitating efforts to strengthen partnerships and increase participation in the Child Safety Learning Collaborative. Measures will include the rate of hospitalization for non-fatal injury per 100,00 adolescents ages 10-19 and ESMs around schools/organizations/SADD chapters providing teen driver safety programs, participation in and reach of Teens in the Driver Seat, and guidelines developed and implemented.

6 - Prevent Adolescent Suicide

Key strategies will include continuing partnership with University of Michigan to implement the ACE Assessment Process, coordinating adolescent suicide prevention efforts and participation in the Child Safety Learning Collaborative, building statewide capacity for sexual violence prevention, increasing WyPREP implementation, integrating messages about healthy sexuality and sexual violence prevention, building/improving relationships with stakeholders engaging youth, continuing QI on WyPREP program evaluation, and developing, sustaining, and supporting a youth council. Measures will include the percent of adolescents ages 12-17 with a preventive medical visit in the past year and ESMs around Bright Futures and Adolescent-Centered Environments in clinics, youth council recommendations, and adult-youth connectedness.

7 - Strengthen MCH Workforce Capacity to Operationalize MCH Core Values

Key strategies will include developing and improving professional development opportunities to increase competencies related to MCH core values, promoting and integrating core values across all MCH domains and state priority needs, and developing an understanding of individual team strengths. WY MCH will measure the percent of new WY MCH staff (including interns and volunteers) who complete MCH orientation, including the MCH Navigator self-assessment, within six months of their hire or start date.

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

Title V funds provide WDH with the workforce capacity, expertise, and infrastructure to address MCH priority needs. The grant partially or fully funds eight MCH staff and four MCH epidemiologists; Title V direct assistance also funds a CDC-assigned MCH epidemiologist. Through these positions and a workforce development/strategic planning contractor, Title V funds support staff capacity to develop, implement, and evaluate strategies within each domain. All 23 counties have state match-funded MCH PHNs who provide home nursing, CSHCN care coordination, and other MCH services. Through Title V, WY MCH provides infrastructure and dedicated staff to support and train PHNs and build local capacity to implement MCH work. Staff members partially funded by Title V blend their work with other state and federally funded activities that enhance MCH work, such as newborn genetic screening, opioid crisis work, CDC RPE, HHS PREP, and CDC ERASE MM.

Title V funds enable WY MCH to leverage partnerships critical to Title V activities. Recent and ongoing contractors include a Youth Council Coordinator, Perinatal Quality Collaborative Coordinator, seven community mini-grants for child safety projects, the University of Michigan to implement youth-friendly practices in clinics, and the University of Utah to bring in genetics clinic specialists. WY MCH will continue many of these partnerships and selectively establish new ones related to the upcoming grant cycle's priorities.

III.A.3. MCH Success Story

WY MCH's strengths as a convener and in equity and engagement are evident in its new youth council, which held its first meeting July 2020 after two years of preparations. The council will amplify youth voices and ensure the health needs of young people guide WDH activities.

In May 2018 WY MCH's Youth and Young Adult Health Program (YAYAHP) took on developing WDH's first-ever youth health advisory council. YAYAHP consulted Colorado, Alaska, Puerto Rico, and other sources for guidance and designed deliverables for a contracted Youth Council Coordinator (YCC) position to support YAYAHP's staff of one. Applications opened May 2019 and WY MCH enthusiastically selected a candidate with 20 years experience working with different youth populations, including teen parents and foster and LGBTQ+ youth, a passion for youth physical and mental health, and extensive statewide connections.

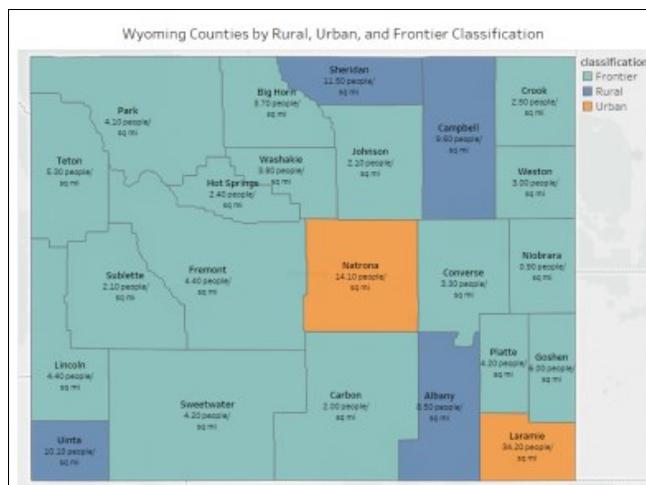
Between contract execution in January 2020 and the final youth interview in June, the YCC selected 16 young adults ages 18-24 to comprise the council's first cohort. They are diverse geographically, ethnically, and in educational, life, and health experiences. The first meeting was held July 19, 2020. Members will name the council and provide feedback and conduct activities around health issues impacting youth and young adults, including suicide prevention, substance use, communicable disease, MVT mortality prevention, and behavioral health to improve outcomes for all young people statewide.

III.B. Overview of the State

Demographics, Geography, and Economy

Geographically, Wyoming is the tenth largest state in the U.S., spanning 97,813 square miles. Wyoming is a rural/frontier state with 23 counties ranging in ecoregion 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. 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, 2020).

Wyoming is the least populous state in the U.S. with a July 2019 estimated population of 578,759, an increase of 0.18 percent from July 2018 (U.S. Census Bureau, 2020). The population is predominantly White alone (92.6%). The remaining population is Black or African American alone (1.3%), American Indian and Alaska Native alone (2.7%), Asian alone (1.1%), Native Hawaiian and Other Pacific Islander alone (0.1%), two or more races (2.2%), and Hispanic or Latino (10.1%). In 2018, 93.0% of the population aged 5 years and older spoke only English at home and 7.0% spoke a language other than English. Overall the minority population has grown 19.2% since 2010, and 1.3% in one year from 2018 to 94,379 in 2019. This counted for nearly all the growth in Wyoming from 2018 to 2019 (U.S. Census, 2020).



Nearly one quarter (23.1%) of the population is under 18 years of age, and 17.1% is over the age of 65 years. Wyoming is a rapidly aging population, where the population of those 65 years and older increased by 3.8% in just one year from 2018 to 2019, and since 2010 this population saw an increase of 41.5%. Ninety-three percent of persons over 24 years of age have a high school education or higher, with 26.9% of this group having at least a bachelor's degree. The median household income is \$62,268, just slightly more than the median household income in the U.S. of \$61,937. Persons in poverty are estimated to be 11.1% of the population, compared to 11.8% nationally (U.S. Census, 2020).

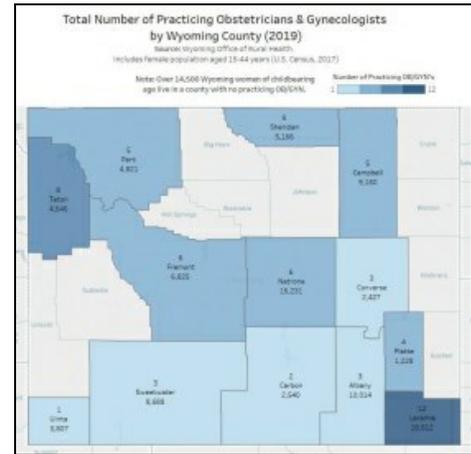
After experiencing a rebound in the economy from the fourth quarter of 2018 to the third quarter of 2019, employment in Wyoming barely grew in the fourth quarter of 2019 compared to the previous year, and the state unemployment rate (2019, Q4) remained at 3.7%, just slightly higher than the U.S. level. Wyoming's growth in employment (only 350 jobs) was much slower than the job growth for the U.S during this period. (Wyoming Economic Analysis Division, 2020). During the spring and summer of 2020, Wyoming's economy faced a significant downturn due to the COVID-19 pandemic and lessened value of its natural resources, and the long-term impacts are uncertain.

Strengths and Challenges

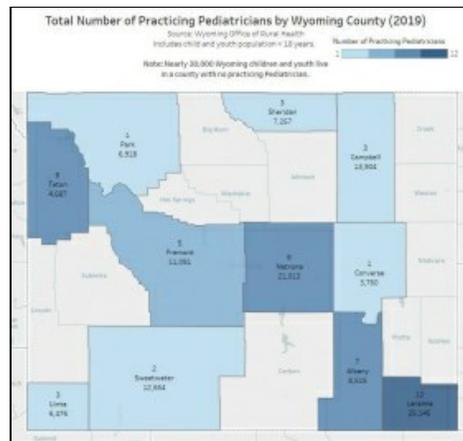
According to the 2019 Annual America's Health Rankings Report, Wyoming ranks 19th in the nation in overall health and was listed as one of three states making the largest improvements in rankings from the previous year. These improvements were driven by an increase in high school graduation prevalence (80.0% in 2018 to 86.2% in 2019, U.S. Department of Education), and a significant decrease (25.7% in 2018 to 21.7% in 2019, BRFSS) in adult

physical inactivity. The listed strengths for Wyoming in the report include low levels of air pollution, low violent crime rate, low levels of children living in poverty, and low prevalence of diabetes. Challenges include high rates of smoking and occupational fatalities, in addition to a high rate of uninsured and a low rate of primary care physicians.

As noted, Wyoming is considered a rural/frontier state, which presents unique challenges. According to the Health Resources and Services Administration’s Designated Health Provider Shortage Areas (HPSA) Quarterly Summary Report, Wyoming had a total of 47 Primary Care Health Provider Shortage Area (HPSA) Designations, with 187,903 residents residing in primary care shortage areas. There were 31 Dental HPSA designations in the state with a total of about 49,650 Wyoming residents residing in these areas. Finally, the entire state (comprising five regions) is considered a HPSA for mental health. Per HRSA’s Designated HPSA Quarterly Summary (12/31/18); only 31.5% of the mental health needs are being met and 25 full-time psychiatrists are needed to meet the needs of the population.



According to the Wyoming Office of Rural Health, in 2020 there are currently 62 physicians practicing obstetrics and gynecology (OB/GYN) in Wyoming and 58 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 28,000 Wyoming children and youth (<18 years of age) live in a county with no practicing pediatrician (CDC Wonder, 2020).



There are 172 family practice physicians in the state. Twenty-seven individuals practice in Natrona County, 24 in Laramie County, 15 in Park County, and 12 in Fremont County. Nine counties have fewer than five family practice physicians (WY Office of Rural Health, 2020).

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. The LOCATe tool has since been revised and may be administered again with WY facilities in the future.

Access to care is a challenge in Wyoming given the rural/frontier nature of the state, especially pertinent to the MCH population given the absence of level III facilities, few specialist providers, and a high uninsured population. In 2018, 11.4% of Wyoming residents had no health insurance coverage, down slightly from the previous year, but still making Wyoming ranked as 7th highest in the nation compared to 8.8% of the population nationally. The percent of children ages 18 and under with no health insurance decreased from 9.5% in 2017 to 7.1% in 2018, compared to 5.2% of

this population nationally (U.S. Census, 2020). Wyoming is one of twelve states that have not expanded Medicaid. Health insurance options in the Federal Health Insurance Marketplace for Wyoming are limited to one insurer, Blue Cross Blue Shield.

According to the 2020 Robert Wood Johnson County Health Rankings & Roadmaps, Wyoming fares better compared to the nation for the proportion of children in poverty, with 13% of children in poverty versus 18% nationally. However, within Wyoming 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, disparities are also observed with child poverty rates range from 6% for Black children to 28% for American Indian and Alaskan Native children (Small Area Income and Poverty Estimates (SAIPE), 2018).

Racial and ethnic disparities are also observed to exist in regard to high school graduation rates. Wyoming's overall high school graduation rates have risen steadily over the past five years from 78.6% (2013-2014) to 82.1% (2018-2019). However, while 83.8% of White youth graduated from high school in the 2018-2019 school year, only 77.1% of Hispanic youth and 58.7% of American Indian youth graduated during the school year (Wyoming State 4-Year Graduation Rates). 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.

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 and 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 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. During the 2021-2025 Title V cycle, the MCH Unit will work intentionally to operationalize all of its core values with specific emphasis on health equity.

Agency Organizational Structure and Role

The Maternal and Child Health Services Title V Block Grant is managed by WY MCH within the Community Health Section (CHS) and Public Health Division (PHD) of the Wyoming Department of Health (WDH). The mission of WDH is to "promote, protect, and enhance the health of all Wyoming residents." The mission of PHD is to "promote, protect, and improve health and prevent disease and injury in Wyoming."

PHD is one of four divisions within WDH, joining the Aging, Behavioral Health, and Health Care Financing (i.e. Wyoming Medicaid) Divisions. Please see the attached org chart for a visualization of the structure. WDH is an executive branch State agency, with an appointed director, that has been granted authority and responsibility to govern health services through Wyoming statutes §§ 9-2-101 through 9-2-127. Specific to PHD, Wyoming statutes §§ 35-1-201 through 35-1-244 contain provisions for public health and safety responsibilities. Various other statutes offer provision for public health services carried out by PHD.

PHD employs approximately 265 staff in a mostly-centralized public health system. All but four public health nursing offices are administered through a state-county partnership. The remaining four are independent local health departments.

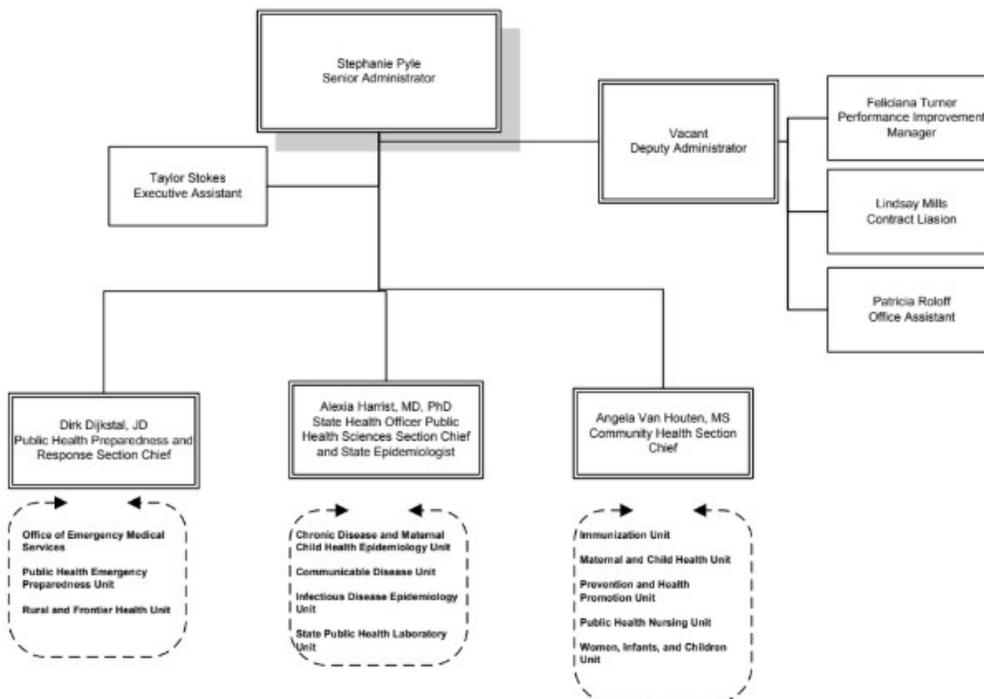
PHD provides a wide range of services that promote, protect, and improve health and prevent disease and injury in Wyoming. The following list outlines PHD's key services,

which are in line with the 10 Essential Public Health Services:

- *Community Health Section*
 - Immunization
 - Maternal and Child Health
 - Prevention and Health Promotion
 - Public Health Nursing
 - Women, Infants, and Children
- *Health Readiness and Response Section*
 - Emergency Medical Services
 - Public Health Preparedness and Response
 - Rural and Frontier Health
- *Public Health Sciences Section*
 - Chronic Disease and Maternal Child Health Epidemiology
 - Communicable Disease Prevention, Surveillance, and Treatment
 - Infectious Disease Epidemiology
 - Public Health Lab

A summary of the PHD organizational structure is included below.

**Public Health Division
Updated July 15, 2019**



PHD is working toward public health accreditation and completed a [State Health Assessment](#) in 2018. A member of the MCH Epidemiology Program is on the SHA Leadership Team. Efforts to develop a State Health Improvement Plan are underway but have been delayed due to COVID-19.

PHD has set several strategic priorities:

- 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
- Build a sustainable, cohesive organization

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

WY MCH provides leadership for state and local level efforts that improve the health of the maternal and child health population and administers the Title V MCH Services Block Grant. Structurally, the unit's programs are divided according to the population groups they serve: women (ages 15-44) and infants (ages <1), children (ages 1-11), 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.

WY MCH envisions a Wyoming where all families and communities are healthy and thriving. The mission of WY 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. WY MCH core values include:

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

The 2020 MCH Needs Assessment resulted in the selection of seven priorities for 2021-2025:

1. Prevent Maternal Mortality (Women/Maternal Domain)
2. Prevent Infant Mortality (Perinatal/Infant Domain)
3. Promote Healthy and Safe Children (Child Domain)
4. Prevent Adolescent Motor Vehicle Mortality (Adolescent Domain)
5. Prevent Adolescent Suicide (Adolescent Domain)
6. Improve Systems of Care for Children and Youth with Special Health Care Needs (CSHCN Domain)
7. Strengthen MCH Workforce Development to Operationalize MCH Core Values (Cross-Cutting Domain)

WY MCH benefits from participating in and aligning with the PHD SHA and SHIP. The SHA identified three top health priority recommendations important to Wyoming citizens: Behavioral Health, Access to Healthcare, and Unintentional Injury. These overall WDH priorities were used to guide WY MCH's 2021-2025 needs assessment and strategic planning.

Systems of Care and Services for Vulnerable Populations, including CSHCN

In Wyoming, about 26,977 (19.4%) of children ages 0-17 have a special health care need (CSHCN). The prevalence of CSHCN being reported as receiving care in a well-functioning system in Wyoming is 9.7% (2017-2018), compared to 13.9% of CSHCN in the U.S. overall, and a decrease from 16.6% from 2016 to 2017 (NSCH).

WY MCH'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/or the Federal Marketplace. The program provides reimbursement to eligible providers for covered services provided to eligible clients. In FY19, the CSH program actively served 640 clients. Of all enrolled clients, 533 were CYSHCN, 83 were high-risk infants, and 24 were high-risk pregnant women.

WY MCH works with partners such as Public Health Nursing, Medicaid and Kid Care CHIP, in-state and out-of-state primary care and speciality providers, early intervention providers, and home visiting providers to ensure vulnerable populations, especially CSHCN, have access to health insurance, a primary care provider or ideally a certified medical home, speciality care services, and other supports and services based on identified family needs.

Strengthening partnerships with out-of-state providers and neighboring Title V agencies help to build Wyoming's health services infrastructure. For example, the Wyoming Newborn Screening and Genetics Programs contract with the Colorado Department of Health and Environment for newborn screening laboratory and short-term follow up services and the University of Utah, Department of Pediatrics for in-person and telehealth genetics services and consultation. Additionally, WY MCH partners with the well-established Utah Perinatal Mortality Review Committee, a project of the Utah Department of Health, to build capacity to review maternal deaths in Wyoming. A planned assessment of the National Standards for Systems of Care for CSHCN in Wyoming will help identify further gaps and opportunities for improvement to ensure CSHCN have access to a comprehensive, coordinated, and family-centered system of care.

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 WDH'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, WY MCH continues to participate in a Wyoming Oral Health Coalition led by the Wyoming Primary Care Association.

State Statutes Relating to MCH

Three state statutes directly impact the work of WY 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. WY MCH's Newborn Screening and Genetics Programs fulfill this statute requirement in partnership with families, providers (including midwives), hospitals, the Colorado Department of Public Health and the Environment (laboratory services and short-term follow up contractor), and a contracted courier service. 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 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. This statute directs PHN to contact eligible women to offer home visitation services as part of the Healthy Baby Home Visitation (HBHV) Program. The initial intent of the legislation was to implement Nurse Family Partnership (NFP), an evidence-based home visiting model, in all 23 counties. Due to challenges

meeting growing fidelity requirements and a small birth cohort in many communities limiting the number of women eligible for the program, NFP sites have reduced significantly over the past ten years. As of July 1, 2020, NFP is no longer delivered in Wyoming. A year-long search to identify a new evidence-based home visitation model ended in early 2020 with a workgroup of PHN and WY MCH staff selecting the Maternal Early Childhood Sustained Home-Visiting (MECSH) program for implementation in FFY21. This program is funded by Temporary Assistance for Needy Families (TANF) funding, and the program also receives State General Funds that count toward the required Title V match.

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. WY 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. WY MCH will continue to partner closely with Wyoming's Title X grantee, the Wyoming Health Council (WHC), to improve access to family planning services.

III.C. Five-Year Needs Assessment Summary (as submitted with the FY 2021 Application/FY 2019 Annual Report)

III.C.2.a. Process Description

A. Process Description

I. Goals, Framework, Methodology

The goal of WY MCH's Five-Year Needs Assessment was to determine MCH priorities that reflect stakeholder input, are supported by evidence, and which WY MCH has the capacity to address. WY MCH based its needs assessment (NA) framework on the six-step Peterson and Alexander NA process and the John M. Bryson strategic planning process. The NA stages are: start-up planning, operational planning, data, needs analysis, program and policy development, and resource allocation. WY MCH adopted core values in 2015 and revised these core values during the start-up planning stage to drive key decision-making during the 18-month process. The core values include:

Data-driven:

WY MCH uses data, evidence, and continuous quality improvement

Engagement:

WY MCH cultivates authentic collaboration and trust with families and community partners

Health Equity:

WY MCH integrates an understanding of how differences in social, economic, cultural, and environmental factors across generations and throughout the lifespan impact health

Life Course Perspective:

WY MCH integrates an understanding of how risk and protective factors influence health across the lifespan and across generations

Systems-Level Approach:

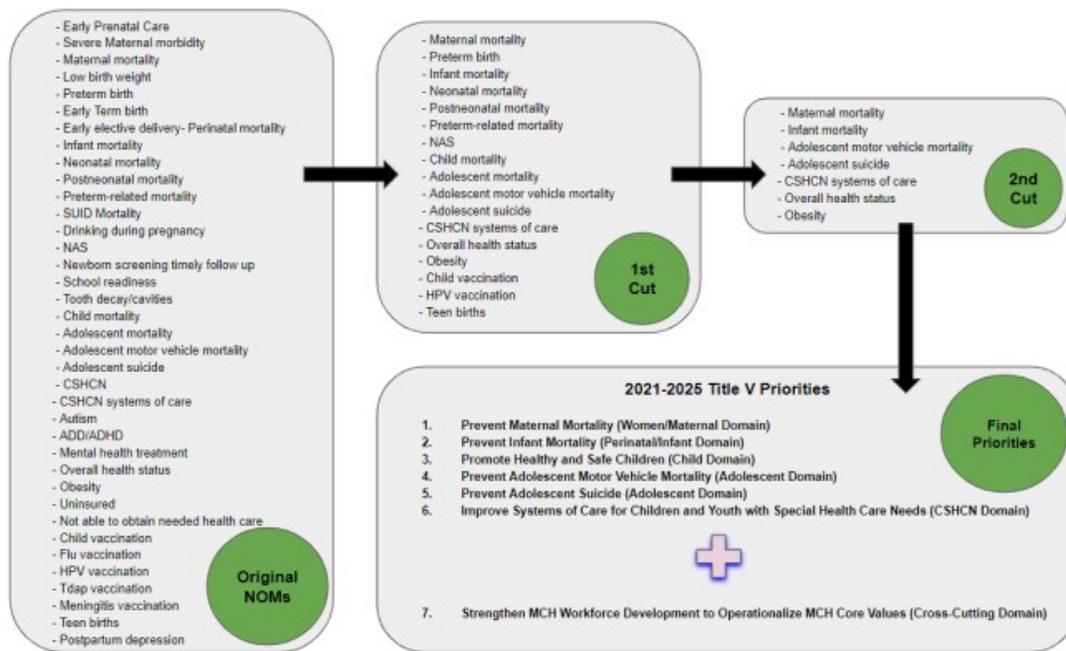
WY MCH prioritizes work that addresses community structures, social norms, environment, and policies to maximize impact

The **Start-up Planning Stage** began in November 2018 with the establishment of a leadership structure for implementing the NA process. A planning group consisting of internal MCH staff (Title V Director, program managers, and MCH Epidemiology staff) determined the NA goals, participants, target populations, and timeline and developed a steering committee of leaders from WDH, state government, and the community to inform and guide the process and hold the Planning Group accountable to the developed plan.

In the **Operational Planning Stage**, the planning group developed an NA [project charter](#) that was approved by the Steering Committee in May 2019. They also developed a stakeholder engagement plan including development of MCH PATs whose membership would be further defined after narrowing potential priorities and a survey of state partners, reviewed qualitative data during SHA community meetings, and compiled data from existing state and national sources.

The **Data Stage**, led by MCH Epidemiology, focused on building a Title V NOM Tableau dashboard using the Federally Available Document produced by HRSA as well as additional state survey data (e.g. NSCH, PRAMS) and vital statistics data. The SHA community meetings, MCH partner survey data, and MCH PAT meetings provided additional qualitative data on the strengths and needs of the WY MCH populations.

The **Needs Analysis Stage** occurred in several iterations; in each, the depth of data presented to decision makers increased and the potential priorities decreased. The image below demonstrates the narrowing of potential priorities from all available NOMs to a final list of Title V priorities.



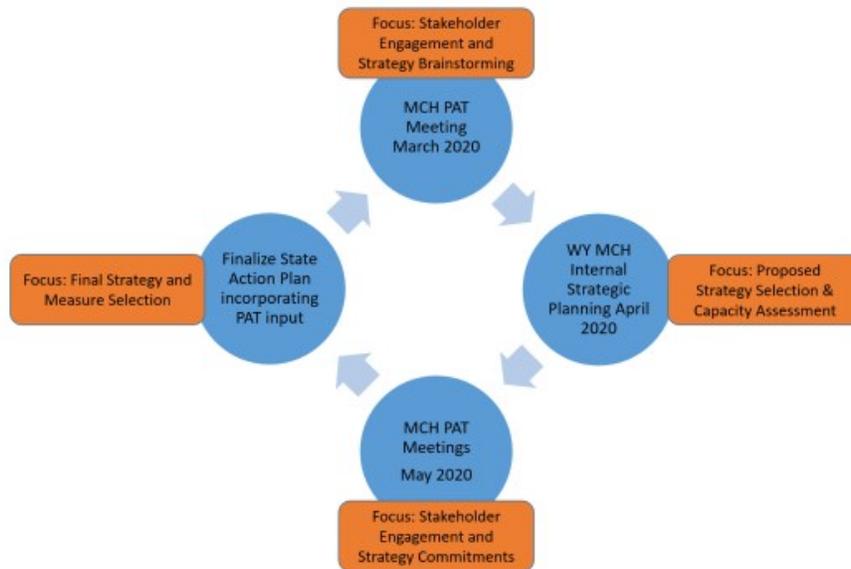
WY MCH staff conducted an initial assessment of each NOM on their perception of its magnitude/burden, MCH leadership role, internal capacity and feasibility, and political leverage. MCH epidemiologists evaluated each indicator for data availability, relation to national indicators, and alignment with themes from the SHA community meeting qualitative data. Following a formal scoring process in May 2019, a narrowed list of NOMs (i.e. 1st Cut) representing the top two quartiles of scored NOMs within each population domain became potential priorities.

In summer and fall 2019, MCH program managers conducted a feasibility assessment for each potential priority topic to evaluate NOMs and NPMs in terms of current activities in the state, the role of MCH, the availability of strategies, and current state capacity.

Program staff also completed a Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis of 2015-2020 NPMs and the narrowed list of potential priority topics for 2021-2025. MCH program managers conducted key informant interviews with stakeholders, reviewed literature on evidence-based strategies, and consulted the MCH Evidence Center to conduct the feasibility assessment. Findings for each priority topic were summarized in a standard NOM overview template with a recommendation and justification for keeping or deleting the priority topic. MCH program managers presented their recommendations to the planning group, then finalized a narrowed list of NOMs for consideration (i.e. 2nd) and presented it to the Steering Committee for approval in January 2020 and the general public (including MCH PAT members) in February 2020.

The final step in the Needs Analysis Stage was the development of priority briefs for each potential priority topic for review by stakeholder groups (i.e. MCH PATs) representing each of the potential priority topics. Each priority brief covered the background/significance of the priority topic, associated NPMs, priority selection process summary, key data, and available strategies. An excerpt can be viewed [here](#).

In March 2020, WY MCH convened five MCH PAT meetings, each representing one-two potential priority topics. These meetings marked the beginning of the **Program and Policy Development Stage** and strategic planning process outlined below, which highlights key internal and external meetings that moved WY MCH from priority selection to strategy selection, measure selection, and the development of a State Action Plan.



The purpose of the March MCH PAT meetings was to share information that informed proposed priority selection and collectively discuss possible strategies for implementation. This convening offered final input on the selection of potential priorities (Needs Analysis Stage) and initial input on the selection of strategies to address each priority topic (Program and Policy Development Stage). The five MCH PAT meetings addressed:

- Systems of care for CYSHCN
- Adolescent suicide
- Maternal and infant mortality
- Child/adolescent mortality with a focus on motor vehicle mortality
- Child obesity/overall child health

At each meeting, the Title V Director provided background on Title V and the NA process to date, followed by brief presentations by the lead MCH program manager on information contained in their respective priority briefs. Then, a contracted facilitator led an interactive dialogue among participants to reflect on the priority brief information, ask questions, gather input, and offer additional strategies for consideration. A note-taker recorded the dialogue.

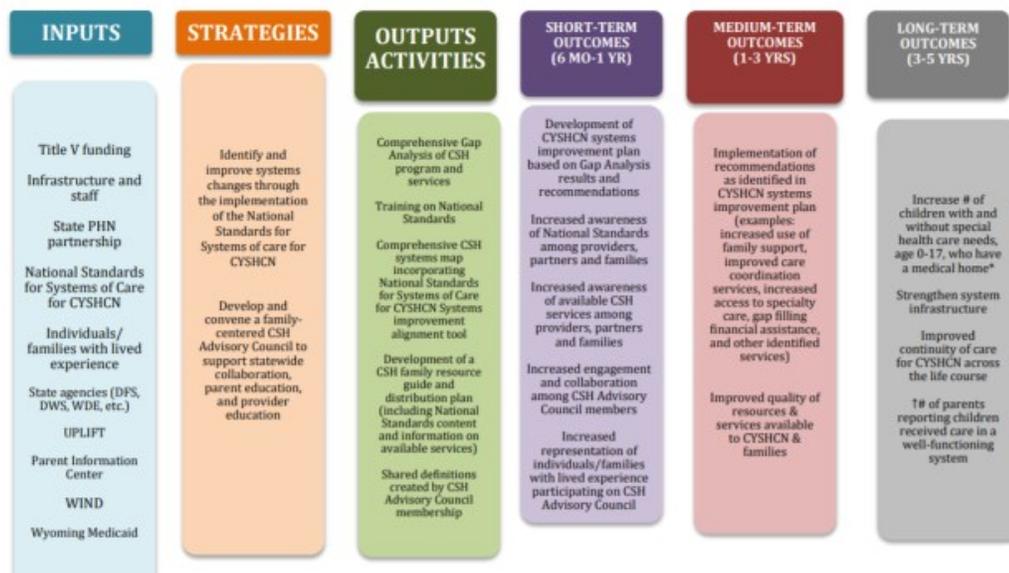
Following the MCH PAT meetings, WY MCH distributed a stakeholder survey to gather input on the strategy options discussed and gauge partner capacity to support. Survey results were shared with each MCH program manager to assist in strategy selection.

MCH program managers completed an [MCH Activity Prioritization Tool](#) that weighed various potential activities/strategies among six strategy screen elements and the five MCH Core Values. These scores further support the prioritization of specific strategies for implementation.

Due to COVID-19, WY MCH met virtually for a four-day strategic planning retreat in April 2020 consisting of nine separate, facilitated one-two-hour sessions. A contracted facilitator launched the retreat with an introduction to strategic planning and an overview of [Strategic Doing and Agile Leadership](#) concepts, including using individual and team strengths in planning and implementation. Subsequent sessions focused individually on each priority topic and the proposed strategies to address them based on feedback from the March PAT meetings, PAT follow up survey results, and the results of the MCH Activity Prioritization Tool. In addition, MCH program managers proposed associated NPMs or SPMs and draft ESMs.

After the conclusion of the internal strategic planning sessions, WY MCH began the final stage of strategic planning by preparing priority logic models to help visualize the connection between the priority need, investments, strategies, and associated measures. An example logic model is below.

Overarching Goal: Improve Systems of Care for CYSHCN



In late May 2020, WY MCH reconvened MCH PATs virtually to present results of the March PAT meeting follow-up survey and MCH Activity Prioritization Tool and a summary of internal strategic planning, and to reveal final draft versions of each priority topic's logic model. The May PAT meetings successfully engaged stakeholders as evidenced by strong attendance, interactivity and commitment to action, and partnership on the part of the stakeholders.

WY MCH is beginning the final **Resource Allocation Stage** and will report on its progress within the NA Summary Update submitted in summer 2021.

II. Stakeholder Involvement

As the NA process described above demonstrates, WY MCH involved stakeholders at every stage. Key stakeholder groups and stakeholder engagement methods are described below.

Steering Committee: The steering committee involved decision makers (e.g. PHD, WDH, partner organization representatives, WY Medicaid, WY Family Voices) to guide NA development, approve priorities, and hold MCH accountable to the plan. The steering committee membership was defined in early 2019 with its first meeting held in May 2019, during which the NA plan and charter were approved. The steering committee met in January 2020 to approve draft priorities. The steering committee also informed the development and membership of MCH PATs and will approve the final priorities and final State Action Plan prior to October 2020. During the 2021-2025 grant cycle, the steering committee will meet once per year to monitor progress on the WY MCH State Action Plan.

SHA Community Meetings: WY MCH aligned with SHA efforts and used results from community meetings held in nine counties to help guide early priority decisions. Counties were selected based on urban, rural, frontier classification; geographic position; county health rank; and minority populations. The MCH Epidemiology Program evaluated the recorded comments from these community meetings by topic area and those which aligned with one of the Title V NOMs were placed in that NOM category. Those NOMs with the largest amount of comments overall, about problems or barriers, and about what the community currently does well were highlighted and considered by program staff during initial NOM selection. The summary can be found [here](#).

Stakeholder Newsletters and Webinars: WY MCH used the newsletter platform to formally launch the 2021-2025 NA process in January 2019 by featuring the Title V NA requirements and releasing a brief survey inviting stakeholders to help identify MCH population needs. Subsequent newsletters and two stakeholder webinars held in June 2019 and February 2020 featured NA updates and opportunities for stakeholders to provide input.

Partner Survey: The partner survey distributed in the January 2019 newsletter solicited feedback from stakeholders on challenges facing MCH populations and ranking of available NPMs. The survey was sent to over 400 WDH, state, and community partners and received 37 responses. All respondents reported working across multiple population domains and half worked for the State of

Wyoming. Major challenges facing MCH populations included access to care, social determinants of health, and access to resources.

Priority Action Teams: After the first cut of potential priority topics, MCH PATs were developed for each priority topic to inform development and implementation of the 2021-2025 State Action Plan. Members were selected based on expertise, experience, and work related to priority topics. MCH PAT members contributed to the priority selection process by completing the MCH partner survey, participating in key informant interviews during the feasibility assessment, and providing key input on selection of strategies to address state priority needs during two spring 2020 meetings.

Public Input Process: WY MCH released a public input survey summarizing programs' report and application content. Survey questions addressed alignment between program activities and community needs, barriers, and health equity. WY MCH received 107 responses from 21 of Wyoming's 23 counties and utilized this feedback to finalize strategies and identify new community partners and local support for selected priorities.

III. Quantitative and Qualitative Methods

WY MCH and the MCH Epidemiology team used a variety of methods to assess the strengths and needs of each of the six domains. Quantitative methods included analyzing Wyoming-specific NOMs in comparison to the U.S. Where possible, these measures were broken down and examined by different populations (e.g. age, gender, race/race ethnicity, socioeconomic status) to better understand disparities. Qualitatively, the Wyoming SHA was utilized. Responses/comments from members of the community that mentioned MCH populations were evaluated.

IV. Data Sources

Data from many different sources were utilized to inform the NA process. Quantitative analysis relied on the Federal Available Document (FAD) produced by HRSA to examine both NOM and NPM data. Data from surveys (e.g. NSCH, PRAMS) and Wyoming Vital Statistical Services data was utilized, outside of what was already provided in the FAD, to further look at disparities facing MCH populations. Qualitative data from the SHA Community Meetings was utilized to assess perceptions of needs and successes related to health broadly as well as those comments specific to MCH populations.

III.C.2.b. Findings

III.C.2.b.i. MCH Population Health Status

B. Findings

I. MCH Population Health Status

Women's/Maternal Health

Maternal Mortality and Morbidity

Due to Wyoming's small population and small numbers of maternal deaths, maternal death rates fluctuate. Aggregated data suggests that the 2013-2017 Wyoming maternal mortality rate is similar to the national rate. An analysis of Wyoming pregnancy-associated deaths from 2013-2015 vital records mortality files indicated 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. A joint UT-WY Maternal Mortality Review is currently being implemented to improve the understanding of the causes of maternal deaths and surveillance of maternal mortality in Wyoming.

In 2017, Wyoming's severe maternal morbidity rate of 46.3/10,000 delivery hospitalizations was lower than the rate of 73.1/10,000 delivery hospitalizations the previous year, and significantly lower than the 2017 U.S. rate of 70.9/10,000 delivery hospitalizations (Healthcare Cost and Utilization Project - State Inpatient Database). Comparisons to the rate before the implementation of ICD-10 are not possible. The most common severe maternal morbidity is transfusion, followed by eclampsia.

Maternal Mental Health

As suicide and drug overdoses are among the leading causes of maternal mortality in Wyoming, maternal mental health is an area of focus. Wyoming PRAMS continues to collect data on opioid use before and during pregnancy for a second year to have sufficient data to track potential trends and associations between maternal mental health and opioid use. Seventeen point three percent of women reported depression prior to pregnancy, and 15.9% reported depression during pregnancy (PRAMS, 2016-2018).

In Wyoming the prevalence of postpartum depression (13.2%) is similar to the U.S. rate. Women aged 15-19 reported the highest prevalence of postpartum depression (23.6%), followed by 20-24 years old (19.0%). Reported prevalence of postpartum depression was also

significantly higher for women reporting incomes levels $\leq 100\%$ of the Federal Poverty level (FPL) (17.9%) and 101-200% FPL (16.1%) compared to women reporting incomes $\geq 300\%$ FPL (6.5%). A majority (84.7%) of women reported their providers discussed depression with them at a postpartum visit, but this did not vary maternal age group or income level (PRAMS, 2016-2018). Due to small numbers of respondents, differences in reported rates of postpartum depression or providers asking about postpartum depression by race could not be evaluated.

Preconception Health

According to the Behavioral Risk Factor Surveillance System, in 2018 64.8% of Wyoming women reported having a preventive medical visit in the past year, significantly less than the U.S. rate of 73.6% for the same year. These rates were lowest for Wyoming women ages 25-34 years (58.3%) and uninsured women (52.4%). However, due to small numbers, caution should be taken when drawing conclusions in regard to differences in preventive medical visits between different groups of Wyoming women.

PRAMS data (2016-2018) indicate that 4.4% of women had hypertension before their most recent pregnancy and 3.9% had diabetes. During pregnancy, 11.3% of women reported having hypertension and 6.5% reported developing gestational diabetes. Several PRAMS respondents commented on the barriers to high-risk maternal care in their community.

Maternal Smoking

National Vital Statistics Services (VSS) data show significant reductions in the percent of women giving birth reporting smoking during pregnancy since 2009, both in Wyoming and the U.S. In 2018, 13.4% of Wyoming women giving birth reported smoking during pregnancy, compared to 19.3% in 2009. Wyoming PRAMS data also indicate reductions in smoking during the last three months of pregnancy.

Family Planning

In 2018, 26.1% of women reported having an unintended pregnancy, down slightly from 2012 when 33.1% percent of women reported having an unintended pregnancy; this is not a significant change. In 2018, 16.7% of women reported being unsure of what they wanted in regards to being pregnant and this has stayed consistent since 2012 (PRAMS). The rate of unintended pregnancies did not differ by race, but differences were seen by income level. Women with reported incomes of $\leq 100\%$ FPL reported having an unintended pregnancy significantly more (40.0%, 95%CI:34.8%-45.5%) than women with incomes greater than $>100\%$ FPL.

In 2018, 34.4% of Wyoming women reported use of the most effective form of contraception (including permanent methods and highly effective reversible methods). This dropped slightly from 2017 (29.8%) but has not changed significantly since 2012. In 2018, 25.4% of women reported the use of moderately effective birth control., and this has not changed significantly since 2012.

Perinatal/infant Health

Infant Mortality

Wyoming's 2014-2018 infant mortality rate (IMR) was 5.2 deaths per 1,000 live births, with 33.3% of the deaths occurring among postneonatal infants and 66.7% among neonatal infants. The Wyoming IMR was lower than the national rate of 5.8 deaths per 1,000 live births in 2017 and meets the Healthy People 2020 objective (6.0 deaths per 1,000 live births). Both the neonatal and postneonatal mortality rates have been similar to the U.S. rates. The leading causes of deaths for neonatal infants were congenital malformation, deformations, and chromosomal abnormalities followed by disorders related to short gestation and low birth weight. For postneonatal infant deaths from 2014-2018, the leading causes were sleep-related sudden unexpected infant death (SUID), followed by congenital malformation, deformations, and chromosomal abnormalities (VSS).

Due to small numbers, differences in IMR by subpopulation are difficult to ascertain. VSS data indicate that Wyoming's neonatal IMR is significantly higher than the U.S. for those reporting a public insurance other than Medicaid, which is not observed in the postneonatal IMR. Disparities by county in infant mortality from 2009 to 2018 are also seen, ranging from 3.2 deaths/1,000 live births in Teton County to 8.6/1,000 in Goshen County, indicating the need for further exploration in potential existing disparities across the state. From 2015 to 2017, the IMR was significantly higher among infants born to women with less than a high school education (11.1/1000), compared to some college (4.0/1000) or those with a college degree or higher (2.7/1000). A noted gap in services is that Wyoming has no level III NICU facility.

Preterm and Low Birthweight Births

Between 2009 and 2018, the prevalence of low birthweight and preterm deliveries in Wyoming, which are leading causes of death among neonatal infants, remained relatively stable. These did not differ much from the U.S. prevalences. In 2018, Wyoming had not met the HP2020 preterm goal of 9.4%, with 9.8% of Wyoming births being preterm, nor the HP2020 low birthweight goal of 7.8%, with 9.4% of Wyoming births being low birthweight (VSS, 2018).

In 2018, Wyoming saw significantly higher prevalences of premature and low birthweight births for women giving birth who are uninsured compared to the U.S. rate(VSS). Women under 20 years of age giving birth had the highest prevalence of preterm and low birthweight

births (13.2% and 13.4%), with the low birthweight prevalence significantly higher than for women ages 25-29 and 30-34 giving birth. A promising observation for Wyoming in both 2017 and 2018 was that the prevalence of very low-weight births in Wyoming (0.9% and 1.1%) was significantly less than the prevalence of very low birth weight births in the U.S. (1.4% and 1.4%) (VSS).

Infant Sleep Environment

As mentioned, a leading cause of death among postneonatal infants in Wyoming is SUID, which includes sudden infant death syndrome (SIDS), accidental suffocation and strangulation in bed, and unknown causes. SUID accounted for 37.4% of postneonatal deaths in Wyoming from 2009 to 2013 and 41.8% of postneonatal deaths from 2014 to 2018. Eighty-five point five percent of Wyoming women reported their infants are put to sleep on their backs (PRAMS, 2016-2018), exceeding the HP2020 goal of 75.8%. This did not differ between women of different races, ages, or income levels.

During this same time period, 76.8% of women reported their infants always or often slept alone in their crib or bed. This differed by maternal age, with 15-19-year-olds reporting this significantly less often (55.1%) compared to 24-34-year-olds (80.0%) and those women 35 years or older (78.2%). American Indian women reported their infant always or often slept alone (66.2%) significantly less than White women (79.4%). Differences by income level were also observed, with women reporting incomes >300% FPL also reporting that their infant slept alone always or often (86.7%) significantly more than women reporting incomes 0-100% FPL (70.7%) and 101-200% FPL (73.4%) (PRAMS, 2016-2018).

Additional disparities in infant sleep environments were also seen by race/ethnicity and income level. American Indian women reported significantly more often that their infant slept on a twin mattress or bed (50.8%) compared to white women (24.0%), and significantly less often that their infant slept in a crib, bassinet, or Pack & Play (76.8%) compared to White women (89.5%). Women reporting incomes \geq 301%FPL reported their baby sleeps in a crib, bassinet, or Pack & Play significantly more (94.1%) than women reporting incomes of 0-100% FPL or 101-200% FPL (80.9% and 85.1%). Women reporting higher incomes were also reporting significantly less that their baby slept with a blanket (53.7%) compared to women reporting incomes 0-100% FPL (74.7%) or with toys, a cushion, or a pillow (5.5%) compared to women reporting incomes 101-200% FPL (13.2%).

A noted gap seen is that while American Indian women reported a health care provider spoke with them about placing their infant to sleep in a crib, bassinet, or Pack & Play (85.2%), placing a crib in the same room as them (58.5%), and what things should and should not go in bed with their infant (86.4%) significantly more often compared to White women (76.4%, 43.5%, and 77.1%), this is not reflected in the actual sleep environments for infants as reported and noted above. There was no difference seen in provider counseling on safe sleep environments by income level, indicating disparities around barriers to providing a safe sleep environment potentially exist more between different socioeconomic statuses, which potentially could be better addressed.

Breastfeeding

Previous MCH work in Wyoming had been focused on improving breastfeeding initiation and duration. Breastfeeding initiation rates in Wyoming continue to exceed (90.6%) the HP2020 Goal of 81.9% children who are ever breastfed (PRAMS, 2016-2018). No difference is seen by maternal age; however, disparities are observed by education level, with women with >12 years of education being significantly more likely to initiate breastfeeding (93.3%) than both those with 12 years of education (86.8%) and with <12 years of education (83.2%). Disparities in regard to breastfeeding initiation are also observed by race, with White (92.2%) and Hispanic (95.5%) women reporting initiating breastfeeding significantly more than women who are American Indian (76.9%) or other races (73.3%) in Wyoming (PRAMS, 2016-2018).

Wyoming also exceeded (31.4%) the HP2020 Goal of 25.5% of children who are breastfed exclusively through six months (National Immunization Survey, 2016).

Child Health

Child Mortality

In 2018 the Wyoming mortality rate for children ages 1-9 (CMR) was 17.0/100,000. The CMR has remained fairly constant since 2009 and has not significantly differed from the U.S. CMR. NVSS data from 2016 to 2018 reveals a gender difference in the CMR, but Wyoming data indicate no significant difference in the CMR between males (17.9/100,000) and females (20.0/100,000) during the same time period (NVSS).

Unintentional Injury

Unintentional injury remains the second-leading cause of death (after natural causes) for children ages 1-9 in Wyoming, and rates are significantly higher than the U.S. rates. From 2008 to 2018, 24% of injury deaths among 1-4-year-olds and 26% among 5-9-year-olds in Wyoming were due to motor vehicle traffic, the leading contributor to injury deaths in both age groups (VSS).

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. WY MCH relies 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 to ICD-10 in Wyoming hospitals led to difficulty in classifying injury hospitalizations.

According to the Healthcare Cost and Utilization Project - State Inpatient Database, the Wyoming child injury hospitalization rates in 2016 (88.0/100,000) and 2017 (119.9/100,000) were both lower than the U.S. rates, significantly so in 2016. The increase seen in Wyoming between 2016 and 2017 was not significant.

Overall Health and Preventative Care

Most children ages 0-11 years (92.6%) were reported to be in excellent or very good health, 48.9% received care in a medical home, 61.9% had adequate and continuous insurance, and 22.4% received care in a well-functioning system (NSCH). Data indicate that children with a medical home were reported as being in excellent or very good overall health significantly more compared to those children who did not have a medical home.

Wyoming parents reported that 22.5% of Wyoming children 9-35 months old received a developmental screening using a parent-completed screening tool in the past year (NSCH, 2017-2018), down from 27.0% the previous two years combined (NCSH 2016-2017). In 2018, 64.2% of eligible, Medicaid-enrolled children ages 1-9 who should receive at least one initial or periodic Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screening received at least one such screening. The percent of eligible children receiving at least one EPSDT screening in Wyoming has increased by 17.2% since 2013 (Wyoming CMS 416 report).

Obesity and Physical Activity

In 2016, WIC data indicated that 9.1% of Wyoming children ages 2-4 were obese, with BMIs at or above the 95th percentile, a rate that has been significantly less than the U.S. rate since 2008. Between 2017 and 2018, 13.1% of Wyoming children ages 10-13 were reported as being obese, with BMI at or above the 95th percentile (NSCH).

According to parent reports, 30.2% of Wyoming children ages 6-11 were active for 60 minutes every day, similar to the U.S. rate (NSCH, 2017-2018). Due to small numbers, any noted disparities in physical activity based on special health care needs, race, or ethnicity were not observed. A greater percentage of males of this age group were reported to be physically active for 60 minutes every day (31.4%) compared to females (28.9%); however, this was not statistically different and follows a similar pattern seen in the U.S.

WY MCH has recently developed a Healthy Policies Toolkit to improve overall childhood health in Wyoming, especially around obesity and physical activity. Planned strategies include increasing implementation of the toolkit in schools and organizations.

Adolescent Health

Adolescent Mortality

The Wyoming adolescent (ages 10-19) mortality rate (AMR) has decreased significantly since 2009. In 2018, the Wyoming AMR was 31.8/100,000, compared to the U.S. rate of 32.2/100,000 (VSS). While the adolescent motor vehicle mortality rate (AMVMR) in Wyoming has been decreasing since 2009, it has continued to be significantly higher than the U.S. rate. Unlike the U.S., there was no significant difference in the AMVMR between males in females, at 19.9/100,000 and 20.5/100,000, between 2014 and 2018.

Suicide, Self-Harm, and Risk and Protective Factors

Over the last decade, Wyoming adolescent suicide rates have been increasing at a rate of more than double the U.S. rate, and it was about triple the U.S. rate between 2013 and 2015. For adolescents ages 10-19, suicide made up just under one third (29.8%) of all deaths for this age group from 2008 to 2018 (VSS). Data indicate adolescent males in Wyoming die by suicide at significantly higher rates than females, a trend that is also observed in the U.S. overall. However, due to small numbers in Wyoming, this should be interpreted with caution and disparities by race/ethnicity are difficult to examine. The leading mechanisms for death by suicide for adolescents were firearm and suffocation.

Regarding self-harm in Wyoming, 2009-2016 inpatient hospital discharge data indicated female adolescents ages 12-24 have significantly higher rates of self-harm (74.7/100,000) than males (34.1/100,000), with the leading mechanisms being poisoning and cutting (WY HDD). According to the Wyoming Prevention Needs Assessment (PNA), in 2018 18.5% of students reported ever seriously considering attempting suicide in the past 12 months, compared to 15.3% in 2012 (WY PNA).

Bullying is considered a major public health problem, as victims of bullying tend to report more negative feelings such as depression, anxiety, and suicidal ideation. Via parent report, significantly more Wyoming adolescents ages 12-17 were bullied by others (59.6%) compared to in the U.S. (38.9%), and significantly more Wyoming adolescents bullied others (25.0%) compared to 15.3% in the U.S. (NSCH, 2018). In 2018, 32.0% of Wyoming students reported being bullied in the last 12 months (WY PNA, 2018).

Teen Births

Since 2009, the Wyoming teen birth rate (TBR) has significantly decreased like the U.S. rate; however, it continues to be significantly higher than the U.S. rate. The most recent data from Wyoming VSS indicated the 2019 Wyoming TBR was 19.4/1000 females ages 15-19, which is less than half of the rate observed in 2009 (43.4/1000). Differences in rates between races and by county continue to be observed in Wyoming, with American Indian teens having a significantly higher teen birth rate than White and Black teens over the last ten years (WY VSS).

Overall Health and Preventative Care

For adolescents ages 12-17 years, significantly fewer (56.1%) were reported by their parents as having adequate and continuous insurance coverage for the entire past 12 months compared to 64.0% in the U.S., and 41.7% of Wyoming adolescents had a medical home. Over half of Wyoming adolescents (54.8%) have experienced at least one adverse childhood experience (ACE), with 33.2% being reported as having experienced two or more ACEs (NSCH, 2017-2018).

In Wyoming 18.1% of adolescents were reported as being physically active for at least 60 minutes every day, with 10.2% being obese. However, the obesity prevalence should be interpreted with caution due to small sample size. Of adolescents ages 12-17, 87.4% were reported as being in excellent or very good health, similar to the U.S. prevalence of 87.2% (NSCH, 2017-2018).

Substance Use

The prevalence of cigarette use among Wyoming adolescents has been decreasing since 2001. In 2001, 16.6% of middle school and high school students reported some cigarette use in the past 20 days. By 2018, this dropped to 6.4% (WY PNA). In 2018 17.2% of high school students and 3.7% of middle school students reported marijuana use at least once in the last 30 days (WY PNA, 2018).

In 2018, 33.7% of Wyoming high school students reported at least one occasion of alcohol use in the past 30 days, down from 44.8% in 2001. Nine point four percent of middle school students reported at least one occasion of alcohol use in the past 30 days, compared to 12.8% in 2001 (WY PNA).

In 2018, 71.3% of Wyoming students reported they perceived using cigarettes once or twice a week to be a great risk of harm. Almost half (45.5%) of Wyoming middle and high school students reported their perceived harm of alcohol use once or twice a week to be a great risk of harm. Of middle school students, 53.0% reported they perceived marijuana use to be a great risk of harm, while only 23.3% of high school students perceived the harm of marijuana use to be a great risk, and 28.7% of high school students reported they thought there was no risk of harm from marijuana use once or twice a week. Half 53.8% of Wyoming adolescents reported they had spoken with at least one parent about the danger of tobacco, alcohol, or drug use in the past 12 months (WY PNA, 2018).

A challenge faced by WY MCH is that Wyoming no longer administers the Youth Risk Behavior Surveillance System (YRBSS) and the last available year of data in Wyoming is 2015. As a result, infrastructure and capacity for data surveillance among the adolescent population is lessened and making comparisons between Wyoming, other states, and the U.S. is a challenge. 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 (CSHCN)

In Wyoming 26,977 or 19.4% of children ages 0-17 have a special health care need. Significantly more male (25.5%) than female (13.3%) children have a special health care need, and the prevalence is highest among children ages 12-17 (31.4%). The prevalence of Wyoming CSHCN reported as receiving care in a well-functioning system is 9.7%, compared to 13.9% of CSHCN in the U.S., and a decrease from 16.6% from 2016 to 2017 (NSCH).

The WY MCH Children's Special Health Program (CSH) provides gap-filling financial assistance and serves about 640 CSHCH a year, reaching 3.4% of the Wyoming CSHCN population (MCH Program Data, 2018). In 2021-2025, CSH will focus on systems of care in order to reach more of the CSHCN population in Wyoming. CSH has recently implemented a genetics telehealth project and a transition to adulthood assessment. In Wyoming, a smaller proportion of CSHCN (13.4%) were reported to have received the services necessary to transition to adulthood compared to the non-CSHCN population (20.3%); in the U.S., a significantly larger proportion of CSHCN are reported to receive the necessary services to transition to adulthood compared to the non-CSHCN (18.9% and 14.2%) (NSCH, 2017-2018).

During 2017-2018, insurance was considered inadequate for a child's health needs (i.e. it was not adequate or continuous in the past 12 months) for 42.6% of Wyoming CSHCN ages 0-17. Between 2017 and 2018, 38.1% of Wyoming CSHCN were reported as having a medical home, compared to 48.6% of non-CSHCN and 42.7% of CSHCN in the U.S. CSH has identified a need to focus more on the care-coordination component of medical home for the CSHCN population. Similar to U.S. trends, a significantly lower proportion of CSHCN in Wyoming (50.9%) received needed care coordination, compared to 72.8% of non-CSHCN who needed care coordination.

Additional disparities in health status measures between CSHCN and non-CSHCN status are also observed in regard to physical activity and obesity in Wyoming. A smaller proportion of CSHCN (17.7%) compared to non-CSHCN (26.4%) are reported to exercise at least 60 minutes every day, and a larger proportion of CSHCN (20.0%) are reported to be obese compared to non-CSHCN (8.6%) Significantly more parents of CSHCN reported concern that their child's weight was too high (61.1%) compared to parents of non-CSHCN (4.0%) in Wyoming

(NSCH, 2017-2018). As a noted priority of promoting physical activity in children via the Child Health domain, a strength of WY MCH is its ability to incorporate CSHCN into other priorities.

III.C.2.b.ii. Title V Program Capacity

III.C.2.b.ii.a. Organizational Structure

II. Title V Program Capacity

a. Organizational Structure

WY MCH is housed within the Community Health Section and Public Health Division (PHD) at the Wyoming Department of Health (WDH), which is one of 47 state agencies comprising the executive branch under the leadership of Governor Mark Gordon. PHD is one of four divisions within WDH, joining the Aging, Behavioral Health, and Health Care Financing (i.e. Wyoming Medicaid) Divisions. Within PHD, there are three sections that oversee public health functions and programming. The Community Health Section optimizes quality of life through the promotion of health, protection of community health, and prevention of disease and injury. The other two sections are Health Readiness & Response and Public Health Sciences. Organizational charts for WDH and PHD are attached.

WY MCH and MCH Epidemiology Program staff are funded by federal (including Title V) and state funds that are included in the Title V maintenance of effort (MOE). WY MCH also receives the PRAMS, State Systems Development Initiative (SSDI), Rape Prevention and Education (RPE), and PREP grants, which provide additional funding for staff and specific programs. MCH block grant funding supports contracts and services to accomplish goals and objectives within each of the five MCH population domains. In addition to funding programs within WY MCH and MCH Epidemiology, Title V funds help build staff capacity in the Injury and Violence Prevention Program. Indirect funds help ensure Title V staff have direct access to and support from a Fiscal Manager assigned to WDH-PHD.

III.C.2.b.ii.b. Agency Capacity

b. Agency Capacity

Capacity to Provide and Assure Services within Six MCH Domains

WY MCH manages the Title V MCH Services Block Grant and provides leadership for state and local efforts that improve the health of the maternal and child health population. WY MCH employs a staff of nine full-time staff including a Title V/CSHCN Director, Grants & Contracts Specialist/Title BG Coordinator, four Benefits and Eligibility Specialists, and three Program Managers, each focused on a specific MCH population domain(s). WY MCH programs include Women and Infant Health, Child Health, Youth and Young Adult Health, Newborn Screening and Genetics, and Children's Special Health. WY MCH also partners with the Public Health Nursing (PHN) Unit to implement a statewide home visiting program.

State funding (i.e. MOE/match funds) are allocated via formula to each of Wyoming's 23 local PHN offices to support local MCH programming.

CSHCN Capacity

Title V funding supports three positions who determine eligibility for the Children's Special Health Program (CSH), which sits within WY MCH, and provide state-level care coordination services in partnership with local PHN care coordinators. State general funds provide gap-filling financial assistance for families of children that qualify financially and medically for the program. WY MCH contracts with the University of Utah to provide in-person and telehealth (follow-up) genetics clinics annually and genetics consultation to WY physicians.

CSH partners with organizations such as the Wyoming Institute for Disabilities, Uplift, Early Intervention and Education programs, Wyoming Medicaid, among others, to ensure CSHCN and their families receive comprehensive, community-based, and family-centered care. In 2021-2025, WY MCH will work to assess and strengthen the system of care for CSHCN by using the National Standards of Care for CSHCN and developing a CSHCN advisory council.

Since 2012, CSH has lacked direct leadership with the Title V Director overseeing the program and three separate staff members each supervising a member of the CSH team. This structure led to confusion and inefficiencies and diluted the significant importance of this program for WY's Title V program. To strengthen leadership capacity for CSHCN services in Wyoming, the Title V Director temporarily reassigned the Child Health Program Manager to fulfill current duties as well as interim duties as the CSH Program Manager. Plans are in motion to reclassify a position in 2020 to create dedicated leadership for the CSHCN population domain.

III.C.2.b.ii.c. MCH Workforce Capacity

c. MCH Workforce Development and Capacity

State Title V program capacity to implement the core public health functions is assessed routinely through efforts of the WDH-PHD Workforce Development Workgroup. A PHD Workforce Training Assessment is completed every two years; the tool assesses workforce capacity using the Core Competencies for Public Health Professionals framework. Assessment results from 2018 are shown below and plans are underway to repeat the assessment in late 2020.

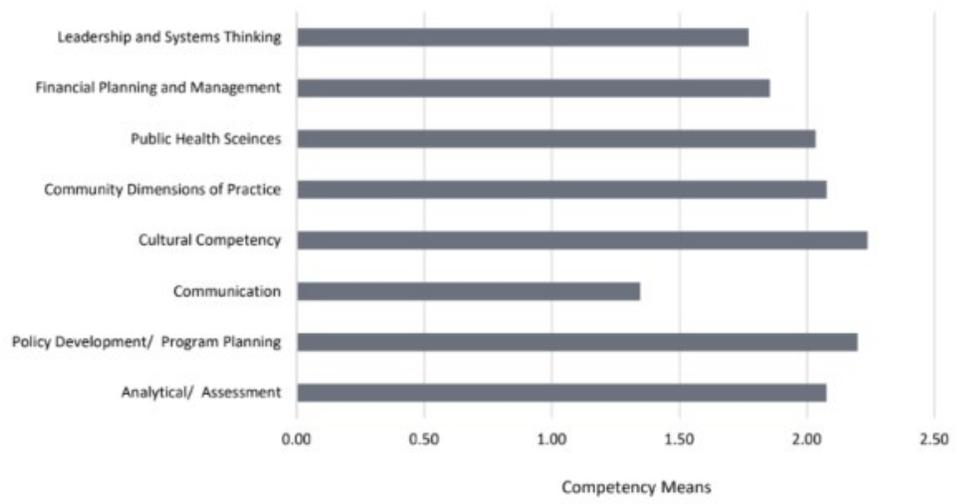


UNIT EMPLOYEE CORE COMPETENCY MEANS

Employee Name	Analytical/ Assessment	Policy Development/ Program Planning	Communication	Cultural Competency	Community Dimensions of Practice	Public Health Sciences	Financial Planning and Management	Leadership and Systems Thinking
	1.64	2.33	2.00	2.00	2.00	2.00	1.71	2.00
	1.79	2.08	1.88	2.00	1.10	2.00	2.00	1.44
	0.64	0.75	1.13	1.14	0.90	0.67	2.00	1.00
	2.00	1.83	1.75	2.00	1.80	2.00	2.00	1.78
	2.33	2.85	0.38	3.00	3.00	2.40	2.00	2.40
	1.29	1.25	0.50	1.00	0.90	0.44	0.86	0.22
	3.00	3.00	0.00	3.00	3.00	2.80	2.00	2.00
	3.00	2.85	1.88	3.00	3.00	3.00	2.44	2.20
	3.00	2.85	2.63	3.00	3.00	3.00	1.69	2.90
Unit Mean	2.08	2.20	1.35	2.24	2.08	2.03	1.86	1.77
Unit Median	2.00	2.33	1.75	2.00	2.00	2.00	2.00	2.00

Competency Key: None = 0, Aware = 1, Knowledgeable = 2, Proficient = 3

Maternal and Child Health Core Competency Means



The Capacity Assessment for Title V programs was used as a resource for program staff when completing the Needs Analysis stage of the NA, specifically when interviewing key stakeholders to understand current activities, capacity, and opportunity for partnership for each potential priority topic. The tool may be important to consider completing formally as part of the WY MCH sixth domain priority, "Strengthen MCH Workforce Capacity to Operationalize MCH Core Values." A University of Wyoming School of Social Work intern placed with the unit for the 2020-2021 school year will assist the Title V Director and staff in developing a comprehensive workforce development plan for MCH staff and contractors.

WY MCH staff are encouraged to use the MCH Navigator platform, which offers a self-assessment and user-directed professional development options to address learning needs at a variety of paces and intensities. While many staff members use the tool, there is no formal requirement and no formal MCH orientation for new staff. This gap represents a significant workforce opportunity leading us into the 2021-2025 grant cycle and one that will be addressed in the sixth domain.

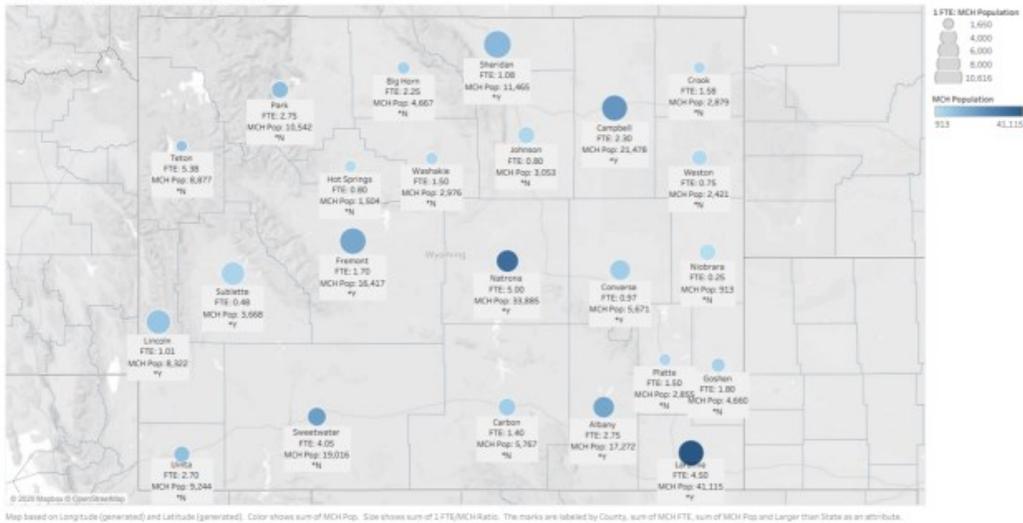
The table below outlines key state MCH and MCH Epidemiology staff who work on behalf of the Title V program. Brief qualifications are noted for each staff person fulfilling a leadership or management role.

Staff Member	Title/Role	Unit/ Program	FTE	Title V Domain	Tenure with WY MCH/ MCH Epi (Tenure with State of Wyoming)
Danielle Marks, MSW, MPH	MCH Unit Manager, Title V Director, and CSHCN Director	MCH	1	All	6 (6)
Jamin Johnson, MS, CHES	Child Health Program Manager and Interim CSHCN Program Manager	MCH	1	Child; Cross-Cutting	2 (4)
Rachel Barber, MS	Youth and Young Adult Health Program Manager	MCH	1	Adolescent; Cross-Cutting	2 (2)
Eighmey Zeeck, MPH	Women and Infant Health Program Manager	MCH	1	Women/Maternal; Perinatal/Infant; Cross-Cutting	1 (1)
Sapphire Heien, BA	MCH Grants and Contracts Specialist, Title V BG Coordinator	MCH	1	All	<1 (5)
Carleigh Soule, MS	Newborn Screening and Genetics Coordinator	MCH	1	Perinatal/Infant; CSHCN; Cross-Cutting	14 (14)
Paula Ray	Children's Special Health Benefits and Eligibility Specialist	MCH	1	CSHCN; Cross-Cutting	20 (20)
Denise Robinson	Children's Special Health Benefits and Eligibility Specialist	MCH	1	CSHCN; Cross-Cutting	<1 (13)
Sheli Gonzales	Children's Special Health Benefits and Eligibility Specialist	MCH	1	CSHCN; Cross-Cutting	14 (18)
Ashley Busacker, PhD	Senior Epidemiology Advisor	MCH Epi	1	All	10 (10)
Moira Lewis, MPH	MCH Epidemiology Program Manager	MCH Epi	1	All	1 (1)
Vacant	PRAMS Coordinator/MCH Epidemiologist	MCH Epi	1	All	N/A
Vacant	MCH/Injury Epidemiologist	MCH Epi	.5	All	N/A

Title V matching funds fully or partially support an estimated 47 FTEs across 23 county PHN offices. The map below demonstrates the total FTEs and MCH population (defined as number of children age 0-19 and number of women of reproductive age (age 20-44).

Wyoming 2019 FTE to MCH Population by County

The State ratio of FTE to MCH population is 1:5046
 *9 Counties have larger FTE/MCH Population Ratios than the State



WY MCH does not currently employ a parent/family member. Wyoming Family Voices identifies a staff member annually to serve as the Wyoming Family Delegate at AMCHP. In 2019, WY MCH began convening a monthly parent/family engagement workgroup to discuss and implement collaboration opportunities amongst agencies and programs. In 2020, WY plans to formalize a partnership with the Wyoming Family Voices affiliate through a contract.

During the 2021-2025 NA process, WY MCH identified an emerging, cross-cutting need related to workforce development, both internal and external to the Title V program, due to significant staff transition and retirements. At full staff capacity, WY MCH and MCH Epidemiology represent 13 FTEs. As of July 2020, two MCH Epidemiology positions are vacant. Of the filled positions, over 50% of staff have been in their positions less than three years. Additionally, all staff in management positions have been in their roles less than four years.

During FFY20, WY MCH will experience two retirements of staff members totalling sixty years of collective experience in MCH and service to the State of Wyoming. This loss of experience and institutional knowledge is significant and will require innovation and strong leadership to overcome.

A 2018 assessment of unit activities related to perceived importance of MCH core values further emphasized a need to invest resources and programming to strengthen WY MCH's ability to operationalize its core values. Staff reported engagement, data-driven, and health equity as the most important core values to communicate to stakeholders. Assessment results indicated opportunities to improve the degree to which all core values drive programmatic decision-making.

III.C.2.b.iii. Title V Program Partnerships, Collaboration, and Coordination

III. Title V Program Partnerships, Collaboration, and Coordination

WY MCH partners with MCH Epidemiology for epidemiology and evaluation support for MCH programming. WY MCH also partners with other State agencies and programs to improve MCH population health, including: Health Care Financing (Medicaid and KidCare CHIP); Department of Workforce Services (Early Head Start); Department of Family Services (Child Care Licensing, Temporary Assistance for Needy Families); Department of Education; WDH Behavioral Health Division (Early Intervention, Behavioral Health Treatment, Early Hearing Detection Intervention Program); WDH PHD (Health Readiness and Response, Substance Abuse Prevention, Tobacco Prevention, Injury and Violence Prevention, Chronic Disease Prevention, Immunizations, Women, Infants, and Children (WIC), Public Health Nursing (PHN)); University of Wyoming (Wyoming Institute for Disabilities, School of Nursing, School of Social Work); the Title X grant, administered by an in-state non-profit partner; the federal Maternal, Infant, Early Childhood Home Visiting grant, administered by an out-of-state non-profit partner; and other statewide organizations and associations (Wyoming Medical Society, Wyoming Primary Care Association, Wyoming American Academy of Pediatrics Chapter, Wyoming American College of Obstetricians and Gynecologists Chapter, Wyoming Kids First, Wyoming Community Foundation).

In 2019, WY MCH, in close partnership with the WDH-PHD Performance Improvement Manager, Rural and Frontier Health Unit Manager, and a Master of Social Work intern, surveyed partners about NA requirements in order to identify collaboration opportunities. Forty-seven percent of respondents responded that their organization had NA requirements. Due to overwhelming

interest by partners, WY MCH helped establish a crosswalk of NA requirements including Title V, MIECHV, Mental Health and Substance Abuse Block Grant, State Primary Care Office, Child Abuse Prevention and Treatment Act (CAPTA), Head Start community-wide NAs, SHA, and hospital community health NAs. Efforts to coordinate future NAs continue with the support of an Americorp Vista assigned to the Performance Improvement Program.

Other MCHB Investments

WY MCH dedicated significant effort in FFY20 to enhance partnership with the Wyoming Family to Family Health Information Center (F2FHIC) and other organizations whose missions include parent/family engagement for MCH populations (e.g. Wyoming Family Voices, Wyoming Parent Information Center, Wyoming Department of Education). Specifically, WY MCH partnered with WY F2FHIC at the Wyoming Institute for Disabilities to coordinate the Title V and F2FHIC NAs. A parent/family engagement workgroup including the partners listed above continues to meet monthly to identify collaboration opportunities.

WY MCH participates in the Mountain States Regional Genetic Network (MSRGN) in order to establish regional networking, implement quality improvement projects and consumer input strategies, and support activities to improve access to genetic services within the region's underserved communities. WY MCH's Newborn Screening and Genetics Coordinator is currently serving a four-year term on the MSRGN Advisory Committee.

WY 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 FFY19, WY MCH 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. Finalization of a MOU was delayed due to leadership changes and COVID-19 but is expected to be executed before fall 2020. 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 as well as relevant PATs. PATNC continues to offer key infrastructure support for the Wyoming Home Visiting Network, of which WY MCH is a member.

WY MCH continues to build workforce and systems capacity to address emerging needs through the offerings of the National MCH Workforce Development Center and the MCH Title V Internship Program. In summer 2019, the Child Health Program Manager applied for technical assistance to convene key statewide stakeholders within the Wyoming early childhood system to define the early childhood system, identify duplicate and complementary services, and identify gaps in available services. In summer 2020, WY MCH welcomed two graduate students as part of the MCH Workforce Development Center's MCH Title V Summer Internship Program. The interns developed a MCH communications plan to assist in plans to better operationalize the unit's core value of engagement.

Other Federal Investments

The Youth and Young Adult Health Program Manager partners with the Communicable Disease Unit to administer the Personal Responsibility Education Program (PREP).

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

The CDC-assigned MCH Epidemiologist remains a member of the State's Child Fatality Review and a member of its leadership council. WY CFR is currently led by the Wyoming Citizen Review Panel to review child maltreatment deaths and major injuries.

The Women and Infant Health Program Manager is the Office of Women's Health representative and attends quarterly meetings that include state updates, resource sharing, and presentations responding to member inquiry and interest.

WY MCH benefits from an organizational structure that promotes collaboration with sister units of WIC, PHN, Immunizations, and Prevention and Health Promotion. Partnership with WIC includes promotion of statewide breastfeeding activities and development of improved lactation policies at WDH. WY MCH partners with PHN, WIC, and Immunizations to promote well visits through the Bright Futures Implementation Task Force.

Other HRSA Programs

Wyoming MCH continues to promote collaboration with the PHD Rural and Frontier Health Unit (RFH) through collaboration breakfasts, casual cross-unit meetings that offer staff an opportunity to learn about and partner with other HRSA-funded programs within RFH.

The Wyoming Primary Care Association (WYPCA) is another key partner of WY MCH and recipient of additional HRSA grants. WYPCA helped fill an important gap in statewide capacity to address oral health after the state-funded program was cut in 2016. WYPCA stepped in to lead the Wyoming Oral Health Coalition and recently joined a HRSA-funded oral health integration project (Rocky Mountain Network of Oral Health) focused on populations ages 0-40 months and pregnant women, with Denver Health serving as the lead agency. Additional HRSA grants administered or received by WYPCA include Primary Care Association grants and a new project with the Health Center Controlled Network with Community Healthcare Association of the Dakotas.

State and Local MCH Programs

WY MCH contracts with all 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. These funds fully or partially support an estimated 47 FTEs across Wyoming in support of MCH services.

Tribes, Tribal Organizations, and Urban Indian Organizations

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

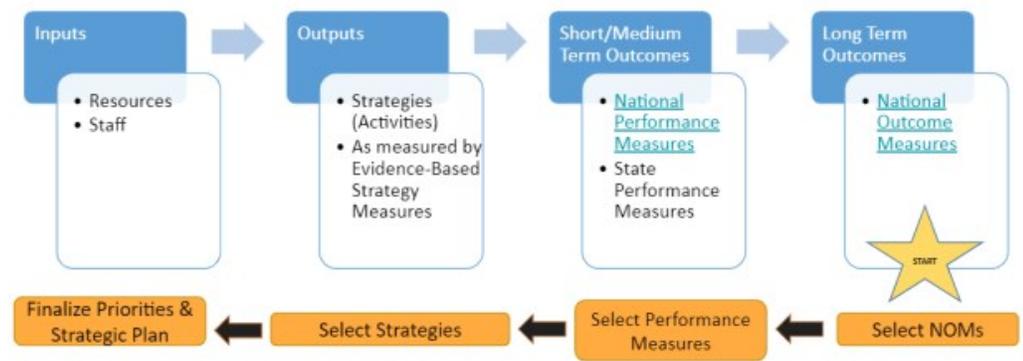
The Wyoming PRAMS project continues to sample all births to Native American women. Wyoming PRAMS staff attend tribal health fairs and work with tribal health program leadership to provide data for review and use in tribal programs.

The Child Health Program Manager represents WY MCH on the Governor's Early Childhood State Advisory Council and the Wyoming Early Intervention Council. The MCH Unit Manager represents WY MCH on the Governor's Developmental Disabilities Council.

III.C.2.c. Identifying Priority Needs and Linking to Performance Measures

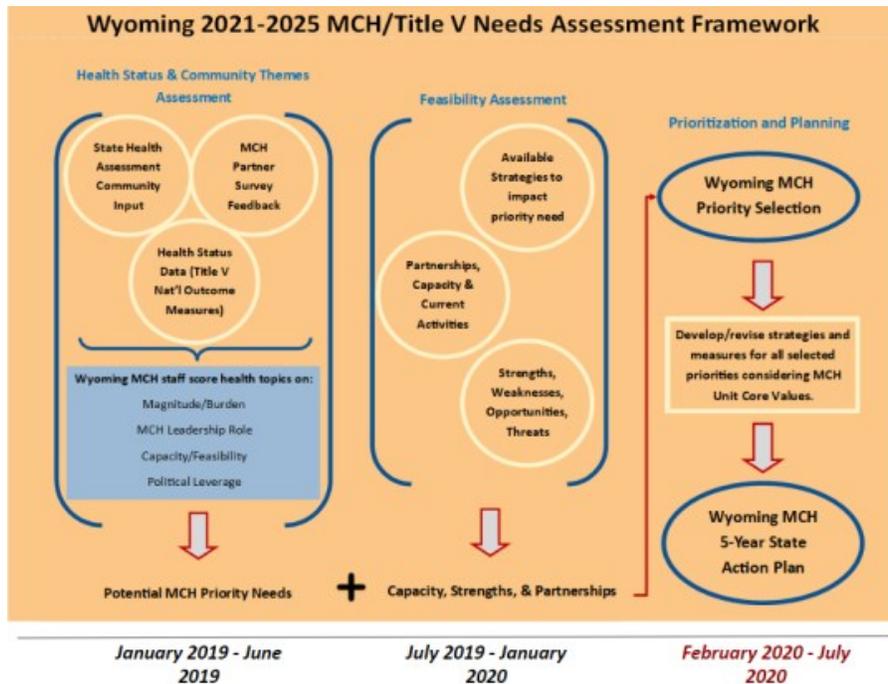
C. Identifying Priority Needs and Linking to Performance Measures

The image below shows the process of selecting 2021-2025 priorities beginning with selecting national outcome measures (NOMs) (and additional emerging topics resulting from the SHA community meetings and MCH partner survey, if appropriate) and moving backward along a logic model continuum ending with finalized priorities and a State Action Plan, complete with selected/linked national or state performance measures and evidence-based strategy measures.



WY MCH focused its prioritization process on NOMs to ensure alignment with the Title V performance measure framework and ensure a limited number of resources were allocated to addressing priorities important both nationally and in WY.

The figure below (Figure XX) provides a high level summary of the prioritization process.



WY MCH cast a wide net to determine priorities to avoid biases in the selection process. Information on potential priorities was collected in three ways: SHA community meetings across the state, a survey of state partners, and a review of national and state health indicators of the MCH population.

As expected, WY MCH identified emerging issues for which MCH leadership role, capacity, feasibility, and/or political will was not sufficient enough for selection as a priority. Examples include mental health treatment for children, adequate insurance for children, and oral health. These topics will be further considered during the interim year needs assessments.

During this needs assessment process, three new emerging issues were identified and selected as new priorities - youth suicide, adolescent motor vehicle mortality, and maternal mortality - selected for their magnitude/burden in WY when compared nationally (suicide and motor vehicle mortality) and for momentum due to new grants and capacity (maternal mortality).

III.D. Financial Narrative

	2017		2018	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	\$1,125,000	\$1,085,502	\$1,125,000	\$1,083,689
State Funds	\$1,775,473	\$1,867,148	\$1,825,591	\$1,948,353
Local Funds	\$0	\$0	\$0	\$0
Other Funds	\$600,119	\$508,443	\$550,000	\$427,238
Program Funds	\$0	\$0	\$0	\$0
SubTotal	\$3,500,592	\$3,461,093	\$3,500,591	\$3,459,280
Other Federal Funds	\$2,179,510	\$1,534,364	\$1,600,234	\$1,559,910
Total	\$5,680,102	\$4,995,457	\$5,100,825	\$5,019,190
	2019		2020	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	\$1,100,000	\$1,046,625	\$1,100,000	
State Funds	\$1,736,286	\$1,853,637	\$1,825,591	
Local Funds	\$0	\$0	\$0	
Other Funds	\$639,305	\$521,954	\$550,000	
Program Funds	\$0	\$0	\$0	
SubTotal	\$3,475,591	\$3,422,216	\$3,475,591	
Other Federal Funds	\$1,578,412	\$1,445,658	\$1,877,176	
Total	\$5,054,003	\$4,867,874	\$5,352,767	

	2021	
	Budgeted	Expended
Federal Allocation	\$1,078,080	
State Funds	\$0	
Local Funds	\$0	
Other Funds	\$0	
Program Funds	\$0	
SubTotal	\$1,078,080	
Other Federal Funds	\$1,957,109	
Total	\$3,035,189	

III.D.1. Expenditures

< The Budget narrative will be finalized before September 2nd>>

III.D.2. Budget

< The Budget narrative will be finalized before September 2nd>>

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](#)

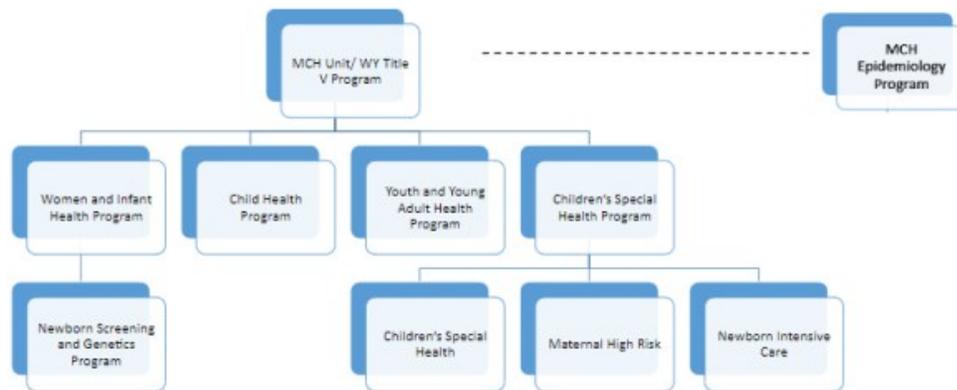
[State Action Plan Table - Legal Size Paper View](#)

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 (WY MCH), is organized within the Community Health Section (CHS) of the Public Health Division (PHD). Structurally, WY MCH'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 MCH population domain. The Women and Infant Health Program Manager is lead for the women/maternal and perinatal/Infant domains. The Child Health Program Manager and interim Children's Special Health Program Manager is lead for the child and CSHCN domains. Lastly, the Youth and Young Adult Health Program Manager is lead for the adolescent domain.

Organizational Structure



The Wyoming Title V Program receives approximately \$1.2 million in federal Title V funding annually. Due to a small budget, small staff capacity, and the rural and frontier nature of Wyoming, WY MCH relies heavily on partnerships to develop and achieve State Action Plan objectives. During the 2021-2025 needs assessment, WY MCH acknowledged a need to formalize partnerships in order to successfully implement strategies, most of which are larger than WY MCH. To accomplish this, MCH Priority Action Teams (PATs) for each priority were developed in March 2020 to guide the strategic planning process and support implementation over the five-year cycle. The strategic planning process ended with development of logic models for each priority, each of which included key partners as “inputs” necessary to achieve success. Each program manager will use Basecamp, a virtual project management tool, to stay connected with MCH PAT members around a shared vision (e.g. each priority’s action plan).

WY MCH strives to partner with all PHD programs with particular emphasis on fellow CHS units including 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 (WIC). 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 WY MCH prioritizes its core value of engagement. These efforts will be

tied to the new 2021-2025 priority to strengthen MCH workforce capacity to operationalize MCH core values.

WY MCH is committed to partnerships that assure access to the delivery of quality health care services for mothers, infants, children, and youth, including CYSHCN. Specifically, under the 2021-2025 State Action Plan, WY MCH will continue to support statewide delivery of high-quality 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 with 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 WY MCH supports a foundation for family and community health include its work toward improving well visit rates and its assessment of levels of maternal and neonatal care.

WY MCH revised its core values in 2018. They are: data driven, engagement, health equity, life course perspective, and systems level approach. This framework, along with realistic assessments of staff capacity, allows MCH to determine its most appropriate role in priority-related work. The strategies found in the State Action Plan underwent a core value screener to ensure strategies aligned with core values where possible.

Finally, WY MCH 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 will be reviewed quarterly with program and epidemiology staff in order to continually assess progress and alignment with state priority needs and emerging needs. The MCH PATs will also meet at least annually to review progress on the State Action Plan and support implementation of its strategies. New in the 2021-2025 cycle will be application of Strategic Doing and Ten Skills for Agile Leadership in routine performance and quality improvement efforts.

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

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

Staffing Structure and Composition

WY MCH has a current staff of nine. 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.

In summer 2019, the MCH Unit Manager successfully reclassified the unit's administrative assistant position to become an MCH Grants and Contracts Specialist/Title V Block Grant Coordinator position, which was filled in November 2019. A new Women and Infant Health Program Manager joined WY MCH in August 2019 along with a new CSH Benefits and Eligibility Specialist in February 2020.

Since 2012, CSH has lacked direct leadership with the Title V Director overseeing the program and three separate program managers each supervising a member of the CSH team. This structure led to confusion and inefficiencies and diluted the significant importance of CSH for WY's Title V program. To strengthen leadership capacity for CSHCN services in Wyoming, the Title V Director temporarily reassigned the Child Health Program Manager to fulfill current duties as well as interim duties as the CSH Program Manager. Plans are in motion to reclassify a position in 2020 to create dedicated leadership for the CSHCN population domain.

WDH Workforce Development Activities

All WY MCH program managers participate in the 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 2019 Healthstat documents for each of the three programs required to report program documentation to the Wyoming legislature each year. In addition, each program manager maintains a program performance dashboard that tracks program goals, objectives, and measures. These program performance dashboards align with content found in the Title V State Action Plan. Each program's dashboard will be updated in fall 2020 to reflect new Title V State Action Plan content for 2021-2025.

WY MCH staff are well represented on PHD workgroups including the following:

- PHD Performance Management and Quality Improvement Council (PMQIC): the PMQIC offers technical assistance and quality improvement tools to programs to help increase program effectiveness and efficiency
- PHD Health Equity Workgroup (HEW): the HEW serves to systematically support PHD's advancement of health equity by providing health equity training, support, services, and promotion
- PHD Workforce Development Workgroup (WFD WG): the purpose of the WFD WG is to foster a competent, flexible workforce across PHD using needs assessments, section/unit mission requirements, and job content questionnaires to identify gaps in knowledge, skills, and abilities, and address gaps through targeted trainings and professional development

All WY MCH staff participate in the State of Wyoming's Performance Management Instrument (PMI) process annually. The PMI process utilizes collaboration between supervisors and employees to develop and set standards that align with State and agency missions and to measure and evaluate performance. To assist staff and leadership in developing annual performance goals, PHD administers a PHD Workforce Training Assessment every two years. The tool assesses workforce capacity using the Core Competencies for Public Health Professionals framework. The Core Competencies are a consensus set of skills for the broad practice of public health, as defined by the 10 Essential Public Health Services. Plans are underway to repeat the assessment in late 2020.

MCH-Specific Workforce Development Activities

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 and MCH Epidemiology Conference. Currently, the Child Health Program Manager and interim Children's Special Health Program Manager is participating in the AMCHP Leadership Lab; he is also participating in the Certified Public Manager course offered by Laramie County Community College and completing a project to develop a PHD mentorship program in order to retain a skilled workforce.

WY MCH continues to support employee development through the use of StrengthsFinder 2.0, an online assessment to assist individuals in identifying, understanding, and maximizing 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 complete the StrengthsFinder assessment upon hire and participate in an Introduction to Strengths session to learn about the assessment tool and receive their results from a trained coach. Additional strengths coaching and/or consultation is available for staff as requested. This offering is especially important in order to support a small staff tasked with expansive priorities. WY MCH currently contracts with Lolina, Inc. to offer this important workforce development opportunity to all staff.

During the 2021-2025 needs assessment, WY MCH staff identified an ongoing need to improve workforce development related to all MCH core values. In addition, WY MCH leadership determined that a formal WY MCH orientation would ensure a smoother onboarding process for new employees, interns, and volunteers. In FFY21, WY MCH will implement the following strategies to address the priority of strengthening MCH workforce capacity to operationalize MCH core values:

1. Develop and improve professional development opportunities to increase competencies related to MCH core values
2. Promote and integrate core values across all MCH domains and state priority needs
3. Develop understanding of individual and team strengths

Internships

WY MCH continues to leverage the following internship opportunities and other workforce programs to increase workforce capacity to address MCH priority needs.

Partnership with University of Wyoming School of Social Work

WY MCH began welcoming Masters-level social work students to the team in 2018 and will welcome a third consecutive intern in August 2020. During the 2019-2020 school year, an intern worked with WY MCH to launch the Bright Futures Implementation Task Force. During the 2020-2021 school year, an intern will support the unit's efforts to strengthen workforce capacity to operationalize MCH core values and support partners in Public Health Nursing to launch a new home visiting model and a Plans of Safe Care initiative, in partnership with the Department of Family Services.

Title V Internship Program

In early 2020, WY MCH submitted a successful application for the National MCH Workforce Development Center's Title V Internship Program to increase MCH involvement in emergency preparedness planning and response. This application was written in response to recent newborn screening emergencies such as snowstorms shutting down primary interstates used by courier services and a contracted courier service filing for bankruptcy during a busy holiday season. It was also submitted acknowledging MCH's absence from emergency preparedness planning discussions. Due to COVID-19, the internship program was moved to a virtual setting and host sites were afforded flexibility in changing assignment projects. WY MCH modified its assignment topic due to COVID-19's impact on

staff capacity to orient and support students. The new project addressed a previously identified need to develop an MCH communications plan, an effort to build WY MCH workforce capacity to operationalize the MCH core value of engagement. A draft of the MCH communications plan can be found in Attachment E.

Public Health Association Program (PHAP)

In spring 2020, WY MCH submitted a successful Public Health Associate Program (PHAP) application to enhance parent/family engagement efforts and establish an MCH emergency preparedness and response plan. The associate joins WY MCH in October 2020 and will work closely with family-run organizations and the PHD Public Health Preparedness and Response, among other partners.

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 WY MCH with tangible tools to promote work that considers the social determinants of health, health equity, and 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

WY MCH revised its core values in December 2018 ahead of the current needs assessment process. The updated core value of engagement demonstrates a unit-wide commitment to “cultivate authentic collaboration and trust with families and community partners.”

During the 2021-2025 needs assessment process, the WY MCH team identified a need to move beyond simply naming core values toward action. In October 2019, a contracted facilitator led staff through a core values exercise to identify how each core value is currently implemented and what improvements WY MCH could make to improve implementation of each core value. A second exercise centered specifically on brainstorming community engagement strategies along a continuum moving from outreach to consultation, involvement, collaboration, and shared leadership. Examples of proposed strategies included development of a MCH communications plan, improving the use of technology (e.g. Zoom) to facilitate remote meetings, development of a parent/family advisory and youth council, and improvement of the public input process. These exercises helped inform the development of a sixth domain Title V priority to strengthen MCH workforce development to operationalize MCH core values.

In March 2020, WY MCH convened MCH Priority Action Teams (PATs) to gather input on the selection of priorities and corresponding strategies for the 2021-2025 needs assessment. The goal of the PATs is to establish consistent and sustained engagement of stakeholders in the planning, development, implementation, and evaluation of the Title V State Action Plan across all MCH population domains. Each PAT will meet again in fall 2020 to launch the 2021-2025 five-year cycle and will meet at least annually thereafter to monitor progress on the State Action Plan and offer support in implementation of MCH activities.

In FFY2021, WY MCH will work with the UPLIFT, the Wyoming Family Voices affiliate, and other parent organizations to identify and recruit parent, family, and youth representatives to serve on each PAT. UPLIFT also supported efforts to improve the public input process in summer 2020 and will do so again in subsequent years. Their involvement, paired with leadership from a new Title V Block Grant Coordinator, led to a significant increase in public input responses from just two in 2019 to 107 in 2020 with responses from 21 of 23 counties.

WY MCH acknowledges that meaningful parent and family partnership requires dedicated staff and resources. In the absence of a dedicated position in WY MCH to do this work, WY MCH leverages other workforce development opportunities. In fall 2018, a WY MCH intern conducted a parent/family engagement stakeholder survey to better understand current requirements and activities and interest in a statewide workgroup to improve parent/family engagement. 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.”

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. While interest among partners was high, WY MCH lacked dedicated capacity to continue to lead this larger workgroup. Instead, a smaller workgroup was formed including WY MCH, UPLIFT (Wyoming Family Voices), Wyoming Institute for Disabilities (WY F2FHIC), WY Parent Information Center, and a representative from the Wyoming Department of Education. The workgroup meets monthly to share updates on parent/family engagement activities and identify collaboration opportunities. In 2020, the workgroup agreed to lead implementation of consumer education strategies to promote well visits as part of the Bright Futures Implementation Task Force. A parent representative joined the group in summer 2020 and the goal is to recruit more parents over the next year. This workgroup has also convened virtually multiple times during the COVID-19 pandemic to learn about families’ challenges and needs during the crisis and share about each

organization's efforts to maintain engagement and provide support.

In 2020, WY MCH submitted a successful Public Health Associate Program (PHAP) application to increase capacity to improve parent and family partnership activities and to develop a statewide MCH Emergency Preparedness Plan informed by and reviewed by parents and families. WY MCH will welcome an associate in October 2020 to complete the following activities:

- Year 1 activities will include completion of environmental scans on best practices related to parent/family/community engagement, current engagement activities, and best practices related to MCH emergency preparedness and response protocols (e.g. emergency transport for high-risk MCH populations, courier services for newborn screening specimens). The PHAP will assist in the completion of an After Action Report on COVID-19 response related to MCH populations including strengths, challenges, and opportunities for improvement.
- Year 2 activities will include development and implementation of a sustainable parent/family engagement strategy that provides meaningful opportunities for parents and families to participate in program planning and improvement activities within MCH and WDH, and across state agencies. The PHAP will develop a statewide MCH Emergency Preparedness Plan informed by Year 1 research and input obtained from parents, families, communities, and key partners. Example topics to be addressed in a plan include: development of protocols to assure MCH essential services (e.g. newborn screening courier services) continue in the face of prolonged weather emergencies, transport protocols for infants and children/youth with special health care needs, and guidance to assure access to safe sleep environments in emergencies.

Fatherhood Engagement

A WY MCH 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 that will be distributed in the coming months. Due to COVID-19, no recent progress has been made on this effort.

Family Voices Partnership

WY MCH continues to work toward strengthening its relationship with UPLIFT, Wyoming's Family Voices affiliate. WY MCH supported UPLIFT's Executive Director's attendance at the 2019 Family Voices conference and the 2020 virtual AMCHP conference. In FY21, WY MCH will formalize a partnership with WY Family Voices for the latter to provide technical assistance to WY MCH staff to engage parents and families in MCH program planning, implementation, and evaluation.

Family-to-Family Health Information Center Partnership

WY MCH collaborated with the WY F2FHIC in 2019 and 2020 on CSHCN needs assessment activities. In summer 2020, both organizations jointly released a provider survey on the level and type of care provided to CSHCN in their practices.

Youth Council

In 2019, the Youth and Young Adult Health Program released a Request for Applications to support the development of a statewide youth advisory council. This council will bring youth voices and experiences together with health programs, promoting success, increased youth engagement, and quality improvement. A contract with the selected applicant was executed in January 2020. As of August 2020, membership recruitment is complete and a first meeting was held.

Children's Special Health Advisory Council

The 2021-2025 needs assessment identified a priority to improve systems of care for CSHCN. A key strategy of this priority is to develop and convene a CSHCN Advisory Council with the goal of including members with lived experience. This council will support the program in completing an assessment of the National Standards for Systems of Care for CSHCN and implementing an action plan to address opportunities and gaps.

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) supporting 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 participated in the planning group for the 2021-2025 Needs Assessment and supported the process by providing tools to assist in assessing both Title V National Outcome Measures (NOMs) and National Performance Measures (NPMs).

Access to Timely and Accurate MCH Data

SSDI continues to support the work of the Wyoming Vital Statistics Services (VSS) office as it works to improve timeliness and accuracy of its 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 MCH Epidemiology's ability to monitor infant and maternal mortality
- Creation of real-time access to reports, focused on newly developed linkages
- Creation of electronic maternal death reporting - enhancing quality and timeliness for MCH projects including the Maternal Mortality Review (MMRC)
- 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 their 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 that is contracted to Market Decisions, LLC

MCH Surveillance

Ongoing surveillance is being developed for key MCH indicators. Epidemiologists utilize Tableau software for a dashboard that tracks injuries (including childhood injuries) and will be used to model MCH surveillance efforts. Tableau Dashboards have also been created to monitor Title V National NOMs.

Current contract negotiations are also taking place for the creation of two Tableau dashboards to visualize Wyoming PRAMS data and Wyoming MCH VSS data. These will be made publicly available and will be used to assist with monitoring the status of the MCH population in Wyoming.

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, one county with 100% State staff, and the remaining 19 counties utilizing both state and county staff. WY MCH 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.

Using primarily matching funds, WY MCH'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. WY 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
- Evaluating the effectiveness of service delivery in meeting client and family needs

In 2016, WY MCH and the 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 10% of births occur outside of Wyoming, though there is limited data available to determine the reason for delivering outside of the state. There are future plans to repeat LOCATe statewide using the revised tool. The act of completing the assessment has significantly increased engagement with the Wyoming Hospital Association and with individual facilities and helped to formally establish the Wyoming Perinatal Quality Collaborative. This is an example of WY MCH'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, allowing 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. WY MCH routinely provides updates to the PHD Senior Administrator to discuss during these partnership meetings. WY MCH and Medicaid actively partner to address the following state priority needs, including new (2021-2025) and old (2016-2020) priorities:

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

Examples of current WY MCH and Medicaid collaborative projects include:

- Bright Futures Implementation Task Force and associated activities within four subcommittees (Provider Education, Consumer Education, Medical Coding, and Access to Care). The Wyoming Medicaid Medical Advisory Group voted to adopt Bright Futures, 4th Edition after participating in a WY MCH-facilitated presentation by a nationally recognized EPSDT/Bright Futures expert. Both WY MCH and Medicaid participated in the development of a Bright Futures Implementation Guide for Wyoming, led by two Title V Internship Program interns. The task force used the guide to inform development of its membership, structure, and activities.
- Long Acting Reversible Contraception (LARC) Workgroup and associated activities to unbundle reimbursement for LARC insertion, device, and removal in federally qualified health centers and rural health clinics and in hospitals (i.e. immediate postpartum LARC). This work was originally funded through a grant from the National Institute of Reproductive Health but is ongoing with support from WY MCH and Wyoming Primary Care Association leadership.
- Medicaid Innovation Accelerator Program (Building Partnerships and Data Analytic Capacity to Address Maternal Mortality and Severe Maternal Morbidity).
- Maternal Mortality Review Committee. The Medicaid Medical Director is a member of the newly formed UT-WY MMRC, a cross-state committee reviewing Utah and Wyoming maternal deaths; Wyoming maternal deaths will be reviewed twice annually.
- Wyoming Perinatal Quality Collaborative. The Medicaid Medical Director, Health Management Contract Manager, and representatives from the Medicaid Health Management Contractor (WYhealth) attend regularly and participate in projects.
- Meetings with Medicaid, WYhealth, and PHN to identify opportunities to improve coordination of services for CSHCN, pregnant women, and families with children. A draft crosswalk was developed to show how different program services overlapped and each entity has agreed to present on its program services to the workgroup.

The Title V-Title XIX interagency agreement was last updated in 2013. In FFY21, the WY MCH plans to facilitate collaborative discussions regarding current language and proposed updates.

Early Childhood Home Visiting System

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. Parents as Teachers provides infrastructure and leadership for the WYHVN.

Partnership with the University of Wyoming

Wyoming has one university. The Department of Health has a formal Affiliation Agreement with the University of

Wyoming to support internship opportunities for students. In addition, many public health programs have established relationships with faculty and staff to advance public health initiatives. The Community Health Section Chief is leading efforts to further establish partnership opportunities with the WWAMI (Wyoming, Washington, Alaska, Montana, Idaho) Program, which serves as Wyoming's medical school.

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

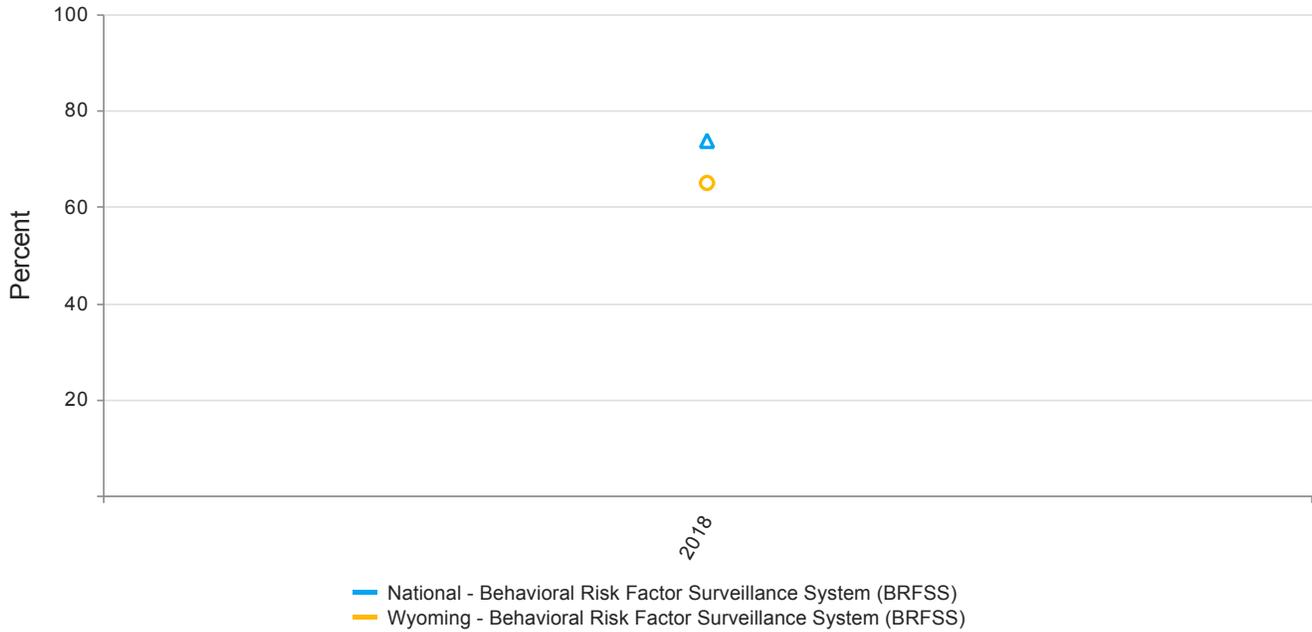
Women/Maternal Health

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-2017	46.3	NPM 1 NPM 14.1
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS-2014_2018	Data Not Available or Not Reportable	NPM 1 NPM 14.1
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2018	9.4 %	NPM 1 NPM 14.1
NOM 5 - Percent of preterm births (<37 weeks)	NVSS-2018	9.8 %	NPM 1 NPM 14.1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2018	27.4 %	NPM 1 NPM 14.1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2017	4.5	NPM 1 NPM 14.1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2017	4.6	NPM 1 NPM 14.1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2017	2.9	NPM 1 NPM 14.1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2017	1.7	NPM 1 NPM 14.1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2017	Data Not Available or Not Reportable	NPM 1 NPM 14.1
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2017	Data Not Available or Not Reportable	NPM 14.1
NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy	PRAMS-2018	3.3 %	NPM 1
NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births	SID-2017	4.4	NPM 1
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2017_2018	90.9 %	NPM 14.1
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2018	20.8	NPM 1
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth	PRAMS-2018	15.7 %	NPM 1

National Performance Measures

**NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year
Indicators and Annual Objectives**



Federally Available Data	
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)	
	2019
Annual Objective	
Annual Indicator	64.8
Numerator	61,481
Denominator	94,822
Data Source	BRFSS
Data Source Year	2018

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective					

Evidence-Based or –Informed Strategy Measures

ESM 1.1 - Number of women ages 18-44 enrolled in the My 307 Wellness App

Measure Status:	Active
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Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	10.0	12.0	14.0	16.0	18.0

ESM 1.2 - Number of women who interact with developed messaging on the well woman visit

Measure Status:	Active
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Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective					

State Performance Measures

SPM 1 - Percent of women who smoke during pregnancy

Measure Status:	Active
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Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective					

State Action Plan Table

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

Priority Need

Prevent Maternal Mortality

NPM

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Objectives

Increase understanding of maternal deaths in Wyoming and develop recommendations for implementation by WY MCH and/or the WYPQC.

Strategies

Stand up a joint state Maternal Mortality Review Committee with the Utah Department of Health and develop Wyoming specific protocols.

ESMs

Status

ESM 1.1 - Number of women ages 18-44 enrolled in the My 307 Wellness App

Active

ESM 1.2 - Number of women who interact with developed messaging on the well woman visit

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 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy

NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births

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

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

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

Priority Need

Prevent Maternal Mortality

NPM

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Objectives

Increase awareness of the importance of an annual well woman visit

Strategies

Develop culturally appropriate communication campaign(s) on the importance of a well woman visit

ESMs

Status

ESM 1.1 - Number of women ages 18-44 enrolled in the My 307 Wellness App

Active

ESM 1.2 - Number of women who interact with developed messaging on the well woman visit

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 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy

NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births

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

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

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

Priority Need

Prevent Maternal Mortality

NPM

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Objectives

Improve the mental health infrastructure for women of reproductive age

Strategies

Work with Medicaid, the Behavioral Health Division and other partners to conduct a gap analysis and map of the current mental health infrastructure for women of reproductive age in Wyoming.

ESMs

Status

ESM 1.1 - Number of women ages 18-44 enrolled in the My 307 Wellness App

Active

ESM 1.2 - Number of women who interact with developed messaging on the well woman visit

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 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy

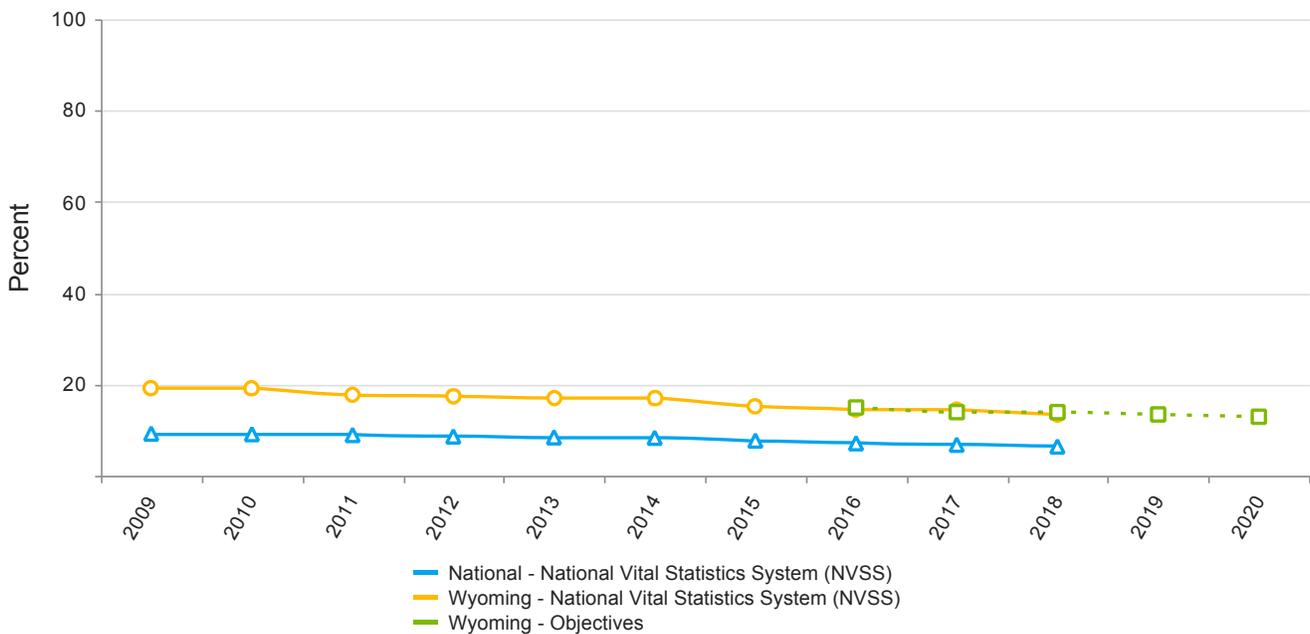
NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births

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

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

2016-2020: National Performance Measures

2016-2020: NPM 14.1 - Percent of women who smoke during pregnancy
Indicators and Annual Objectives



Federally Available Data**Data Source: National Vital Statistics System (NVSS)**

	2016	2017	2018	2019
Annual Objective	15	14	14	13.5
Annual Indicator	15.2	14.6	14.4	13.4
Numerator	1,148	1,043	968	859
Denominator	7,540	7,152	6,735	6,404
Data Source	NVSS	NVSS	NVSS	NVSS
Data Source Year	2015	2016	2017	2018

State Provided Data

	2016	2017	2018	2019
Annual Objective	15	14	14	13.5
Annual Indicator	13.5	11.2		
Numerator				
Denominator				
Data Source	PRAMS	PRAMS		
Data Source Year	2015	2016		
Provisional or Final ?	Final	Final		

2016-2020: Evidence-Based or –Informed Strategy Measures

2016-2020: ESM 14.1.1 - # of pregnant women referred to the WY Quitline services from Healthy Baby Home Visitation

Measure Status:		Active		
State Provided Data				
	2017	2018	2019	
Annual Objective			25	
Annual Indicator			16	
Numerator				
Denominator				
Data Source			WY Quitline	
Data Source Year			2019	
Provisional or Final ?			Provisional	

2016-2020: ESM 14.1.2 - # of providers trained on SCRIPT implementation

Measure Status:		Active		
State Provided Data				
	2017	2018	2019	
Annual Objective			7	
Annual Indicator			7	
Numerator				
Denominator				
Data Source			Program Data	
Data Source Year			FFY19	
Provisional or Final ?			Final	

2016-2020: State Performance Measures

2016-2020: SPM 6 - Use of most/moderately effective contraception by postpartum women

Measure Status:		Active		
State Provided Data				
	2017	2018	2019	
Annual Objective			66	
Annual Indicator			66.4	
Numerator			3,517	
Denominator			5,296	
Data Source			PRAMS	
Data Source Year			2018	
Provisional or Final ?			Provisional	

Women/Maternal Health - Annual Report

Annual Report Fiscal Year 2019: This section provides a summary of Federal Fiscal Year 2019 (FFY19) 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

Health care 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, helps women 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 they are often not accessible or offered to women as a contraceptive choice.

The Wyoming Pregnancy Risk Assessment Monitoring Survey (PRAMS) aggregate data for 2016-2018 show that 25.8% of live births in Wyoming were the result of unintended pregnancies and 15.5% of women indicated that they were not sure what they wanted before becoming pregnant.

One July 2020 public input survey respondent stated, "When families have the resources they need to plan, prepare, and space their family planning needs it helps the whole community."

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

The Women and Infant Health Program (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 working group 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 a 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. Although the working group identified billing workarounds, none were sustainable. In early 2019, the LARC workgroup decided to pause efforts to unbundle billing codes for IPP LARC in hospital settings until Wyoming Medicaid completed diagnosis-related group (DRG) implementation. Instead, the LARC workgroup focused efforts on federally qualified health centers (FQHCs) and rural health clinics (RHCs).

Strategy 2: Develop an IPP LARC Toolkit

The LARC working group worked on developing a LARC Toolkit for providers to access in a virtual space, which will be seen as a living document upon completion. This document will provide videos, guided steps, and billing information for providers at FQHCs, RHCs, and other clinics that perform outpatient LARC insertions.

Strategy 3: Complete a cost analysis on LARC versus unintended pregnancy in Wyoming; Strategy 4: Change Medicaid policies related to LARC reimbursement in hospitals (IPP LARC), RHCs, FQHCs, and Indian Health Service (IHS) (Global LARC)

In order to further focus efforts on the reimbursement challenges of LARCs, 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 funded a cost analysis on the use of LARCs versus the cost of an unintended pregnancy in Wyoming. The cost analysis demonstrated the need for unbundling the cost of LARC devices in FQHCs, RHCs, and hospital settings under both public and private insurance. Due to barriers around bundled codes in the hospital setting, WIHP focused 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 state’s most rural and frontier locations. WY MCH 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.

Wyoming Medicaid agreed to apply for a State Plan Amendment (SPA) with the Centers for Medicare and Medicaid Services (CMS) to unbundle the billing codes for outpatient LARC insertion at FQHCs and RHCs upon completion of the cost analysis and white paper. However, CMS notified Wyoming Medicaid that an SPA was not necessary, opening the door for outpatient LARCs to be provided in FQHCs and RHCs across the state.

A Medicaid Bulletin released in January 2020 notified providers of the new billing practice in FQHCs and RHCs. LARC insertion training took place on January 30-31, 2020 in Casper, WY with the assistance of the Family Planning National Training Center with 23 attendees, including Wyoming providers, out-of-state regional providers, and providers from the military base.

SPM 6, 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. According to Wyoming PRAMS, between 2016 and 2018, 68.0% of postpartum women in Wyoming, at risk for pregnancy, and excluding those who reported they were not currently sexually active, also reported they were using the most or moderately effective form of contraception. The MCH Epidemiology Program also tracks 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	<ul style="list-style-type: none"> 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

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 infants, including low birth weight,

increased risk of premature birth, and increased risk of sudden unexplained infant death (SUID).

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

WIHP provided training at the Wyoming Public Health Association annual conference in September 2018 on SCRIPT implementation; eight public health providers, including six public health nurses (PHNs), were trained on SCRIPT implementation. Sweetwater County Public Health expressed plans to implement SCRIPT in their home visitation program, with data on this effort to be collected through the Healthy Baby Home Visitation program through the new PHN electronic health record, WebChart, which was implemented in late 2018. Currently, due to turnover, no MCH staff are trained in SCRIPT.

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

WIHP is 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, WY MCH requires PHNs to ask about smoking status at every home visit and refer smoking clients to the Wyoming Quitline. 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 who call the Wyoming Quitline. The Quitline is an evidence-based strategy for quitting tobacco. Wyoming has an incentive program for enrollment in the program during pregnancy, and the incentives are currently being increased. The incentives are prepaid gift cards worth \$10 for calls completed while pregnant and \$20 for calls completed postpartum. In FFY19, 16 pregnant women were referred to the pregnant women Quitline services.

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

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

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 Levels of Care Assessment Tool (LOCATe) results and identified opportunities to improve maternal emergency protocols and drills. Wyoming is not an AIM state and therefore cannot directly participate in AIM work, but the partnership with Utah allows Wyoming hospitals to participate. 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. Wyoming facilities were invited to participate in the closing, in-person meeting held in Salt Lake City, UT in March 2020.

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 AIM 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 latter safety bundle based on feedback from both Wyoming and Utah hospitals and held a kick-off in-person meeting in Salt Lake City, UT in March 2020. Six birthing facilities from Wyoming chose to participate in this safety bundle and the WIHP covered the cost of travel to the in person meeting kick off for up to two staff per hospital. The WIHP continues to work closely with the Utah Perinatal Quality Collaborative Coordinator to ensure the ECHO topics are relevant for Wyoming facilities, laws, and systems-level infrastructures. This coordination effort led to a Wyoming Department of Family Services policy webinar. Due to Covid-19 the series has dropped down to monthly, but is looking to go back to twice a month beginning in the Fall of FFY21.

Strategy 2: Offer provider training on safe prescribing to reduce opioid use/misuse in pregnancy and postpartum periods

In early FFY19, WIHP started work on training healthcare providers on safe prescribing of opioids during pregnancy and postpartum in partnership with the WDH Public Health Preparedness and Response Unit (PHPR) and their Cooperative Agreement for Emergency Response: Public Health Crisis Response funding. The October 2019 training helped providers meet a new legislative requirement of receiving three continuing medical education (CME) hours on safe prescribing every two years. WIHP worked with partners at tertiary care facilities in Colorado to identify trainers: Dr. Kaylin Klie from Colorado Children's Hospital and Dr. Lesley Brooks from the Northern Colorado Health Alliance. The training was advertised widely with assistance from the Wyoming Perinatal Quality Collaborative (WYPQC), and CMEs were provided through the Cheyenne Regional Medical Center. Attendance was regional to Cheyenne but also attracted attendance from staff from the local military base. Thirteen providers attended the training with eleven filling out surveys. A majority of attendees appreciated the CME credits that were provided.

Through the same partnership with PHPR and their public health crisis response funding, WIHP released 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. WY MCH leveraged Title V funds and crisis funds to support grants for two Wyoming hospitals to join the Colorado Substance Exposed Newborns (CHoSEN) Hospital Learning Collaborative. This collaborative assists hospitals and their staff in changing hospital policies around the treatment of women with opioid use disorder and their substance exposed infants. It also encourages hospitals to adopt the Eat, Sleep, Console rooming-in model of care for infants who are diagnosed with Neonatal Abstinence Syndrome (NAS).

In November 2019 the WYPQC, Iverson Memorial Hospital (Laramie, WY), and Wyoming Medical Center (Casper, WY) sent staff to Glenwood Springs, CO for a kick-off meeting of the CHoSEN Hospital Learning Collaborative, a project offered through a partnership with the Children's Hospital of Colorado, Illuminate Colorado, and the Colorado Perinatal Care Quality Collaborative. The two participating hospitals signed data use agreements in order to enter their maternal opioid use disorder and neonatal abstinence rate data into RedCap. As part of their CHoSEN work, one hospital grantee hosted an Eat, Sleep, Console training for their entire labor and delivery staff as well as a few staff from two other state birthing hospitals on January 16, 2020. This same hospital was also able to utilize grant funding to create a "Stork Closet" to provide high-risk mothers and families with car seats, clothing, diapers, and other needed items. The community has gotten behind the project and donated money and goods to continue to keep the Stork Closet open. Both hospitals have used funds to provide training for staff and improve labor and delivery systems. Due to COVID-19 response both hospitals have had to put this project temporarily on hold, but they still have policies in place to attempt to continue to serve women and infants with opioid use disorder who enter their care based on new protocols.

Prior to COVID-19 at least two other hospitals were interested in joining the CHoSEN project without receiving funding from the WIHP. Due to COVID-19 response those plans to fully participate have been put on hold.

Additional WIHP Activities:

OMNI:

In late summer 2019, WY MCH applied to join the second cohort of the Association of State and Territorial Health Officials (ASTHO) Opioid Use Disorder, Maternal Outcome, Neonatal Abstinence Syndrome (OMNI) Learning Community. The Wyoming team consisted of the State Health Officer, the Medicaid Medical Director, the MCH Unit Manager, a representative from the Wyoming Department of Family Services, and two provider champions.

The Wyoming team sent seven representatives to attend the in-person meeting kick-off in Washington, D.C. in August 2019. During this meeting the Wyoming team created an action plan to implement Plans of Safe Care in accordance with the federal CARA/CAPTA laws, implement implicit bias training for WDH staff and providers, and pilot universal verbal screening of pregnant women for substance use disorder in two clinics in Wyoming. Through collaborative efforts with the Department of Family Services, a contract is now in place to have the Public Health Nurse Home Visitation Program implement plans of safe care for clients enrolled in the program.

Due to COVID-19 this Learning Community has been put on hold, as have the implicit bias training and piloting of the universal verbal screening tool. The literature states that implicit bias training is more successful when done in person, which is not possible at present.

Maternal High Risk (MHR) Program

The MHR Program ensures high-risk pregnant women have access to care coordination services and limited gap-filling financial assistance to enhance perinatal outcomes. Promotion of this program further supports 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 this essential gap-filling program come from providers around the state, as well as from our tertiary care facilities that are attending high-risk births from Wyoming mothers. The MHR program served 24 high risk pregnant women in FFY2019. The WIHP plans to increase program referrals through increased education and outreach to the Public Health Nursing Offices and to providers through the WYPQC.

Maternal Mortality Review

Over the past two years, the CDC-assigned MCH Epidemiologist closely evaluated Wyoming's maternal mortality data, including evaluating the use of the pregnancy check box on death certificates and developing a plan for case finding. Through work with the Wyoming Vital Statistics Services (VSS) office, the epidemiologist coordinated changes to the pregnancy check box to ensure more accurate data and participated in 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 March 2019, the CDC released a funding opportunity for existing Maternal Mortality Review Committees (MMRCs). The Utah Department of Health and WDH jointly applied for CDC MMRC funding (Utah was lead applicant) and included a subrecipient budget to support Wyoming efforts. Utah and Wyoming were awarded funding from the CDC ERASE MM Grant for five years beginning October 1, 2019. After the grant was awarded the two state teams established monthly check-ins with each other and their CDC project officer to help coordinate efforts on this cross-state initiative. This grant award marked a significant success for WY MCH by building capacity to review maternal deaths for the first time in the program's history and establishing an important cross-state partnership with Utah.

As part of the ERASE MM grant, Wyoming sent the WIHPM and CDC-assigned MCH Epidemiologist to Atlanta, GA in December 2019 to attend a required Maternal Mortality Review Information Application (MMRIA) User Meeting. The contract between WY MCH and the Utah Department of Health formally establishing the joint MMRC was executed in April 2020. Following a Request for Application (RFA) process, the University of Wyoming Fay W. Whitney School of Nursing was selected to provide case abstraction services and a contract was also executed in April 2020. In June 2020, the memorandum of understanding and data sharing agreement between WY MCH and the CDC for the use of the MMRIA system were executed. In June 2020, the WIHPM released an RFA to recruit Wyoming MMRC members. The Wyoming committee is made up of five members: the case abstractor, the CDC-assigned MCH Epidemiologist, the WIHP Manager, the Medicaid Medical Director, and a family physician. The committee will also have ad hoc members that currently represent Public Health Nursing and Labor and Delivery Nurse Managers. Wyoming cases will be reviewed at the first joint Utah-Wyoming MMRC meeting in October 2020.

Due to COVID-19 all reviews have been moved online, and several in-person conferences, including a planned Native Maternal Health Conference on the Wind River Indian Reservation and a Utah Maternal Mortality Summit, were cancelled. The CDC has been able to continue to host training sessions for essential MMRC state staff in a virtual space.

Women/Maternal Health - Application Year

Application Year Plan (FFY21): This section presents strategies/activities for 2021-2025 MCH priorities related to Women/Maternal Health. See Five-Year State Action Plan Table for more information.

Priority	Performance Measure	ESM (if applicable)
Prevent Maternal Mortality	NPM 1: % of women, ages 18-44, with a preventive medical visit in the past year	ESM 1.1: # of women ages 18-44 enrolled in the My 307 Wellness App ESM 1.2: # of women (18-44) interacting with developed messaging in regards to the well-women visit and its importance on the My 307 Wellness App

Maternal mortality is an indicator of health and health care quality. Maternal deaths can be prevented or reduced by improving both underlying maternal health and health care quality for leading causes of maternal death.

There are several national performance measures (NPMs) mapped to maternal mortality with NPM 1, well woman visit, being broad enough to touch on several topics that affect maternal outcomes during pregnancy and up to one year postpartum. These topics include mental health screening, preconception care, and substance use disorder care in the pre- and postnatal period. The American College of Obstetricians and Gynecologists stated in Committee Opinion 755 that the well woman visit is not only important for discussing maintaining healthy lifestyles and mitigating health risks, but also for performing screenings, evaluations, and counseling.

Of women respondents to a July 2020 public input survey, thirty-nine percent indicated that there are barriers that make it hard for them to see a doctor every year. Cited barriers included cost, lack of childcare, lack of insurance, needing to travel due to a lack of providers or specialists in the area, lack of female providers in the area, and needing to take time off work / limited after-work appointment slots.

In FFY21, the Women and Infant Health Program (WIHP) will implement the following strategies to address NPM 1:

1. Develop a culturally appropriate communication campaign using the My 307 Wellness app in the first year, with the potential to expand the campaign to other social media sources as MCH-specific pages are developed, to communicate the importance of a well woman visit for all women of reproductive age. The My 307 Wellness app is a phone application that residents of Wyoming can use to learn more about their health and receive alerts on when it is time to schedule an exam with their primary care provider.
2. Conduct a gap analysis and map out Wyoming’s current mental health infrastructure for women of reproductive age in collaboration with partners such as the Wyoming Behavioral Health Division. The WYPQC will play a large role in conducting this gap analysis along with using Medicaid and PRAMS data to identify and understand screening rates for postpartum depression and other mental illnesses.
3. Stand up a joint state Maternal Mortality Review Committee with the Utah Department of Health, create Wyoming-specific review protocols, and develop recommendations based on bi-annual reviews. The recommendations will be shared with the WYPQC to turn into action for system change.

Eighty-four percent of July 2020 public input survey respondents indicated that they believe WIHP’s planned

women/maternal work for 2021-2025 fits the needs of their community well or very well. One survey respondent stated that WIHP's planned work "will give women access to better care and therefore increase their quality of life." Another indicated, "This work affects each one of us in our communities. The wellness and healthy development of all pregnant mothers and infants is directly related to the future of all of our communities."

Other Programmatic Activities

Wyoming Perinatal Quality Collaborative (WYPQC)

The WIHP Manager will continue to provide support to the development and ongoing work of the WYPQC, including providing funding for a WYPQC Coordinator, meeting facilitation, and ongoing data support.

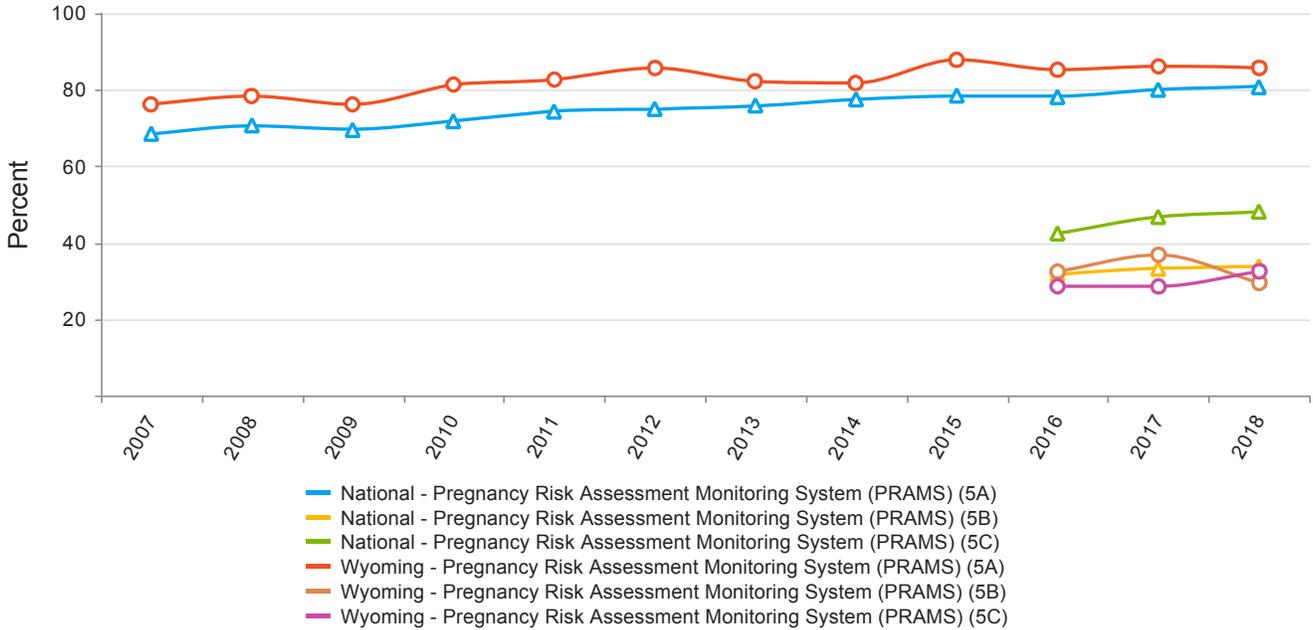
Perinatal/Infant Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2017	4.6	NPM 4 NPM 5
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2017	1.7	NPM 4 NPM 5
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2017	Data Not Available or Not Reportable	NPM 4 NPM 5

National Performance Measures

**NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding
Indicators and Annual Objectives**



NPM 5A - Percent of infants placed to sleep on their backs

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2019
Annual Objective	
Annual Indicator	85.7
Numerator	5,251
Denominator	6,130
Data Source	PRAMS
Data Source Year	2018

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective					

NPM 5B - Percent of infants placed to sleep on a separate approved sleep surface

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2019
Annual Objective	
Annual Indicator	29.6
Numerator	1,775
Denominator	5,999
Data Source	PRAMS
Data Source Year	2018

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective					

NPM 5C - Percent of infants placed to sleep without soft objects or loose bedding

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2019
Annual Objective	
Annual Indicator	32.6
Numerator	1,928
Denominator	5,918
Data Source	PRAMS
Data Source Year	2018

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective					

Evidence-Based or –Informed Strategy Measures

None

State Performance Measures

SPM 1 - Percent of women who smoke during pregnancy

Measure Status:	Active
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Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective					

State Action Plan Table

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

Priority Need

Prevent Infant Mortality

NPM

NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Objectives

Understand data related to safe sleep in order to target training

Strategies

Utilize PRAMS data to identify disparities in safe sleep practices for Wyoming families that use the home visitation program. Offer provider training on safe sleep using a health equity lens.

ESMs

Status

ESM 5.1 - Among PRAMS respondents reporting having had a home visit, % who report their baby sleeps on a separate approved sleep surface	Active
ESM 5.2 - Among PRAMS respondents reporting having had a home visit, % who report their baby sleeps without soft objects or loose bedding.	Active
ESM 5.3 - Percent of PRAMS respondents reporting their provider spoke to them about safe sleep	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 women who smoke during pregnancy

Objectives

Increase referrals to all smoking cessation programs in WY Increase the number of women who enroll in the Wyoming Quitline

Strategies

Survey providers and Public Health Nurses to learn about screening/referral efforts for women of reproductive age, partners and families who use tobacco products. Use survey results to inform education/training.

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

Priority Need

Prevent Infant Mortality

Objectives

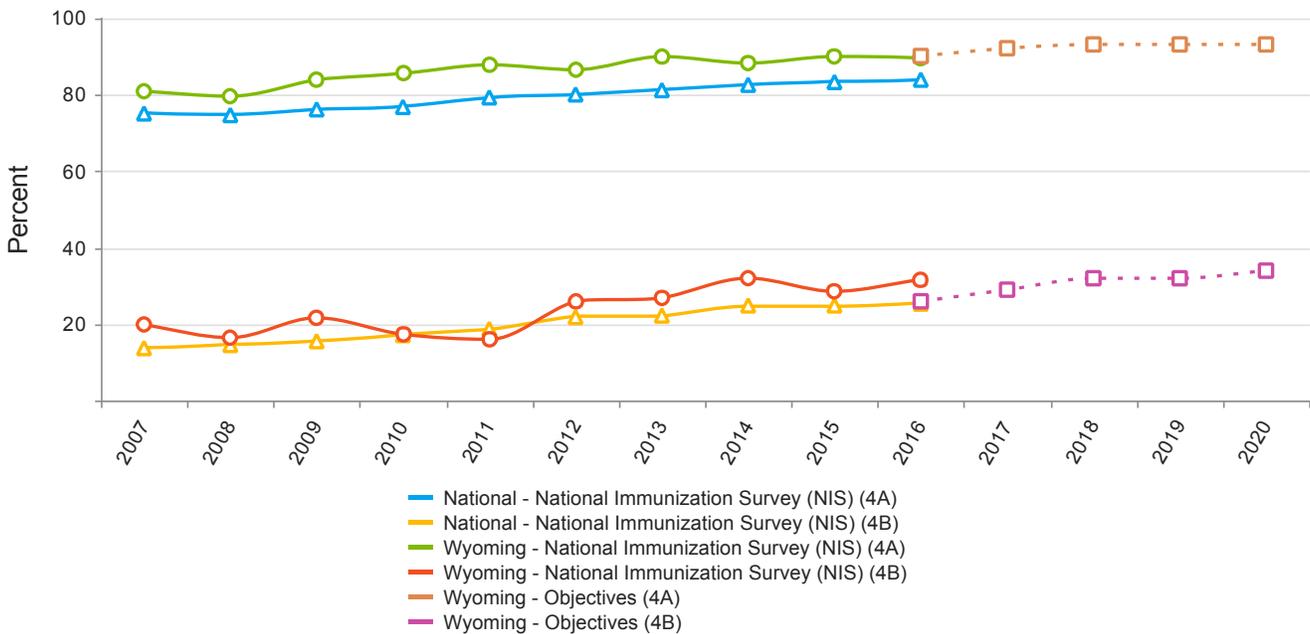
Evaluate capacity to implement FIMR at the state or county level

Strategies

Hold several meetings with county and state level partners to determine if FIMR should be conducted at the state or county level. Begin implementation during five-year cycle.

2016-2020: National Performance Measures

2016-2020: NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months
Indicators and Annual Objectives



2016-2020: NPM 4A - Percent of infants who are ever breastfed

Federally Available Data**Data Source: National Immunization Survey (NIS)**

	2016	2017	2018	2019
Annual Objective	90	92	93	93
Annual Indicator	89.7	88.3	90.0	89.6
Numerator	5,817	5,853	6,269	4,671
Denominator	6,486	6,628	6,963	5,216
Data Source	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016

State Provided Data

	2016	2017	2018	2019
Annual Objective	90	92	93	93
Annual Indicator	91	90.7		
Numerator				
Denominator				
Data Source	PRAMS	PRAMS		
Data Source Year	2014	2016		
Provisional or Final ?	Final	Final		

2016-2020: NPM 4B - Percent of infants breastfed exclusively through 6 months

Federally Available Data				
Data Source: National Immunization Survey (NIS)				
	2016	2017	2018	2019
Annual Objective	26	29	32	32
Annual Indicator	27.0	32.0	28.8	31.4
Numerator	1,693	2,049	1,959	1,578
Denominator	6,263	6,412	6,790	5,027
Data Source	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016

2016-2020: Evidence-Based or –Informed Strategy Measures

2016-2020: ESM 4.4 - Number of Hospitals Participating in the Wyoming 5-Steps to Breastfeeding Success Program

Measure Status:		Active		
State Provided Data				
	2017	2018	2019	
Annual Objective	4	4	0	
Annual Indicator	4	4	0	
Numerator				
Denominator				
Data Source	Women and Infant Program	Women and Infant Health Program	Women and Infant Health Program	
Data Source Year	2017	2018	2019	
Provisional or Final ?	Final	Final	Final	

2016-2020: 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		
State Provided Data				
	2017	2018	2019	
Annual Objective			100	
Annual Indicator			100	
Numerator			4	
Denominator			4	
Data Source			Program Data (self report from hospitals)	
Data Source Year			CY 2018	
Provisional or Final ?			Final	

2016-2020: ESM 4.7 - Percent of counties that have at least one public health nurse trained as a Certified Lactation Consultant (CLC)

Measure Status:		Active		
State Provided Data				
	2017	2018	2019	
Annual Objective			90	
Annual Indicator			100	
Numerator			23	
Denominator			23	
Data Source			Public Health Nursing Program Data	
Data Source Year			SFY 2020	
Provisional or Final ?			Provisional	

2016-2020: State Performance Measures

2016-2020: 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	2019
Annual Objective		54	70	80
Annual Indicator	51.9	68	80.6	73.6
Numerator	42	68	50	53
Denominator	81	100	62	72
Data Source	Wyoming Vital Statistics Services			
Data Source Year	2015	2016	2017	2018
Provisional or Final ?	Final	Final	Final	Final

Perinatal/Infant Health - Annual Report

Annual Report Fiscal Year 2019: This section provides a summary of Federal Fiscal Year 2019 (FFY19) 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)
<p>Improve Breastfeeding Duration</p>	<p>NPM 4: A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months</p>	<ul style="list-style-type: none"> • 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 months and encourages breastfeeding through at least the infant’s first birthday in order to maximize health benefits associated with breastfeeding. Breastfed infants are less likely to develop diabetes or obesity and mothers who breastfeed lower their risk of breast cancer, ovarian cancer, diabetes, and heart disease.

- 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 public health nurses (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 PHNs as CLCs. The goal is to have a CLC-trained nurse in all 23 Wyoming counties, and in FFY19, 100% of counties had a CLC-trained nurse. CLC-trained nurses are able to provide breastfeeding and lactation support, including assessing the latching and feeding process, providing corrective interventions, counseling mothers, and understanding and applying knowledge of milk production. This effort supports new mothers through the challenges and uncertainty around breastfeeding, and it helps to increase the number of new mothers who are able to breastfeed successfully. Where possible, the WIHPM partners with PHN and the Women, Infants, and Children (WIC) Unit to coordinate in-state CLC trainings so that both WIC and PHN staff may benefit.

Through the ongoing collaboration between PHN and WY MCH, breastfeeding practices and support are offered through the Healthy Baby Home Visitation (HBHV) program. The HBHV Program is delivered by PHNs in all 23 counties in Wyoming to pregnant and postpartum mothers and their families. Through an MOU with WY 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, and 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; 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% of infants who are ever breastfed as far back as 2007. The Wyoming 5-Steps to Breastfeeding Success was launched in 2017 and provided mini-grants to four hospitals to use evidence-based methods to increase breastfeeding initiation and duration. All funded hospitals participated in required technical assistance calls with WDH, and 100% of grantees reported an improvement from baseline on a hospital self-assessment. Due to ongoing success in breastfeeding rates statewide, limited capacity and resources, and staff turnover, the WIHP did not release a second RFA and has not developed a Wyoming 5-Steps to Breastfeeding Success hospital recognition program. The WIHPM will remain available to hospitals to provide technical assistance as needed to support ongoing facility-specific breastfeeding improvement activities.

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 CDC's Maternity Practices in Infant Nutrition and Care (mPINC) Survey, Pregnancy Risk Assessment Monitoring System (PRAMS), and Wyoming Vital Statistics 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. The Wyoming team consulted AMCHP as well as Wyoming hospitals to inform poster content development. In early 2019, the Wyoming team 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.

Breastfeeding in Wyoming Hospitals Opportunities and Successes

Breastfeeding supports healthier moms and babies. Mom's first breastfeeding experience is in the hospital.



The Wyoming 5-Steps to Breastfeeding Success outlines areas of **opportunity** for hospitals to contribute to **breastfeeding success**.

<p>Mom is informed about benefits and management of breastfeeding.</p> <p> 13% of hospitals report staff receive appropriate breastfeeding education.</p> <p>93% of moms said WY hospital staff gave them information on breastfeeding.</p>	1
<p>Infant receives no food/drink in the hospital other than breast milk. (unless medically indicated)</p> <p>35% of hospitals report supplemental feedings to infants are rare.</p> <p> "The greatest bond is the ability to feed/nurse my baby! I recommend breastfeeding for all mothers." -WY PRAMS mom</p>	2
<p>Infant stays in same room with mom in the hospital.</p> <p> 97% of moms stayed in the same room with their baby in WY hospitals.</p>	3
<p>Infant does not use a pacifier in the hospital.</p> <p>1 in 4 hospitals rarely provide pacifiers to breastfeeding infants.</p> <p>100% of Wyoming 5-Steps grantees implemented policies related to restricted pacifier use.</p> <p></p>	4
<p>Mom is given a telephone number to call for help with breastfeeding. (after discharge)</p> <p>79% of moms got a phone number from WY hospitals for breastfeeding help.</p> <p> "The lactation consultant was amazing! If it wasn't for her, I wouldn't be breastfeeding..." -WY PRAMS mom</p>	5
<p>The Wyoming Department of Health is committed to supporting work that sustains breastfeeding success in Wyoming hospitals. If your facility is interested in getting assistance with implementing the Wyoming 5-Steps to Breastfeeding Success program, we can help!</p> <p> Wyoming Department of Health</p> <p>For more information contact: Christina Taylor, MPH christina.taylor@wyo.gov 307-777-7944 Published November 2018</p>	

For more information on the data provided, please visit: health.wyo.gov/public-health/health-promotion-and-prevention/health/breastfeeding-5-steps/

Additional Strategies:

Develop a WDH breastfeeding at work policy in collaboration with Wyoming WIC

From 2017 to present, the WIHP has worked closely with the Wyoming WIC Unit to create a breastfeeding at work policy to support working parents employed by WDH and to promote increased breastfeeding duration. Approximately 35% of the WDH workforce is made up of women of childbearing age. This policy has the potential to positively impact a large portion of new mothers in the state by modeling positive breastfeeding support practices to the larger community and other organizations. The WIHP and WIC Unit modeled the draft policy after other state health departments that have demonstrated success in breastfeeding support among their staff. It also better outlines WDH accommodations that have been put in place to support lactating women in the workplace, including the

provision of hospital-grade pumps and compatible pump kits by WY MCH, access to lactation rooms in state offices, and information on Fair Labor Standards Act (FLSA) policies that protect breastfeeding parents.

The draft policy was reviewed by Public Health Division leadership but due to changing WDH leadership and other emerging priorities, the policy was not adopted. WY MCH and WIC continue to support and implement workplace improvements to encourage breastfeeding duration, such as ensuring every floor in the new state office buildings have mothers rooms with new chairs for lactating women to use as well as a refrigerator to store expressed breastmilk. WY MCH and WIC also worked closely with Human Resources to make sure federal and state breastfeeding laws are discussed during new hire orientation.

Priority	Performance Measure	ESM (if applicable)
Prevent 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 1970s 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

WY MCH provided interested hospitals with a draft LOCATe report and had them meet with the CDC-assigned MCH Epidemiologist to discuss their assessments. This epidemiologist linked LOCATe data with hospital discharge data to examine pregnancy complications and the existence of maternal emergency hospital protocols and drills.

A success related to risk-appropriate perinatal care is evident in two of Wyoming’s largest hospitals signing alliance agreements with a neighboring state children’s hospital to ensure a formal process for consultation and transport. According to these hospitals this alliance has enabled the hospitals to reduce the number of neonatal transports, as well as better coordinate back-transports for infants and children who meet the criteria for a step-down in the level of care. One hospital has a teleneonatology service as part of this alliance agreement that has been in place since October 1, 2019. While this particular service is not used often, the hospital stated it gives providers confidence that they have support if needed. Through the teleneonatology service this hospital now has a neonatologist on staff who is able to review cases and provide feedback to improve care. Both hospitals also receive constant training from this children’s hospital, which has benefited both provider and nursing staff. One hospital also benefits from residency referrals, which help with acuity at the hospital.

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.

No plans are in place to repeat the LOCATe tool; however, this remains a possibility during the 2021-2025 grant cycle.

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

Through Wyoming’s risk-appropriate care work, WIHP formed a partnership with the Utah Department of Health, specifically around their AIM maternal safety bundles. In 2018 six of the twenty-three Wyoming birthing hospitals joined the AIM Maternal Hypertensive Emergencies Safety Bundle. This safety bundle was important due to the increased rate of maternal mortality seen in the U.S., and hypertensive emergencies can lead to neonatal mortality or morbidity as well. This safety bundle closed with an in-person meeting in Salt Lake City in March 2020 with representatives from all six Wyoming hospitals participating.

Strategy 3: Develop a Wyoming Perinatal Quality Collaborative (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. In 2018 the WYPQC held a retreat and created a vision statement, mission statement, and core principles to help guide the collaborative’s operations.

Wyoming Perinatal Quality Collaborative (WYPQC)

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

Mission: The 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

The WIHP released an RFA for coordination of the WYPQC in late 2018, and in April 2019 awarded a contract to Brenda Burnett, RN, MSN, PCMH CCE, of Brenda Burnett Clinical Consulting LLC. Ms. Burnett brought with her a wealth of clinical expertise in perinatal issues, as well as project management and quality improvement experience. Brenda facilitated the WYPQC through meetings and project planning, coordinated communication and activities, developed toolkits and outreach materials for projects, and ensured ongoing engagement and recruitment of project partners and stakeholders. Brenda maintained her contract through December 2019; the WIHP is currently in the process of rehiring for the position. In late 2019, the WIHP released a call for nominations for WYPQC leadership roles, including Co-Chair. In December 2019 WYPC elected Erin McKinney, RN, MSN to serve as Chair; she also serves as Clinical Director of Women & Children’s Services at Cheyenne Regional Medical Center in Cheyenne.

The WYPQC meets quarterly providing updates from WIHP and reports from hospitals that are engaged in substance use disorder work, educational discussion from other programs that affect the maternal and infant population, and discussions on next steps for the collaborative.

Strategy 4: Implement Fetal and Infant Mortality Review (FIMR) in pilot community

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 stakeholder engagement the expansion of a FIMR either at the state or county level will be explored through FFY21. The WYPQC will be imperative in the exploratory process and the WIHPM has been coordinating efforts with other mortality reviews within Wyoming to discover any duplicative efforts. Training materials from the previous FIMR work are still available to train potential FIMR members and The National Center for Fatality Review and Prevention has offered technical assistance for this project. Considerations for continuing this project include resources, staff capacity, local level interest, data support capacity, legal authority and protections, and opportunities to coordinate efforts with other death reviews.

Additional Strategies:

Award Childhood Injury Prevention Mini-Grants

WY MCH funded seven organizations to implement evidence-based strategies to prevent childhood injury. WIHP provided technical assistance to two counties (Uinta and Johnson) on activities related to improving safe sleep and infant fall prevention. These counties worked on improving knowledge of crib safety and provided safe sleep education to caregivers in their respective communities.

Promote the MCH Unit's Newborn Intensive Care (NBIC) Program

The NBIC Program ensures high-risk infants and their families have access to care coordination services and limited gap-filling financial assistance to enhance perinatal and infant outcomes. Promotion of this program further supports 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 this gap-filling program come from providers around the state, as well as from our out-of-state tertiary care facilities with NICUs. The NBIC program served 83 high risk infants in FFY2019. The WIHP plans to increase program referrals through increased education and outreach to the Public Health Nursing Offices and to providers through 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 FFY18/19, In August 2019, the Wyoming Newborn Screening Advisory Committee met to vote on changes to the current Rules and Regulations to improve program operations. The committee voted to increase the fee from \$84.00 to \$97.32 and add Spinal Muscular Atrophy (SMA) to the Wyoming Newborn Screening Panel. The Newborn Screening Program (NBS) then drafted Rules to include adding a public URL to view the types of conditions included in the Wyoming Newborn Screening Panel, add a section requiring qualified healthcare professionals to collect a second newborn screen between seven and fourteen days after birth, add clarifying language to the informed consent section that covers initial and second blood spot specimens, and give the program the authority to increase the fee by 25% should the program necessitate it. The WIHP also decided to pay for courier services via FedEx for midwives who collect the blood spot specimens in Wyoming to ensure that the specimens reach the testing laboratory in a timely manner. At present, the Governor of Wyoming has the proposed Rules to sign, and they will be

effective once he does so.

In December 2019 the courier that transported newborn screening specimens from every birthing facility in Wyoming to the contracted testing laboratory in Colorado ceased operations suddenly. NBS implemented a stop-gap solution for the birthing facilities to use FedEx to courier the specimens until another courier option could be put into place. A new courier was selected through an RFP process and began operations July 20, 2020.

The NBS program worked with MCH Epidemiology to create a newborn screening dashboard using Tableau data visualization software. The dashboard can pull data on key quality indicators (e.g. collection time, courier time) directly from the feed from the Colorado Department of Public Health and Environment (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. CDPHE identified a data quality issue, which has since been resolved. NBS will work closely with MCH Epidemiology, the Wyoming Hospital Association, hospitals, and other stakeholders to finalize and launch the dashboard. In the meanwhile, the dashboard will be used internally to identify quality improvement needs.

Other WIHP Activities:

Healthy Baby Home Visitation Program

WY MCH partially funds the HBHV Program offered by trained PHNs in all 23 Wyoming counties using Title V matching funds. Through an MOU with WY MCH, each county provides home visitation services and care coordination services for high-risk pregnant women, high-risk infants, and children and youth with special health care needs. Through June 30, 2020, 23 counties delivered the Best Beginnings model based on the Florida State University Partners for a Healthy Baby curriculum and four counties delivered the evidence-based Nurse Family Partnership model. In FFY19, WY MCH partnered with PHN and MCH Epidemiology to research other available evidence-based models that were nurse-delivered and well-suited for a rural/frontier environment. Presentations on models under consideration were held in late 2019 with local PHN staff and WDH leadership. With leadership approval, the PHN Unit is pursuing a contract to deliver the Maternal Early Childhood Sustained Home-Visiting (MECSH) model. As of July 1, 2020, all clients served through Nurse Family Partnership have transitioned to Best Beginnings. Over the next year, all clients served through Best Beginnings will be transitioned to MECSH. WY MCH will continue to provide ongoing support to PHN during this transition.

The Wyoming Home Visiting Network (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 it continues to meet quarterly to ensure ongoing coordination of home visiting services. WYHVN is committed to improving cross-model referrals statewide, and to promoting the available home visiting models in each county through marketing and outreach. In early 2019 the WYHVN also worked to coordinate with PAT to support the MIECHV needs assessment process, and to ensure that the product of the needs assessment reflects the needs of the entire home visiting system in Wyoming.

Perinatal/Infant Health - Application Year

Application Year Plan (FFY21): This section presents strategies/activities for 2021-2025 MCH priorities related to Perinatal/Infant Health. See Five-Year State Action Plan Table for more information.

Sixty-one percent of July 2020 public input survey respondents indicated that they believe infants passing away is at least somewhat of a problem in their community. Of the respondents who indicated that they have an infant in their household, 69% indicated that they believe it is at least somewhat of a problem.

Priority	Performance Measure	ESM (if applicable)
<p>Prevent Infant Mortality</p>	<p>NPM 5: A) % of infants placed to sleep on their backs; B) % of infants placed to sleep on a separate approved sleep surface; C) % of infants placed to sleep without soft objects or loose bedding</p>	<p>ESM 5.1: % of PRAMS moms reporting their baby sleeps on a separate approved sleep surface, who reported having a home visit</p> <p>ESM 5.2: % of PRAMS moms reporting their baby sleeps without soft objects or loose bedding, among moms who reported having a home visit</p> <p>ESM 5.3: % of PRAMS moms reporting their provider spoke to them about safe sleep</p>

Wyoming PRAMS data indicate that the majority of infants in Wyoming often sleep in unsafe sleep environments. From 2016 to 2018, the majority (64.7%) of women in Wyoming reported that in the past two weeks their infant usually slept with a blanket, just under one third (27.7%) reported their infants usually slept on a twin or larger mattress or bed, 14.9% reported their infant slept with crib bumper pads, 11.3% reported their infant usually slept on a couch, sofa, or armchair, and 9.8% of women reported their infant usually slept with toys, cushions, or pillows in the past two weeks. The data also indicate that those women with lower incomes, those who use Medicaid, and those enrolled in WIC were more likely to report their infant usually sleeps in an unsafe environment. While women reported their provider spoke to them about their infants being put to sleep on their back with no difference by race, women who identify as white were less likely to receive information about a safe sleep environment from their providers than women who identify as American Indian or Alaska Native (PRAMS, 2016-2018).

In FFY21, the Women and Infant Health Program (WIHP) will implement the following strategies to address NPM 5:

1. Utilize PRAMS data to identify disparities in safe sleep practices for Wyoming families that use the home visitation program.

2. When disparities are identified, the WIHPM will provide education and resources to providers and public health nurses to promote safe sleep practices in communities using an equity lens. Education and/or resources may include print materials, social media campaigns, virtual provider training, and implicit bias

training.

Priority	Performance Measure	ESM (if applicable)
Prevent Infant Mortality	SPM (NPM 14.1 and 14.2): % of women who smoke during pregnancy; % of children, ages 0-17, who live in households where someone smokes	N/A

Smoking cessation remains a priority for the WIHPM and will be tracked as a State Performance Measure in this new five year grant cycle. A 2019 *Pediatrics* article (Anderson, et. al) found that women who smoke double the risk of their infants dying suddenly. Infants exposed to secondhand smoke also have a higher risk of sudden unexplained infant death (SUID), as well as a higher risk of developing chronic diseases like asthma as they grow older.

In FFY21, the Women and Infant Health Program (WIHP) will implement the following strategies to address the SPM within the Smoking Cessation priority:

1. The WIHPM and partners will develop a training module on screening, referral and treatment best practices in order to improve referrals to the Wyoming QuitLine and participation in other evidence-based smoking cessation programs, such as Smoking Cessation and Reduction in Pregnancy Treatment Program (SCRIPT). The WIHPM will research and promote other available evidence-based smoking cessation programs. This strategy will focus primarily on women of reproductive age, pregnant women, and families experiencing second-hand smoke exposure.

Ninety-one percent of July 2020 public input survey respondents indicated that they believe WIHP's planned perinatal/infant work for 2021-2025 fits the needs of their community somewhat well. One survey respondent stated, "This work affects each one of us in our communities. The wellness and healthy development of all infants is directly related to the future of all of our communities."

Other Programmatic Activities

Fetal, Infant Mortality Review (FIMR)

Through several partner meetings WIHP determined there is a need for a Fetal and Infant Mortality Review (FIMR) in Wyoming. A FIMR will be crucial to better understand Wyoming's fetal and infant deaths. In FFY21 state and local partners will meet to learn about the national FIMR model and decide whether a statewide review or local reviews would work best for Wyoming. WIHP will compile lessons learned from the Fremont County pilot implementation and work closely with other state and local death review programs to ensure coordination.. All efforts will be made to ensure cross-model collaboration and statewide dissemination of best practices related to death review implementation, with the National Center for Fatality Review & Prevention agreeing to assist Wyoming with any technical assistance needs for this program.

Newborn Screening

The Wyoming Newborn Screening Program will launch hospital and provider educational initiatives to ensure that providers understand Wyoming's newborn screening statute and that screenings are done in a timely and accurate

manner. Technical assistance for quality improvement projects will be offered. In FFY2021 The Newborn Screening Program will also launch dashboards to help hospitals and midwives better understand their timeliness of screening and correct data collection for clients.

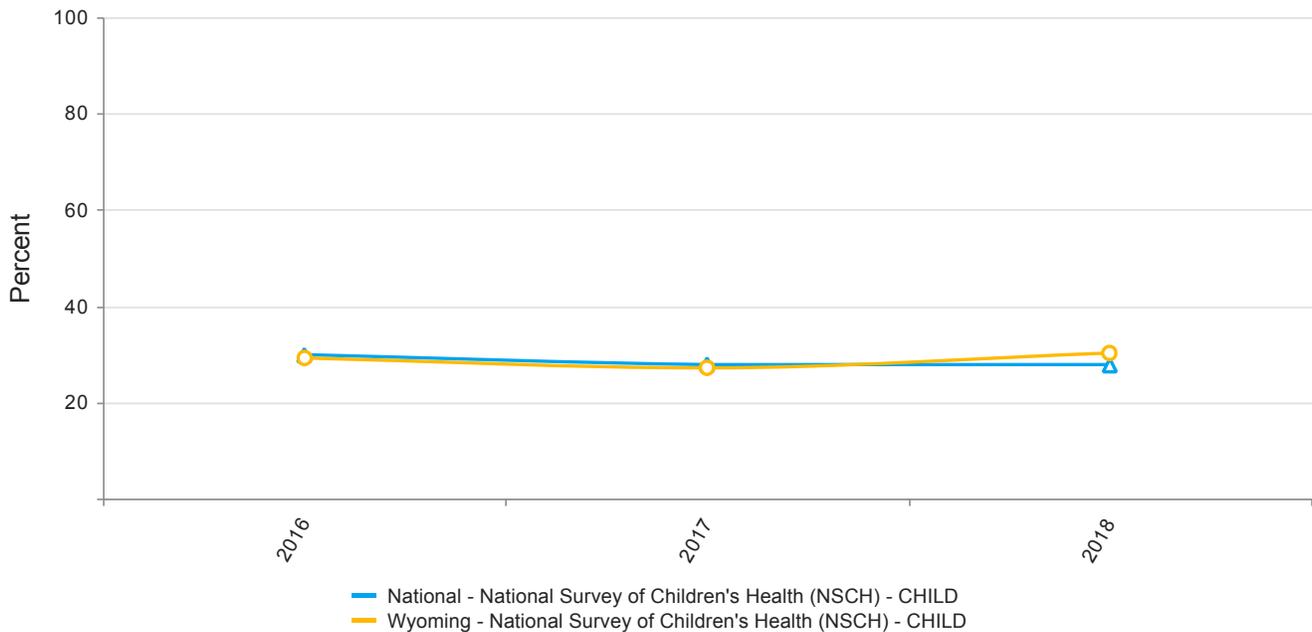
Child Health

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-2017_2018	90.9 %	NPM 6 NPM 8.1
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-2017_2018	11.8 %	NPM 8.1
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-2016	9.1 %	NPM 8.1
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 8.1

National Performance Measures

**NPM 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day
Indicators and Annual Objectives**



Federally Available Data

Data Source: National Survey of Children's Health (NSCH) - CHILD

	2016	2019
Annual Objective		
Annual Indicator		30.2
Numerator		14,688
Denominator		48,676
Data Source		NSCH-CHILD
Data Source Year		2017_2018

i 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

	2021	2022	2023	2024	2025
Annual Objective					

Evidence-Based or –Informed Strategy Measures

None

State Action Plan Table

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

Priority Need

Promote Healthy and Safe Children

NPM

NPM 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Objectives

Increase the % childcare providers receiving orientation training and technical assistance on WY Healthy Policies Toolkit
Increase the number of childcare providers providing teacher-led physical activity as part of daily curriculum

Strategies

Provide technical assistance and networking promoting expansion of child physical activity and nutrition education in early care and education settings

ESMs

Status

ESM 8.1.1 - Number of childcare facilities reporting adoption of one or more model policies from the WY Healthy Policies Toolkit Active

NOMs

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)

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

Priority Need

Promote Healthy and Safe Children

SPM

SPM 4 - Percent of children receiving at least 1 EPSDT visit as noted within CMS 416 report

Objectives

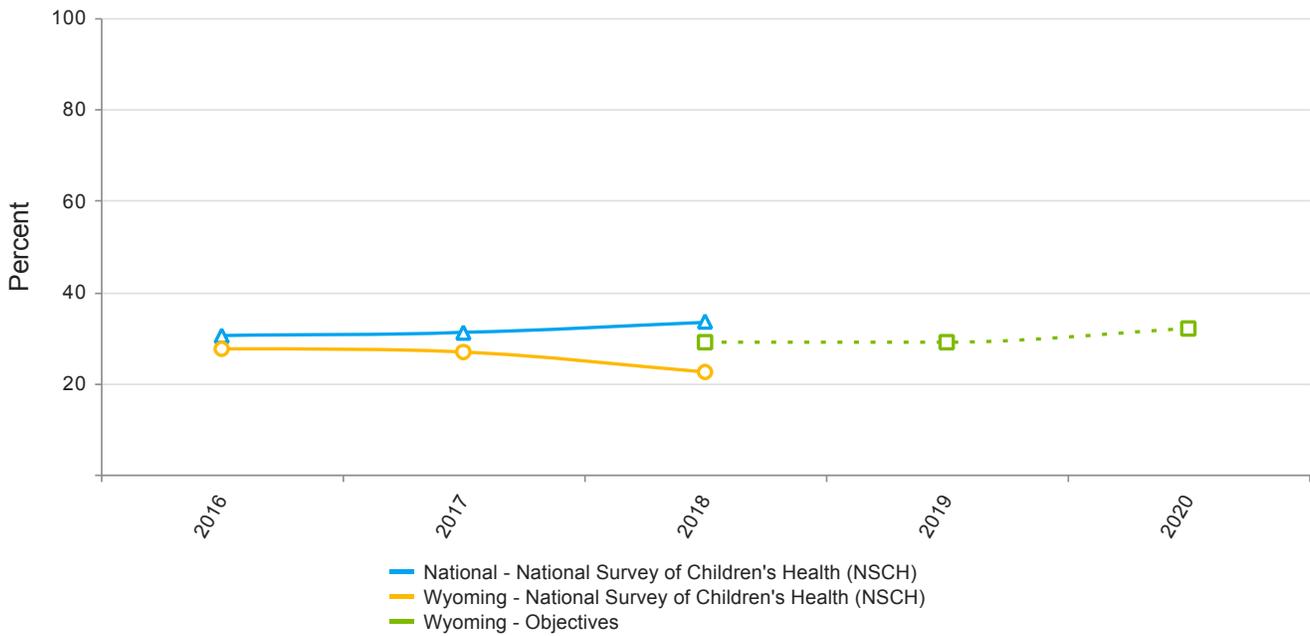
Increase the number of providers reporting implementation of BF guidelines within their practice

Strategies

Convene Bright Futures Implementation Task Force to Bright Futures (4th Ed.) Guidelines with health care providers and community partners. Promotion may range from general awareness related activities such as ensuring providers and community partners are aware that Bright Futures is Wyoming's EPSDT periodicity schedule, to topic specific initiatives such as child lead screening, childhood obesity and physical activity promotion, promotion of comprehensive annual well child visits, or universal developmental screening as recommended by Bright Futures. Promotion may include verbal communications, distributing specific written resources, describing initiatives, website updates, support for regional community meetings, etc.

2016-2020: National Performance Measures

2016-2020: 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	2019
Annual Objective			29	29
Annual Indicator		27.6	27.0	22.5
Numerator		4,900	4,651	3,759
Denominator		17,751	17,226	16,730
Data Source		NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018

i 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.

2016-2020: Evidence-Based or –Informed Strategy Measures

2016-2020: ESM 6.3 - 211 Referrals to Help Me Grow

Measure Status:		Active		
State Provided Data				
	2017	2018	2019	
Annual Objective	30	45	60	
Annual Indicator	39	49	14	
Numerator				
Denominator				
Data Source	HMG Reports	HMG Reports	HMG Reports	
Data Source Year	2017	2018	2019	
Provisional or Final ?	Final	Final	Final	

2016-2020: ESM 6.6 - Number of referrals from HMG to community resources resulting in services

Measure Status:		Active		
State Provided Data				
	2017	2018	2019	
Annual Objective			50	
Annual Indicator			41	
Numerator				
Denominator				
Data Source			HMG Reports	
Data Source Year			2019	
Provisional or Final ?			Final	

2016-2020: ESM 6.7 - Number of providers trained on Bright Futures

Measure Status:		Active		
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Baseline data was not available/provided.

2016-2020: State Performance Measures

2016-2020: 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	2019
Annual Objective		20	30	30
Annual Indicator	25.3	32.2	13	14.5
Numerator	22	28	11	12
Denominator	86,903	86,855	84,348	83,015
Data Source	Wyoming Hospital Discharge Data			
Data Source Year	FY 2015	CY 2016	CY17	CY18
Provisional or Final ?	Final	Final	Final	Final

2016-2020: SPM 5 - Percent of children (6-11 years) who are physically active at least 60 minutes per day.

Measure Status:		Active		
State Provided Data				
	2017	2018	2019	
Annual Objective			32	
Annual Indicator			30.2	
Numerator			14,688	
Denominator			48,676	
Data Source			NSCH	
Data Source Year			2017-2018	
Provisional or Final ?			Provisional	

Child Health - Annual Report

Annual Report Fiscal Year 2019: This section provides a summary of Federal Fiscal Year 2019 (FFY19) 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 and Adolescents	NPM 6: Percent of children (10-71 months) receiving developmental screen using a parent-completed tool (National Survey of Children's Health (NSCH))	<ul style="list-style-type: none">• 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 Adolescents 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.

Strategy 1: Provide Ages and Stages training to Wyoming providers

The Child Health Program (CHP) has continued to support efforts to increase developmental screening through training on and distribution of the Ages and Stages Questionnaire (ASQ) screening tools. In addition, the Child Health Program Manager (CHPM) has remained an active member of the Governor's Early Intervention Council (EIC). The EIC's mission is to advise and assist coordinated community-based programs and services for families and their children ages birth through five who are identified as having developmental delays and/or disabilities.

As mentioned in previous years, WY MCH historically provided ASQ training and resources to a wide range of partners including daycare providers, child development center staff, health care providers, PHNs, and home visiting staff. The CHP maintains a commitment to providing limited training and support of the ASQ tool to community providers and partners. WY MCH does not currently have any staff certified to train on the ASQ tool and has relied on trained partners at the Wyoming Children's Trust Fund (WCTF) as needed.

In early 2019 the University of Wyoming Family Medicine residency program located in Casper, WY (UWFMRC) contacted the CHPM regarding training staff, including physicians completing residency, on the use of the ASQ. The UWFMRC is a Federally Qualified Health Center (FQHC) operating within Wyoming. In addition, UWFMRC have worked towards maintaining National Committee for Quality Assurance (NCQA) accreditation as a patient/family-centered medical home.

The WCTF completed an in-person ASQ training for the UWFMRC 14 providers and two social workers in Casper, WY. Upon completion of the training course the CHP provided the clinic with ASQ resources, including Spanish versions of the ASQ-3, ASQ-SE-2, and ASQ-3, for implementation within the clinic. CHP provided four ASQ kits to

the UWMRC, one for each of the four case managers at the clinic.

The program identified challenges collecting data on usage of the ASQ from a diverse group of partners outside of PHN offices due to the absence of any shared or central data system. However, with the implementation of a new PHN data system in October of 2018 the CHP and PHN can report that between October 2018 and September 2019 5,523 ASQ screenings were completed in partnership between parents/caregivers and PHN staff. In addition, in December 2019 WY MCH distributed 17 ASQ kits to five county PHN offices and one medical clinic. CHP reached out to all county Public Health Nursing offices to offer additional ASQ kits as needed.

Strategy 2: 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 created a voluntary program to assist with testing for lead in drinking water at schools and child care programs. In late 2019 the DEQ released a Request for Proposal for the selection of a contractor to facilitate the testing and monitoring program within schools. As of July 2020 a contract has still not been executed to complete deliverables related to this funding opportunity.

WDH lost funding for a dedicated Environmental Health/Lead Prevention Program in 2014. Due to this absence and the increased interest the DEQ lead grant has generated, WDH staff led by the State Health Officer and including representatives from WY MCH, the Wyoming Public Health Laboratory, Wyoming Medicaid, WIC, Immunizations, and PHN have partnered internally. The focus of this internal workgroup has been to better coordinate messaging, education, screening, and prevention efforts related to lead screening. Through this work a draft letter was created to be endorsed by the Wyoming State Health Officer for publication in the Wyoming Medical Society Magazine addressing the need for child lead screening. The work group also drafted an application to the Centers for Disease Control and Prevention (CDC) Childhood Lead Prevention grant funding opportunity. Unfortunately, due to COVID-19, the letter has not yet been submitted to the Wyoming Medical Society Magazine and the CDC temporarily suspended the grant opportunity. However, WY MCH was able to support the strengthening of internal partnerships and will support renewed education efforts in the future.

Strategy 3: Train providers on Bright Futures recommendations

Improving well visits rates and the quality of well visits for Wyoming children is a priority of WY MCH, Wyoming Medicaid, and other partners. The percent of eligible, Medicaid enrolled children ages 1-9 years, who should receive at least one initial or periodic Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screening in Wyoming and did receive a screen was 64.2% during FY 2018. The percent of eligible children receiving at least one EPSDT screening in Wyoming has increased by 17.2% since FY 2013 when it was 54.8% (Wyoming CMS 416 report).

In partnership with WY MCH, Wyoming Medicaid adopted the Bright Futures, 4th Edition as the standard of care for well visits in Wyoming in Fall 2017. In FY2019 CHP worked to implement Bright Futures implementation recommendations made in the previous year by two Title V MCH interns affiliated with 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 in summer 2018. One recommendation that emerged from this work was the need to create and support a state-level Bright Futures Implementation Taskforce.

To support the creation of the Bright Futures Implementation Task Force, WY MCH accepted a masters-level social work intern through the University of Wyoming. With leadership and support from the Wyoming Title V Director and the CHPM, who also serves as the Interim Children's Special Health Program Manager (CSHPM), the intern convened a large group of stakeholders to identify strategy areas for the taskforce to target. Based upon the initial

input of this group of stakeholders the taskforce identified the following four main areas of focus (due to the newness of this strategy, heavy focus on infrastructure was needed in addition to providing training):

- **Medical coding** was identified based upon the need to explore the relationship between EPSDT well-visit rates in Wyoming and possible ICD-10 coding errors.
- **Family/consumer education** was identified based upon the understanding that adaptation of Bright Futures implementation needed to meet identified family needs.
- **Provider education** was identified based upon the need to build provider champions with knowledge and understanding of the Bright Futures guidelines.
- **Access to care** was selected to identify barriers and gaps impacting families' ability to access needed healthcare services, including preventive well visits.

WY MCH has convened the Bright Futures Implementation Taskforce four times with plans to convene bimonthly moving forward. Key strategies the taskforce plans to implement in FFY21 include family focus groups on the strengths and barriers related to well visits and coordinated messaging around the importance of well visits. In addition, CHP used Title V funds to purchase the Bright Futures online toolkit and other materials to build local clinic capacity to implement guidelines; the program plans to put heavy focus on provider training in FFY21.

Strategy 4: Pilot Help Me Grow model in two counties (inactive as of June 30, 2019)

In 2015 the CHP selected the national Help Me Grow (HMG) model to support a systems-level approach to improving access to existing developmental resources and services for children through age eight, including children with special health care needs. In October 2016 WDH contracted with Wyoming 211 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 was divided into three main stages: (1) building the infrastructure, (2) building the system, and (3) sustaining the system. During FFY18, Wyoming primarily focused on stage one, infrastructure building, but also made some progress in system building in the area of developing a centralized telephone access system.

The rural and frontier nature of Wyoming meant that centralized telephone access was necessary to link children and families to needed resources. HMG received referrals in two main ways: through direct contact with HMG by phone, mail, walk-in, or word of mouth, or through a referral from the 211 call center. Unfortunately, the number of unique contacts referred to HMG remained limited throughout the pilot, and anecdotally, community partners reported that they could not recognize the difference between Wyoming HMG and 211.

HMG relied on 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 Wyoming 211, WY MCH, and HMG throughout the pilot but especially during FFY18 and FFY19. Turnover contributed to significant implementation gaps and delays.

In fall of 2018, Wyoming 211 upgraded their data system to improve data collection and reporting. Additionally, CHP and HMG staff worked to better define the measures being collected in order to match measures with program performance and outcomes. Both of these changes allowed for more accurate data collection and usage. However, the data revealed low uptake of HMG: between October 2019 and the end of the contract in June 2019, HMG reported receiving only 14 referrals. In addition, HMG made just 41 referrals of Wyoming families to resources for

support and service.

As the three-year pilot neared its end, WY MCH met with key stakeholders and Wyoming 211/HMG staff to discuss progress and challenges. Although Wyoming 211 staff dedicated considerable time and effort to learning and implementing the HMG model, the successes were outweighed by the long-term challenges, including:

- 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, and Wyoming Child Fund
- Community push-back in pilot communities (i.e. lack of stakeholder support and buy-in)
- Limited data on the impact and value of HMG pilot project in Laramie and Albany Counties
- No clearly identified provider champion

WY MCH 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. CHP used FFY20 to convene key statewide stakeholders within the Wyoming early childhood system, including WDH, Wyoming Department of Workforce Services, Wyoming Department of Family Services, Wyoming Department of Education, the 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.

In 2019 WY MCH requested technical assistance from the National MCH Workforce Development Center in hosting an in-state National MCH Workforce Development Center Learning Institute. This in-state learning institute brought together a large and diverse group of stakeholders positioned across the Wyoming Early Childhood system. This request was made based upon the recognition that the Wyoming early childhood system remains fragmented and opportunities for systems-level improvement exist. The initial goals of convening this diverse group together were:

1. Develop a shared vision for delivering high-quality services to children and families that meet identified needs
2. Create a unified mission statement
3. Set a plan to convene regularly to assess gaps and barriers
4. Develop common messaging
5. Set measurable short-term and intermediate strategic goals
6. Evaluate success

At the conclusion of the three-day in-person learning institute the group established several action items to move forward together. Those actions included the reinvigoration of the Wyoming Governor's Early Childhood State Advisory Council and the successful pursuit of the Birth to Five preschool development grant. The CHPM was appointed by the Governor of Wyoming to represent the Wyoming Department of Health and the Public Health Division on the Wyoming Governor's Early Childhood State Advisory Council. In addition, The Governor directed that the Wyoming Governor's Early Childhood State Advisory Council oversee and direct the activities of Wyoming Preschool Development grant .

The CHPM and other team members directing the Wyoming Preschool Development Grant incorporated the mission and vision drafted during the National MCH Workforce Development Center Learning Institute as the foundation for Wyoming's successful Preschool Development Grant Application. Throughout the first year of this funding opportunity the CHPM has actively participated in the creation and review of an Request for Proposal (RFP) to conduct a comprehensive needs assessment and action plan in support of early childhood system improvement.

In addition, The CHPM has served on Two workgroups connected to the grant activities. The CHPM sits upon the family and provider engagement workgroup and the Data and evaluation work group.

Priority	Performance Measure	ESM (if applicable)
Reduce and 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. Increasing physical activity remains the key strategy to reduce childhood obesity.

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

Over the past several years, the CHP has maintained a partnership with the Chronic Disease Prevention Program (CDPP) to implement nutrition and physical activity promotion efforts in early childhood settings. In FFY18 the CDPP was forced to adjust its programmatic activities based upon changes in grant funding opportunities. As a result the CDPP received zero funding to address childhood obesity or to target children 0-18 for FFY19, so the CHP adjusted strategies to fill an important gap. In FFY18 and FFY19 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. A distribution plan was created in partnership with the Wyoming Department of Workforce Services, Wyoming Department of Education, Wyoming Department of Family Services, and the University of Wyoming to distribute kits to licensed childcare providers and Wyoming public. This toolkit was distributed to all 633 licensed childcare providers within Wyoming as well as all 249 public elementary schools. The Wyoming Department of Family Services (the Wyoming agency responsible for licensing child care providers) continues to distribute the toolkit to all newly licensed providers. In addition, the toolkit is available online for free download; the CHP will work with the Wyoming Department of Workforce Services to determine if data on the number of downloads can be tracked moving forward.

The University of Wyoming Centsible Nutrition Program maintains Certified Nutrition Educators (CNEs) in all 23 Wyoming counties and the Wind River Indian Reservation. The CNEs have targeted childcare facilities serving low-income populations for site-specific technical assistance and training. All CNEs utilize the policy toolkit as a standardized framework to support settings in increasing physical activity and reducing obesity.

The Centsible Nutrition Program Manager and the CHPM conducted in-service training on November 19, 2019 for all CNEs related to the use of the toolkit to support consistent and uniform implementation of the toolkit.

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)*	N/A

Injury related hospitalization and death remains the leading cause of preventable hospitalization and death in Wyoming. The CHP remained committed to reducing the rate of children being hospitalized due to preventable injury. The CHP was also equally committed to reducing the child mortality rate.

One July 2020 public input survey respondent stated, "I have grandchildren and their safety and well being is always on my mind [...] More tools and resources for parents is always a good thing."

Strategy 1: Implement community based grants with targeted evidence-based strategies to address the major causes of childhood injury/hospitalizations in Wyoming

Wyoming MCH adjusted efforts related to childhood injury prevention in order to expand our reach and impact. Wyoming MCH historically focused primarily upon Child passenger safety. In response to emerging priorities like adolescent motor vehicle safety and adolescent suicide prevention the CHP and Youth and Young Adult Health Program shifted our funding model for this priority away from statewide Safe Kids Worldwide coordination and towards a statewide mini-grant program. This mini-grant program increased the amount of resources going directly to local implementation of evidence-based or evidence-informed childhood injury prevention strategies. WY MCH utilized the Child Safety Networks (CSN) established child injury prevention change packages to highlight suggested evidence-based interventions for mini-grant applicants.

Seven organizations receive funding through this mini-grant program and each developed an independent project work plan. A brief description of each grant recipient's project is listed below:

- **Youth Emergency Services, Inc. (Y.E.S. House)** (adolescent suicide prevention)
Campbell County has a large demand for ACES training and support. YES House conducted community adverse childhood experiences (ACE) training and partnered with the local school district to strengthen community relationships. For more detail on this grant project refer to the Adolescent Health Section.
- **Campbell County School District** (adolescent suicide prevention)
The Campbell County School District worked to establish active HOPE Squads (which work to change school culture around suicide by reducing stigmas) with the aim of identifying, protecting, and helping students in crisis. For more detail on this grant project refer to the Adolescent Health Section.
- **Cheyenne Regional Medical Center (CRMC)** (child passenger safety, water safety)
CRMC used the mini-grant funds to support advertising for community events on child passenger safety and water safety/drowning prevention. CRMC also released a large media campaign connected to drowning prevention, which had wide newspaper circulation reaching 28,000 recipients. CRMC was unable to conduct targeted outreach training due to COVID-19 but did reach 325 children through in-person school-based education outreach activities. Additionally, 271 parents received targeted educational material related to child water safety.
- **Cheyenne Regional Medical Center (CRMC)** (prescription drug monitoring system)
CRMC integrated their Electronic Health Record (EHR) called EPIC with the Prescription Drug Monitoring System (PDMP). In addition, CRMC worked to conduct training for providers on the use of newly available integrated data. This tool, in conjunction with the PDMP linkage to EPIC, enables practitioners to follow best practices identified by the American Academy of Pediatrics' Committee on Substance Use and Prevention to screen, treat, and refer adolescents with substance use disorders. Though integration was successful, data is not yet available regarding the effect on the prescribing practices and patient outcomes. However, this is an evidence-based approach and research suggests that ease of access and more abundant data will drive better outcomes for patients and reduce opioid prescribing. Ultimately, less prescribing should lead to less misuse among adolescent patients and less availability to adolescents through family members.
- **Johnson County** (child passenger safety, pedestrian safety, infant and child fall prevention, safe sleep,

water safety)

Johnson County provided water safety education and a developed classroom-based curriculum to 72 second grade students. In addition, the local elementary schools will utilize the curriculum in the next academic year to instruct the incoming class of second graders. Johnson County was also able to support child passenger safety education through community outreach events and documented a reach of 26 families prior to the onset of Covid-19. Johnson County also reported that they provided safe sleep education and support directly to 24 families.

- **Wyoming Highway Patrol (WHP)** (Child/Adolescent Motor-vehicle safety)

The WHP utilized the mini-grant funding to enhance program materials to help educate young drivers on the dangers of distracted driving and driving without seatbelts. WHP reached 948 children and adolescents in 68 schools across the state, targeting children 6-18 years of age.

- **Uinta County** (safe sleep, child passenger safety, medication safety, water safety) Uinta County was able to recertify two Public Health Nurses as car seat technicians and purchase car seats for replacements for families in the community that cannot afford a new and safe car seat. Due to Covid-19 the normal Safe Kids Fair was cancelled, but they were able to generate information that would normally be discussed at this fair for an insert in the paper. Earlier in the year they were able to bring in a national level speaker to discuss ACE's with service providers in the County as well as incorporating the messaging around ACE's into the home visitation program. In line with work around ACE's the County has incorporated PURPLE Crying and Shaken Baby Syndrome education into their home visitation program through the distribution of videos and magnets.

CHP, the Youth and Young Adult Health Program, and the WDH Injury and Violence Prevention Program also joined the Child Safety Learning Collaborative (CSLC) through the Child Safety Network (CSN) to focus efforts on reducing fatal and serious injuries among infants, children, and adolescents by building and improving partnerships and implementing and spreading best practice and evidence-based approaches, 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 Youth and Young Adult Health Program Manager has led the SSHP topic and the CHPM led MVTs.

The CHPM has remained an active member of Safe States Alliance and served as a moderator at the 2019 annual conference in Atlanta, Georgia. In addition, the CHPM serves on both the Safe States Alliance Annual Conference Planning Committee and the Plains to Peaks (P2P) Regional Network 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. Participation allows for sharing of information and resources and professional development. The CHPM also served as an abstract reviewer on infant, child, and adolescent injury topics ahead of the September 2019 conference and again in advance of the 2020 virtual annual conference.

Child Health - Application Year

Application Year Plan (FFY21): This section presents strategies/activities for 2021-2025 MCH priorities related to Child Health. See Five-Year State Action Plan Table for more information.

Priority	Performance Measure	ESM (if applicable)
Promoting Healthy and Safe Children	NPM 8.1: % of children, ages 2-4, and adolescents, ages 10-17, who are obese (BMI at or above the 95th percentile) SPM 8.1 # of children receiving at least one EPSDT visit as noted within CMS 416 report	ESM 8.1.1: # of childcare facilities reporting the adoption of one or more model policies from the Wyoming Healthy Policies Toolkit

Childhood obesity is associated with adverse consequences, including increased risk of cardiovascular disease, type 2 diabetes, asthma, social stigmatization, low self-esteem, and adult obesity. Children reported to be in excellent or very good health are more likely to thrive in a variety of health dimensions, including physical and mental health.

Ninety-three percent of July 2020 public input survey respondents indicated that they believe child obesity is a somewhat of a problem in their community. In addition, 98% of respondents indicated that they believe children going hungry is at least somewhat of a problem in their community. One respondent stated, "In a small community it is more important than ever to [...] ensure [our children's] development and keep them healthy. Our facilities are limited compared to larger communities."

In FFY21, the Child Health Program (CHP) will implement the following strategies to address NPM 8.1 and the SPM within the Promoting Healthy and Safe Children priority:

1. Work with the Wyoming Department of Workforce Services, Wyoming Department of Education, Wyoming Department of Family Services, Wyoming Department of Education, University of Wyoming Centsible Nutrition Program, Wyoming Primary Care Association Wyoming Chapter of the American Heart Association, and various community-based partners to increase distribution, promotion, and use of the Wyoming Healthy Policies Toolkit. This toolkit targets early childhood education centers, Head Starts, Early Head Starts, licensed childcare providers, and elementary schools providing evidence-based model policy drafts for adaptation and integration into Wyoming early childcare and education settings.
2. Collaborate with Wyoming Medicaid and other partners to expand the education of providers and parents on the American Academy of Pediatrics (AAP) Bright Futures guidelines (4th ed.). This will primarily be completed through CHP leadership in the Wyoming Bright Futures Implementation Taskforce and involvement in connected workgroups. These collective efforts will support improvements in both access to and quality of Early and Periodic Screening Diagnosis and Treatment (EPSDT) in Wyoming.

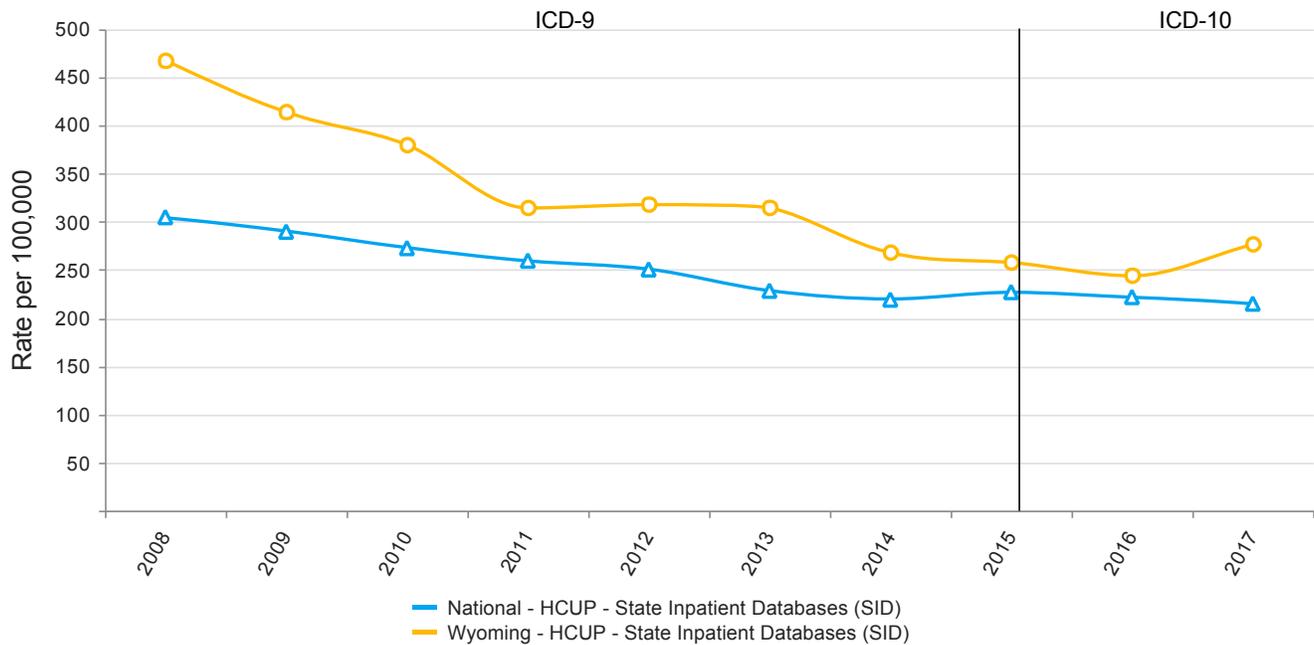
3. Continue participation in a multidisciplinary workgroup focused on improving lead screening rates and on expanding state-level infrastructure to support lead surveillance and prevention efforts.

Adolescent Health
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000	NVSS-2018	17.9	NPM 7.2
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS-2018	31.8	NPM 7.2 NPM 10
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS-2016_2018	20.1	NPM 7.2 NPM 10
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2016_2018	25.6	NPM 7.2 NPM 10
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2017_2018	58.4 %	NPM 10
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2017_2018	90.9 %	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)	NSCH-2017_2018	11.8 %	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-2016	9.1 %	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-2018_2019	46.0 %	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NIS-2018	53.5 %	NPM 10
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS-2018	89.1 %	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-2018	65.1 %	NPM 10
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2018	20.8	NPM 10

National Performance Measures

**NPM 7.2 - Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19
Indicators and Annual Objectives**



Note: ICD-10-CM beginning in 2016; previously ICD-9-CM with 2015 representing January - September

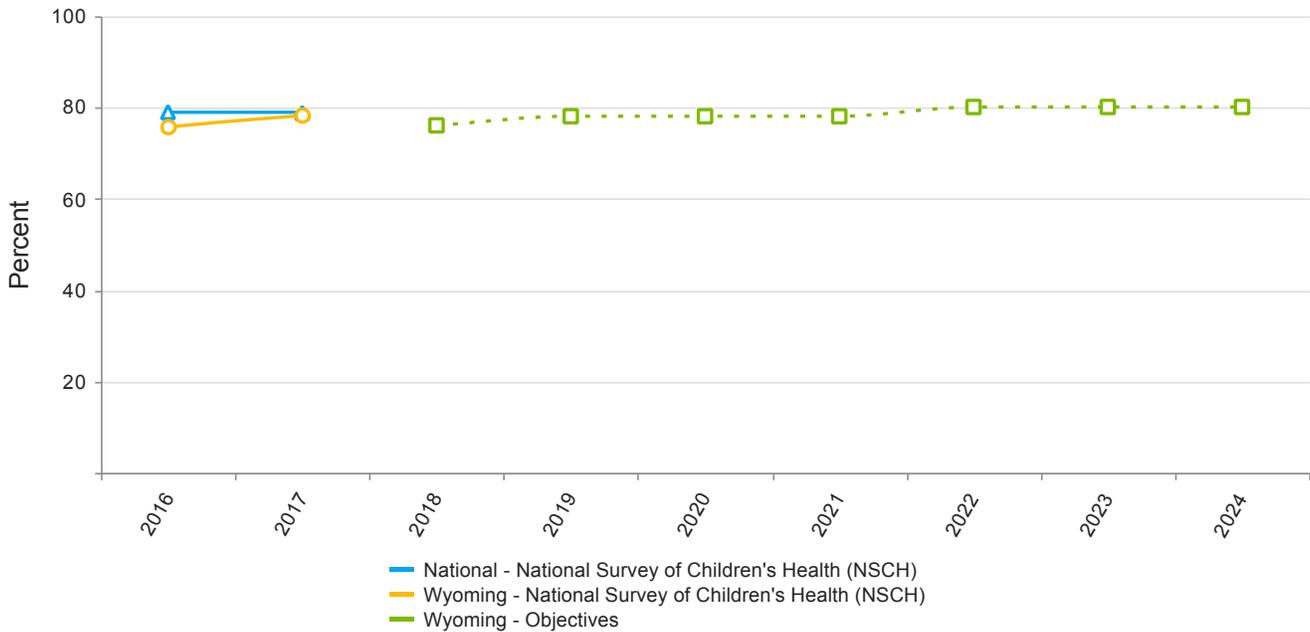
Federally Available Data	
Data Source: HCUP - State Inpatient Databases (SID)	
	2019
Annual Objective	
Annual Indicator	276.4
Numerator	207
Denominator	74,890
Data Source	SID-ADOLESCENT
Data Source Year	2017

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective					

Evidence-Based or –Informed Strategy Measures

None

**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	2019
Annual Objective			76	78
Annual Indicator		75.7	78.2	78.2
Numerator		34,569	35,814	35,814
Denominator		45,669	45,789	45,789
Data Source		NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2016_2017

i 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

	2020	2021	2022	2023	2024	2025
Annual Objective	78.0	78.0	80.0	80.0	80.0	

Evidence-Based or –Informed Strategy Measures

None

State Action Plan Table

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

Priority Need

Prevent Adolescent Suicide

NPM

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

Objectives

To promote and increase annual clinic participation in the ACE-AP

To develop youth and young adult council goals related to adolescent well visit, adolescent suicide prevention, and to increase youth voice in agency programs

To increase/strengthen partnerships, create materials and resources to disseminate statewide, and promote Sources of Strength implementation to increase youth-adult connectedness

Strategies

Continue partnership with University of Michigan Adolescent Health Initiative to implement Adolescent-Centered Environment-Assessment Process (ACE-AP) in Wyoming clinics.

Develop, sustain, and support a youth and young adult council.

Convene statewide partners to coordinate adolescent suicide prevention efforts, increase participation in the Child Safety Learning Collaborative, and promote the implementation of Sources of Strength.

ESMs	Status
ESM 10.1 - Number of clinics trained on Bright Futures and youth friendliness through the Adolescent Health Initiative	Active
ESM 10.2 - Number of clinics implementing Bright Futures guidelines (including youth-related assessments)	Active
ESM 10.3 - Percentage of ACE-AP participating clinics who receive Adolescent Centered Environment certification	Active
ESM 10.4 - Number of clinics showing improvement in at least 50% of selected topics through the ACE-AP	Active
ESM 10.5 - Number of Youth Council recommendations developed	Active
ESM 10.6 - Number of resources developed based on Youth Council recommendations	Active
ESM 10.7 - Number of schools/organizations implementing Sources of Strength	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

Priority Need

Promote Adolescent Motor Vehicle Safety

SPM

SPM 3 - Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19

Objectives

To increase implementation of Wyoming specific MVTS provider guidelines during adolescent well visits to promote teen driver safety.

To improve collaboration with SADD and other existing MVTS groups, increase statewide participation in CSLC, and promote teen driver safety programs.

Strategies

Utilize Bright Futures Implementation Task Force to develop MVTS provider guidelines to promote teen driver safety

Facilitate collaborative effort to strengthen partnerships across entities and increase participation in the Child Safety Learning Collaborative with a focus on implementing evidence-based strategies (e.g. Teens in the Driver Seat) to reduce adolescent MVT mortality.

2016-2020: National Performance Measures

2016-2020: State Performance Measures

2016-2020: 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	2019
Annual Objective		70	70	70
Annual Indicator	68.4	68.4	66.3	66.3
Numerator				
Denominator				
Data Source	Prevention Needs Assessment	Prevention Needs Assessment	Prevention Needs Assessment	Prevention Needs Assessment
Data Source Year	2016	2016	2018	2018
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional

Adolescent Health - Annual Report

Annual Report Fiscal Year 2019: This section provides a summary of Federal Fiscal Year 2019 (FFY19) 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 Children and 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

Adolescence is the period following the onset of puberty during which a young person develops from a child into an adult. A number of events take place during this time, such as assuming responsibility for health habits, initiating risky behaviors, and a series of psychological, social, emotional, and physical changes. Bright Futures guidelines recommend that adolescents have an annual checkup from ages 11-21, as this may help adolescents adopt or maintain healthy habits and behaviors. The visit should cover a comprehensive set of preventive services, such as a physical examination, immunizations, and discussion of health-related behaviors.

Strategy 1: Implement adolescent-centered environment assessment process in Wyoming clinics to improve adolescent-friendly environment

To improve the quality of the adolescent clinical environment with a long-term goal of increasing the number of well visits among youth and young adults, the Youth and Young Adult Health Program (YAYAHP) continued its partnership with the University of Michigan to implement the 18-month Adolescent Centered Environment Assessment Process (ACE-AP) within four pilot clinics between 2017 and 2019. The ACE-AP is a facilitated, comprehensive self-assessment and guided improvement process that includes customized resources, recommendations, technical assistance (TA), as well as implementation plans using Plan, Do, Study, Act (PDSA) improvement cycles. The ACE-AP addresses 12 key areas of adolescent-centered care, listed below along with the number of clinics that chose to work in each key area:

- Access to Care (3 of 4 clinics)
- Adolescent Appropriate Environment (4 of 4 clinics)
- Confidentiality (4 of 4 clinics)
- Best Practices and Standards of Care (4 of 4 clinics)
- Reproductive and Sexual Health (4 of 4 clinics)
- Behavioral Health (4 of 4 clinics)
- Nutritional Health (3 of 4 clinics)
- Cultural Responsiveness (3 of 4 clinics)
- Staff Attitudes and Respectful Treatment (3 of 4 clinics)
- Adolescent Engagement and Empowerment (2 of 4 clinics)
- Parent Engagement (2 of 4 clinics)
- Outreach and Marketing (0 of 4 clinics)

The first cohort of clinics completed a baseline self-assessment of their organization's environment, policies, and practices related to youth-friendly services to identify opportunities for improvement. They then met with the University of Michigan to identify and implement quality improvement initiatives and incorporate Bright Futures into practice in selected clinics. Clinics received up to \$2,000 to implement a change within their clinic to become more adolescent-friendly (e.g. tablets for completion of adolescent screening tools, privacy screens for check-in, youth-friendly posters and materials). To ensure ongoing quality improvement and evaluation, each clinic collected patient satisfaction surveys from all youth and young adults ages 10-25 visiting their clinic.

One common need identified across all four ACE-AP pilot clinics was information and guidance related to adolescent consent and confidentiality. In addition to the consent and confidentiality guides developed by the Center for Adolescent Health and the Law, the University of Michigan summarized Wyoming consent and confidentiality laws to create a handout for participating clinics.

In addition to four clinics completing the ACE-AP, six clinic providers among three of the four participating clinics completed the Maintenance of Certification (MOC) Part IV, which was established in 2000 by the American Board of Medical Specialties (ABMS) on Adolescent Confidentiality to improve the delivery of confidential care to adolescent patients. Clinics used grant funds to purchase items improving the youth friendliness of the environment, such as tablets and accessories, computer hardware, educational brochures, pamphlets, posters, and charging stations. Through the provided training and technical assistance, three of the four participating clinics saw improvement in 10 of the 12 key areas. Some areas experienced as much as a 50% increase.

In summer 2019, YAYAHP released a mini-grant Request for Application (RFA) to recruit the second cohort of clinics to implement the ACE-AP model. Two clinics applied and a review committee selected both to participate. The two participating clinics are the Cheyenne Children's Clinic-Laramie Street and the University of Wyoming Family Medicine Residency Program at Casper/Educational Health Center of Wyoming-Casper.

One of the key challenges of this project for both cohorts has been maintaining engagement of a large and diverse team of stakeholders. The Youth and Young Adult Health Program Manager (YAYAHPM) keeps team members engaged through email communication and in-person meetings as appropriate.

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

CSH program staff continue to send enrolled clients and their families reminders about the importance of attending annual well visits. The CSH Program encourages all clients to have a primary care provider (PCP) but recognizes that Wyoming continues to experience a critical shortage of PCPs. Due to this shortage, CSH does not deny eligibility to any applicant based on the lack of a designated PCP. However, the encouragement of a PCP aligns with patient- and family-centered medical home recommendations and the WY MCH goal of expanding the spread of patient and family-centered medical homes across Wyoming. In addition, state and local staff provide ongoing care coordination for enrolled clients and their families and work to create linkages to local providers and services.

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

YAYAHP seeks to promote youth voice in the development of strategies, materials, and activities. The development of a statewide youth council brings youth voices and experience together with health programs, promoting success, increased youth engagement, and quality improvement. The YAYAHPM developed a framework for the youth council

and released an RFA for the Youth Council Coordinator in May 2019. The key deliverables included:

- Establish, coordinate, and facilitate a statewide youth council
- Recruit members across the state
- Create supportive guidelines and documents for the council (i.e. 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, health equity, and the social ecological model
- Promote youth involvement in relevant topics (e.g. youth suicide, bullying, eating disorders, vaping)
- 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, including drafting emails to be distributed to council members on updates, clarifications, upcoming meetings and events, and data reminders (may be completed in collaboration 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, and social opportunities for youth
- Coordinate ongoing recruitment to promote sustainability
- Manage member leadership roles/responsibilities (e.g. social media, secretary, chair)
- Share volunteer opportunities
- Coordinate reimbursements for youth council members

A contract with the selected applicant was executed in January 2020, and membership recruitment activities are currently underway.

July 2020 public input survey respondents commented that they saw an impact on their communities through the Youth Council “physically includ[ing youth and young adults] in the decision-making process” and “increasing the equity [by] letting them have a voice [in] their goals and their goals for future teenagers, as well.”

Priority	Performance Measure	ESM (if applicable)
Promote Preventive and Quality Care for Children and 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

YAYAHP partnered closely with the CSH Program to promote evidence-based transition assessments and education among CSH clients.

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

WY MCH selected the Promote Healthy and Safe Relationships priority 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 previously measured on the Youth Risk Behavior Surveillance System (YRBSS), but the Wyoming State Legislature eliminated the YRBSS in Wyoming in 2016. There is no longer an effective, statewide measure of youth sexual behavior. However, Wyoming does have a statewide survey called the Prevention Needs Assessment that includes questions about alcohol and drug use.

Prior to fall 2018, Communities that Care was explored as an option to address this priority, but WY MCH ultimately decided to utilize the Collective Impact Model instead. 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 YAYAHPM attended trainings and 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 Block Grant, Rape Prevention and Education (RPE) Program grant, and Preventive Health and Health Services (PHHS) grant.

Strategy 1: Complete RFP process and community selection for Rape Prevention and Education (RPE) Program pilot communities to implement strategies using a Collective Impact Model

The YAYAHPM serves as the RPE Project Director and the MCH Epidemiology Program provides evaluation and data support for the RPE program. WY 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, YAYAHP decided to continue funding two of the pilot communities, as the third community successfully completed a community-level strategy, partnering with the local chamber of commerce and 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.

In April 2019 the YAYAHPM convened stakeholders to develop the Rape Prevention and Education State Action Plan. This State Action Plan:

- Provides a strategic plan to implement sexual violence (SV) strategies that:

- Use the public health approach
- Are based on the best available evidence and data
- Focus implementation on community/societal level strategies and prioritize increasing implementation of community/societal-level strategies to at least 50%
- Provides a strategy for identifying state and local-level data sources, including identifying and tracking SV indicators
- Provides a plan for analyzing data on health disparities to identify populations of interest and address health disparities
- Develops a plan for identifying, establishing, and leveraging partnerships and resources
- Provides plans for sustaining the work of the RPE Program at the end of the five-year cooperative agreement

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, which was developed to increase the effectiveness of violence prevention efforts statewide. In addition to the steering committee, the WSVPC has three workgroups: the Policy and Legislation workgroup; the Education, Training and Outreach workgroup; and the College Sexual Violence Prevention workgroup. These work groups continue to develop strategic goals and work towards statewide shared Collective Impact efforts for sexual violence prevention. In March 2019, WY RPE and WSVPC collaborated with a contractor to create the [Wyoming Rape Prevention and Education \(RPE\) Indicator Dashboard](#); its purpose is to visualize indicators and data sources that measure overarching risk (e.g. lack of employment opportunities, poverty, weak policies, poor parent-child relationships) and protective factors (e.g. access to mental health and substance abuse services, community support, empathy and concern for how one's actions affect others, connectedness) that impact sexual violence in Wyoming. The RPE Dashboard serves as a place to store data, a method to communicate data in a meaningful way to stakeholders, and a tool used to inform future programmatic and policy decision making. In March 2019, the RPE Indicator Dashboard was made available to the public on the YAYAHP webpage. The RPE Indicator Dashboard also includes county-level data from the PNA on 30-day alcohol use among Wyoming students. In August 2019, an in-person meeting brought together council members, key stakeholders, pilot community members, and members of the Campus Consortium (comprised of the University of Wyoming and Wyoming's eight community colleges) to receive training on Collective Impact and identify strategies to promote collaboration on the implementation of statewide primary sexual violence prevention strategies.

Strategy 3: Implement comprehensive sexual education curriculum that includes content on reducing risky behaviors

The YAYAHPM serves as the Wyoming Personal Responsibility Education Program (WyPREP) Project Director and partners with the WDH Communicable Disease Unit (CDU) to manage and implement WyPREP. WyPREP provides training, curricula, and support for implementation of evidence-based, medically accurate curricula in school and community-based settings. Contracts with ten organizations were active in both FFY19 and FFY20: seven school districts, two community-based, youth-serving organizations, and the 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 (2017/2018,

2018/2019, and Fall Semester 2019), WyPREP reached over 2,000 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 entry, exit, and knowledge survey data from their students each school year. Knowledge survey data from the 2017-2018 school year to present indicate 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. A statewide report card is produced for publication and shared with the public and policymakers. See below for an excerpt from the Statewide PREP Report Card representing data from 473 respondents for 2016/2017 school year.

What are the results of WyPREP?

Seven organizations distributed an exit survey. This survey asked about attitudes and behaviors related to sexual behaviors and healthy relationships. Participation in the exit survey was voluntary and required parental consent as well as participant assent. Participants taking the exit survey did so even if they did not complete an entrance survey or attend all sessions. There were 473 respondents who completed the exit survey.

Participant perceptions of program

Adolescents completing the exit survey reported overall positive experiences about being in the program. Over half (53%) reported that they were interested in the program classes all or most of the time. The majority reported that the material was clear (78%) and that the discussions and activities helped them learn (74%).

OVER HALF OF ADOLESCENTS TAKING THE EXIT SURVEY REPORTED THAT THEY WERE SOMEWHAT OR MUCH LESS LIKELY TO HAVE SEXUAL INTERCOURSE IN THE 6-MONTHS FOLLOWING THE PROGRAM.

Sexual intention of exiting participants

20% of adolescents reported that they intended to abstain from sexual intercourse after being in the program. Of those adolescents who did not report they would abstain, the majority reported that after being in the program they were much more or somewhat more likely to use a condom (61%) or birth control (54%) in the next six months.

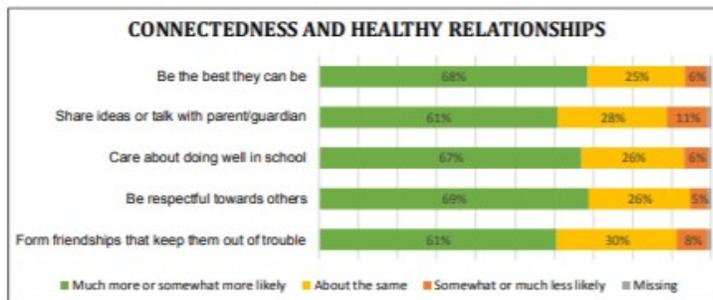
Healthy life skills

When asked how the program impacted healthy life skills, the majority of adolescents reported they were much more, or somewhat more likely after being in the program to:

- make healthy decisions about drugs or alcohol (69%)
- resist or say no to peer pressure (72%)
- manage conflict without causing more conflict (57%)
- get a steady job (70%) or get more education (68%) after finishing high school
- make plans to reach goals (71%)

Increased connectedness of an adolescent with the environment around them has been shown to be an important factor in preventing engagement in risky behaviors and preventing adverse health outcomes¹.

The majority of adolescents completing the exit survey reported positive impacts on questions related to connectedness and healthy relationships including positive relationships with adults, pro-social friendships, and school.



To improve program gaps identified in an evaluation conducted during the Centers for Disease Control and Prevention (CDC) and Harvard School of Public Health Maternal and Child Health Program Evaluation Practicum, the YAYAHPM continues to train new facilitators and offer an annual refresher training for all current facilitators to troubleshoot issues and provide reporting information/updates. WyPREP staff are also available to provide technical assistance throughout the year.

One public input survey respondent said of YAYAHP's work around healthy and safe relationships, "That is amazing! This would be very beneficial to the community and I would love to see this as a parent. I don't think schools really talk much about healthy relationships and red flags. This should definitely be taught as well as safe sex and negotiation-

refusal skills.”

Strategy 4: Develop or maintain statewide youth council to ensure youth voices are included in program development, implementation, and evaluation

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

Other YAYAHP Activities:

YAYAHP partnership development

The YAYAHPM continued to develop and build partnerships with many youth serving organizations, other WDH programs, and other agencies to increase the effectiveness of YAYAHP 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 Highway Patrol
- Wyoming Department of Transportation
- Wyoming Medicaid
- Uplift
- Wyoming County Prevention Specialists
- Office of Health Equity (WDH)
- Injury and Violence Prevention Program
- Communicable Disease Unit
- Immunizations Unit

Campus Consortium

The Campus Consortium (comprised of the University of Wyoming and Wyoming’s eight community colleges), YAYAHP, WSVPC, WCADVSA have worked to ensure primary sexual violence prevention information is shared and technical assistance is provided. Preventive Health and Health Services (PHHS) Block Grant funds were used to support the “Be the Solution” statewide media campaign and dissemination of campaign materials to all institutions of higher learning in Wyoming. The campaign encourages change in community norms.

Child Safety Learning Collaborative

The YAYAHP, Child Health Program, and WDH Injury and Violence Prevention Program joined the Child Safety Learning Collaborative (CSLC) through the Child Safety Network (CSN) to focus efforts on reducing fatal and serious injuries among infants, children, and adolescents by building and improving partnerships and implementing and spreading best practice and evidence-based approaches, 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 due to alarming Wyoming rates compared to nationally. In spring 2020, the

Wyoming team decided to participate in the second cohort of the Child Safety Learning Collaborative. Through research and information gathered during the 2021-2025 Title V needs assessment, WY MCH decided to dedicate one priority to this topic, which directly aligns with the CSLC, and participation in the cohort will greatly enhance and inform youth suicide prevention work across the state.

MCH community mini-grant program

In collaboration with the Child Health Program, YAYAHP released community mini-grants with a focus on childhood injury prevention in summer 2019. The mini-grant projects address a wide variety of injury topics including safe sleep, prescription drug monitoring, adolescent motor vehicle safety, and adolescent suicide prevention. Two of the nine organizations awarded selected strategies that targeted the adolescent population.

Youth Emergency Services, Inc. (Y.E.S. House) is a regional hub for youth-based preventive, intervention, and treatment services in northeast Wyoming. Y.E.S. House utilizes a comprehensive strategy to address youth suicide and has implemented an organization-wide trauma-informed care training and philosophy. Y.E.S. House also has staff trained in Adverse Childhood Experiences (ACEs) to conduct training for other staff and volunteers. With mini-grant funds in the amount of \$7,000, Y.E.S. House was able to expand ACEs training, conducting thirteen training sessions for 491 participants across the county. Sessions were provided to over ten agencies/organizations, including local schools and prevention councils.

Campbell County School District (CCSD) implemented school HOPE Squads. HOPE Squads work to change school culture around suicide by reducing stigmas and aim to identify, protect, and help suicidal students. With mini-grant funds in the amount of \$4,615, CCSD established a new HOPE Squad at a local middle school and two new squads at three elementary schools. Eight new school advisors and one master advisor were also trained. HOPE Squad members worked through ten evidence-based modules of training. CCSD conducted branding, marketing, and other events/activities in the community and within schools to build positive relationships among peers, HOPE Squad members, and school faculty to facilitate acceptance of students seeking help and create a safe and non-threatening environment for all students. Funds to support sustainability have been identified through the County Suicide Coalition and approved by the school district.

WYOMING CAN mini-grant

With funding from the CDC to help advance the RPE goal of preventing sexual violence (SV) perpetration and victimization, the YAYAHP developed and released an RFA for Wyoming organizations to support implementation of community/societal-level primary sexual violence prevention strategies. In April 2020, two applicants were selected to receive funding; they will use a public health approach to implement and evaluate identified sexual violence primary prevention strategies based on the best available evidence at all levels of the Social Ecological Model (SEM). Activities align with the RPE Program's State Action Plan and each address at least one of the following focus areas:

- Provide opportunities to empower and support girls and women
- Create protective environments
- Promote social norms that protect against violence
- Teach skills to prevent sexual violence

Mini-grant recipients were strongly encouraged to consider shared risk and protective factors that impact youth and young adults ages 12-24 and can be addressed at the community/societal level. Recipients were also required to use the Sexual Assault and Domestic Violence Prevention Assessment Tool (SADPAT). The SADPAT, which was developed because Wyoming no longer has the YRBSS, is informed by the CDC's "Connecting the Dots" to include

shared risk and protective factors consistently associated with both sexual assault and domestic violence. When selecting measures/items to assess established risk/protective factors, validity and brevity were guiding considerations. It contains modular content that can be tailored, and can anonymously link respondents' surveys over time. The SADPAT has eight domains:

1. Hypermasculinity in relationships - Adolescent Masculinity in Relationships Scale
2. Delinquency - alcohol consumption content from YRBSS
3. Perceived Peer Support for Sexual Aggression - Family Life and Sexual Health (FLASH) Sexual Attitudes Survey
4. Rape myth acceptance
5. Intimate partner violence (IPV)/relationship control myths - dating and social norms items validated
6. Connectedness - school/teacher/families connectedness scales
7. Sexual assault and intimate partner violence perpetrationb - YRBSS victimization and perpetration items
8. Bystander intent and behavior - Coaching Boys Into Men items

YAYAHPM Memberships

The YAYAHPM has remained an active member of the Association of Maternal and Child Health Programs (AMCHP). Some of the components of active membership include serving as a session facilitator and moderator at the 2019 annual Federal/State Partners Meeting. In addition, the YAYAHPM serves on AMCHP's Global Evidence-Based Practice Workgroup and the Adolescent Pregnancy Prevention annual grantee conference planning committee. As a member of the Public Health Division's Health Equity Workgroup (HEW), the YAYAHPM participates in HEW activities and meetings, identifies inclusive strategies for capturing data and gaps in service due to disparities, and participates in WY MCH discussions related to the 6th domain priority.

Adolescent Health - Application Year

Application Year Plan (FFY21): This section presents strategies/activities for 2021-2025 MCH priorities related to Adolescent Health. See Five-Year State Action Plan Table for more information.

Priority	Performance Measure	ESM (if applicable)
Prevent Adolescent Motor Vehicle Mortality	NPM 7.2: Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10-19	ESM 7.2.1: # of schools/organizations/ SADD chapters providing teen driver safety programs with teens

The Wyoming rate and U.S. rates for adolescent motor vehicle traffic (MVT) mortality have been decreasing, the U.S. rate significantly since 2007; however, teens contribute to, and suffer from, the consequences of motor vehicle collisions at a disproportionate rate. The Wyoming adolescent MVT mortality rate for 15-19 year olds is significantly higher than the U.S. rate.

Of the July 2020 public input survey respondents who indicated that they have a youth or young adult aged 12-24 in their household, 36% indicated that they believe adolescents being injured in or passing away from motor vehicle crashes is a big or very big problem in their community, and 87% indicated that they believe it is at least somewhat of a problem. One respondent stated, “Educating the youth in this age range is critical for future generations and growth in the community. They need to [receive] education and guidance to be informed [about] their health.”

In FFY21, the Youth and Young Adult Health Program (YAYAHP) will implement the following strategies to address NPM 7.2 within the Adolescent Motor Vehicle Mortality Prevention priority:

1. Convene partners and providers to develop Bright Futures Implementation Task Force
 1. The Bright Futures Implementation Task Force will likely partner with the Immunization Unit on developing consistent messaging on the importance of both well visits and childhood immunizations. Providers will be asked about their current awareness of Bright Futures, use of materials, and related needs. The Bright Future Implementation Task Force will also develop Wyoming-specific motor vehicle traffic safety guidelines and disseminate to providers and train on guideline implementation.
2. Facilitate collaborative efforts to strengthen partnerships across entities and increase participation in the Child Safety Learning Collaborative (CSLC).
 1. The CSLC aims to reduce fatal and serious injuries among infants, children, and adolescents. Currently the CSLC is made up of Wyoming Department of Health staff. WY MCH will identify and engage statewide stakeholders by facilitating a collaborative effort to strengthen partnerships across entities and increase participation in the Child Safety Learning Collaborative and implement proven strategies aimed at decreasing MVTS for adolescents.

2. The Teens in the Driver Seat program will be implemented in schools. The most common causes of teen driving crashes are ones that many young drivers and their parents know the least about. Teens in the Driver Seat was started in 2002 and is the first peer-to-peer program for teens that focuses solely on traffic safety and addresses all major risks. The Wyoming CSLC members will collaborate to develop a plan to expand the program.

Priority	Performance Measure	ESM (if applicable)
<p>Prevent Adolescent Suicide</p>	<p>NPM 10: % of adolescents, ages 12-17, with a preventive medical visit in the past year</p> <p>SPM TBD: % of Sources of Strength-participating youth reporting increased youth-adult connectedness</p>	<p>ESM 10.1: # of clinics trained on Bright Futures (BF) and youth friendliness through the Adolescent Health Initiative</p> <p>ESM 10.2: # of clinics completing BF assessments</p> <p>ESM 10.3: % of clinics certified as Adolescent-Friendly Environment</p> <p>ESM 10.4: # of clinics showing improvement in at least 50% of selected topics</p> <p>ESM 10.5: # of Youth Council recommendations developed</p> <p>ESM 10.6: # of resources developed based on Youth Council recommendations</p> <p>ESM 10.7: # of schools/organizations implementing Sources of Strength</p>

The Wyoming adolescent suicide rate is significantly higher than the U.S. and has been since 2007. Both the U.S. and Wyoming adolescent suicide rates have increased; however, the Wyoming rate is increasing at a fast rate. In

2007, the Wyoming rate was 2.5 times higher than the U.S. rate. In 2017, it was three times higher. Suicide among adolescents continues to be a serious problem, and current statewide efforts do not focus predominantly on adolescents.

Adolescence is a period of major physical, psychological, and social development. An annual preventive well visit may help adolescents adopt or maintain healthy habits and behaviors, avoid health-damaging behaviors, manage chronic conditions, and prevent disease.

Of the July 2020 public input survey respondents who indicated that they have a youth or young adult aged 12-24 in their household, 77% indicated that they believe adolescents passing away from suicide is a big or very big problem in their community, and 95% indicated that they believe it is at least somewhat of a problem. One survey respondent expressed that YAYAHP needs to obtain “direct input from our youth for the most impact” in its work.

In FFY21, YAYAHP will implement the following strategies to address NPM 10 within the Suicide Prevention priority:

1. Continue partnership with the University of Michigan (UM) to implement the Adolescent Centered Environment-Assessment Process (ACE-AP) to increase annual clinic participation. UM will provide technical assistance on youth friendliness and the incorporation of elements of Bright Futures into practice within participating clinics, which were selected through a Request for Application process. This strategy also includes working with statewide stakeholders to promote adolescent and young adult well visits in Wyoming and collaborating with the Bright Futures Implementation Task Force to identify current barriers to well-visits from many different perspectives including system, clinic, provider, and consumer.
2. Develop, sustain, and support the Youth Council to increase youth engagement and promote youth voice in the development of strategies and products, including but not limited to adolescent well visit and suicide prevention.
3. Convene statewide partners to coordinate adolescent suicide prevention efforts and increase participation in the Child Safety Learning Collaborative. YAYAHP will continue to promote enhanced provider engagement. The YAYAHP will collaborate with statewide partners to implement Sources of Strength in schools and youth serving organizations. Sources of Strength (SoS) is a best practice youth suicide prevention program designed to highlight and harness the power of peer social networks to change unhealthy norms and culture. The upstream model of SoS strengthens protective factors for young individuals and has been shown to increase youth-adult connectedness and increase positive perceptions of adult support for suicidal youth.

July 2020 public input respondents said of the Youth Council that “youth provide essential input on what they need to be successful” and stressed the importance of members representing “a cross-section of the population” including “race, culture, religion, and socioeconomic status.”

YAYAHP will promote continue to promote healthy and safe relationships for adolescents by implementing the following strategies:

1. Continue to build statewide capacity for sexual violence prevention among youth and young adults through the Wyoming Sexual Violence Prevention Council.
2. Continue to increase the number of communities implementing WyPREP curriculum and provide technical assistance and support.

3. 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.
4. Continue quality improvement on WyPREP program evaluation.
5. Continue to build/improve relationships with stakeholders to engage youth.

Seventy-nine percent of July 2020 public input survey respondents indicated that they believe YAYAHP's planned work for 2021-2025 fits the needs of their community well or very well, and 90% indicated that they believe it fits at least somewhat well. Of the respondents who indicated that they have a youth or young adult aged 12-24 in their household, 85% indicated that they believe it fits well or very well, and 95% indicated that they believe it fits at least somewhat well. One survey respondent stated, "This work affects each one of us in our communities. The wellness and healthy development of all youth and young adults is directly related to the future of all our communities."

Children with Special Health Care Needs

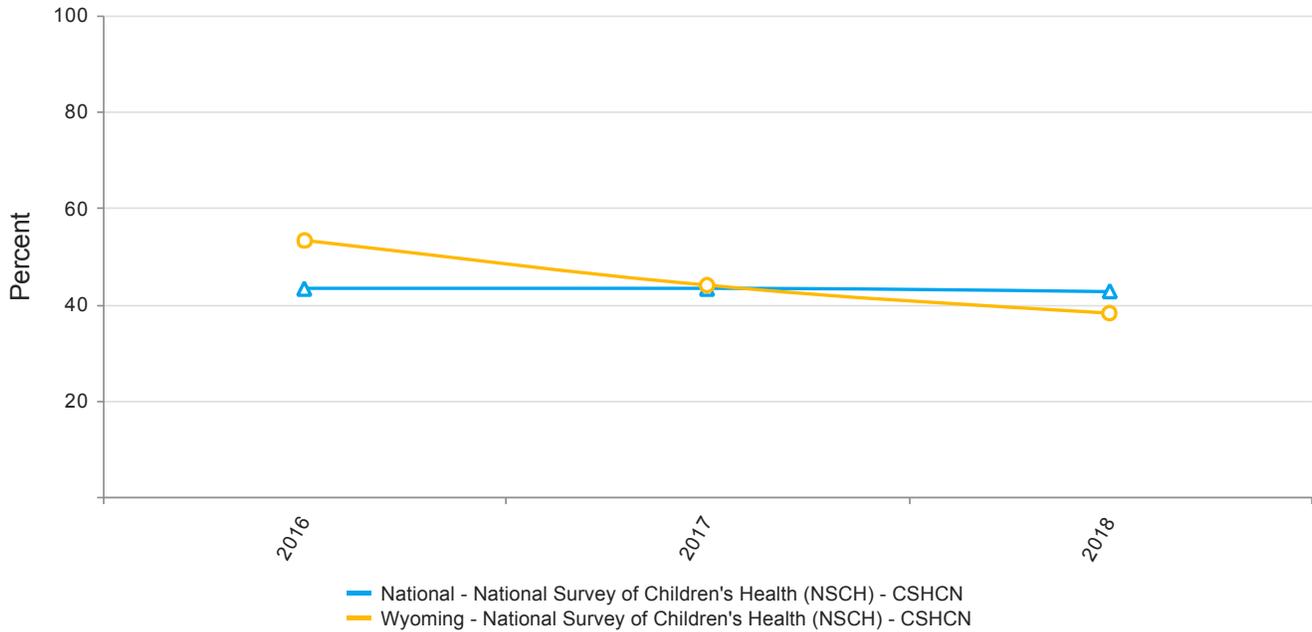
Linked National Outcome Measures

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-2017_2018	9.7 %	NPM 11 NPM 12
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2017_2018	58.4 %	NPM 11
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2017_2018	90.9 %	NPM 11
NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year	NSCH-2017_2018	3.5 %	NPM 11

National Performance Measures

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Indicators and Annual Objectives



NPM 11 - Children with Special Health Care Needs

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - CSHCN		
	2016	2019
Annual Objective		
Annual Indicator		38.1
Numerator		10,270
Denominator		26,977
Data Source		NSCH-CSHCN
Data Source Year		2017_2018

i 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					
	2021	2022	2023	2024	2025
Annual Objective					

Evidence-Based or –Informed Strategy Measures

ESM 11.1 - Percent of CSH Advisory Council members with lived experience

Measure Status:	Active
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Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	50.0	50.0	50.0	50.0	50.0

State Action Plan Table

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

Priority Need

Improve Systems of Care for Children and Youth with Special Health Care Needs

NPM

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Objectives

Increase reach of current CSH program and implement the National Standards for Systems of Care of CYSHCN.

Increase collaboration between PHN, WIC, Part C, University of Wyoming, PIC, etc. and other partners providing support to CYSHCN children and families.

Strategies

Identify and implement internal systems changes that support implementation of the National Standards for Systems of Care for CYSHCN within Wyoming CSHCN Program.

ESMs

Status

ESM 11.1 - Percent of CSH Advisory Council members with lived experience

Active

ESM 11.2 - Percent of gaps identified by systems map that the CSHCN Program, Advisory Council, and/or partners are actively addressing

Active

ESM 11.3 - Number of family members, providers, and/or partners trained on National Standards for Systems of Care for CYSHCN

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

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 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year

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

Priority Need

Improve Systems of Care for Children and Youth with Special Health Care Needs

Objectives

To convene a CSH advisory council, develop a CSH family resource guide and increase family involvement in programming.

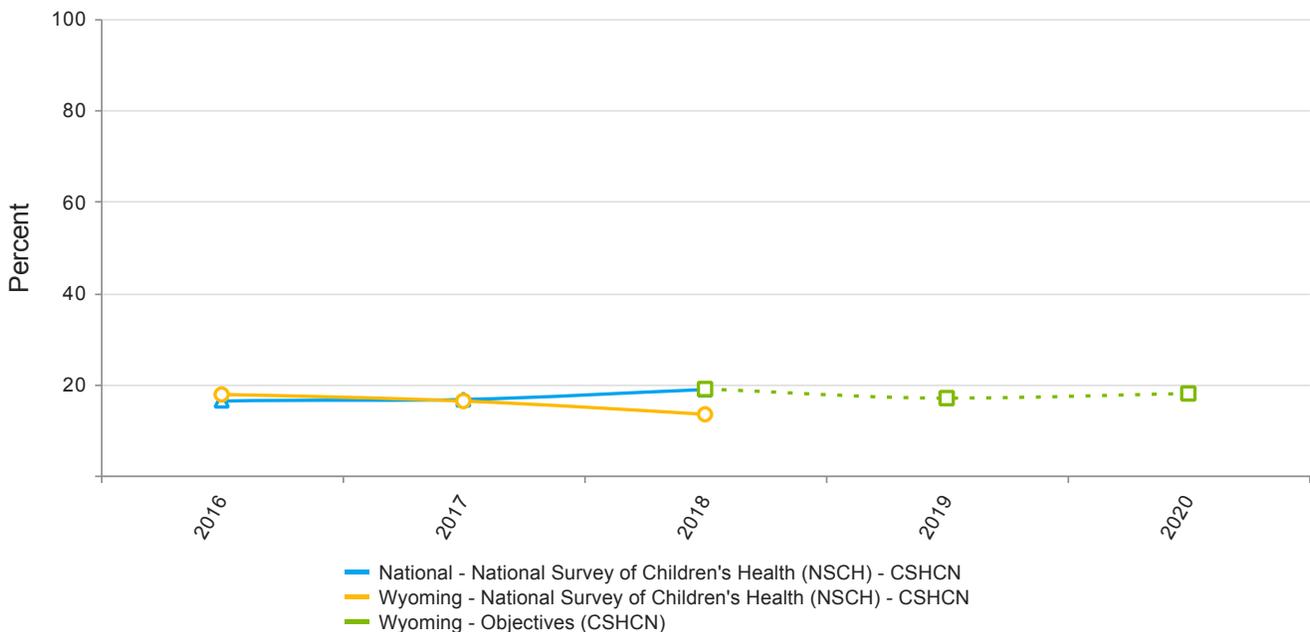
Increase collaboration and coordination between State agencies, community-based organizations, families, service providers and the University of Wyoming.

Strategies

Convene a CSH Advisory Council with the goal of including members with lived experience to support statewide collaboration, parent education, and provider education through the development of a CSH family resource guide and distribution plan (including National Standards content and information on available services) and the creation of shared definitions.

2016-2020: National Performance Measures

2016-2020: 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



2016-2020: NPM 12 - Children with Special Health Care Needs

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - CSHCN				
	2016	2017	2018	2019
Annual Objective			19	17
Annual Indicator		17.9	16.5	13.4
Numerator		2,073	2,119	1,872
Denominator		11,609	12,855	13,940
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018

i 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.

2016-2020: Evidence-Based or –Informed Strategy Measures

2016-2020: ESM 12.4 - # of parent or youth completed transition readiness assessments completed by PHN in CSH program

Measure Status:		Active		
State Provided Data				
	2017	2018	2019	
Annual Objective			45	
Annual Indicator			49	
Numerator				
Denominator				
Data Source			CSH Program Data	
Data Source Year			FFY19	
Provisional or Final ?			Final	

2016-2020: State Performance Measures

2016-2020: SPM 7 - Percent of children with and without special health care needs having a medical home

Measure Status:	Active
------------------------	---------------

Baseline data was not available/provided.

Children with Special Health Care Needs - Annual Report

Annual Report Fiscal Year 2019: This section provides a summary of Federal Fiscal Year 2019 (FFY19) 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: Percent of children with and without special health care needs having a medical home (NSCH)	N/A

The Children's Special Health Program (CSH) has continued to support efforts to increase the number of children and families receiving care in a medical home. This is done through focusing efforts on expanded care coordination and increased training of PHN partners. The percentage of Wyoming children with and without a special healthcare needs receiving care in a medical home was 46.6% during 2017-2018, similar to the U.S. percent of 48.2% (NSCH, 2017-2018). While a greater proportion (48.6%) of non-CSHCN children in Wyoming were reported as receiving care in a medical home than CSHCN children (38.1%), this was not significantly different. However, the difference in these percentages is greater than that seen between the proportion of non-CSHCN children in the U.S. reported as receiving care in a medical home (49.4%), compared to CSHCN children in the U.S. (42.7%), which was significantly different. Due to this fact, and the challenge of small samples of CSHCN populations surveyed each year, CSH considers this an important area of focus.

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 WY MCH, the Mountain States Regional Genetics Network, and the Hali Project. This evidence-informed program helps medical homes identify and hire a parent who has a child with special health care needs within their practice. These parents, called Parent Partners, are on staff approximately 16 hours per 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 a patient-centered medical home and is paid \$15/hour. In June 2019, in response to identified lack of statewide PPP leadership, WY MCH amended a contract with the Hali Project to identify a current Parent Partner who would serve as a statewide coordinator supporting outreach and program expansion efforts. In addition, the Wyoming Coordinator would conduct ongoing inservice training for Wyoming PPP staff. During the remaining contract term, the Wyoming PPP was unable to identify an existing Wyoming PPP staff member to move into this position.

WY MCH, in consultation with the Hali Project, determined that one Parent Partner would begin providing services virtually in an effort to better address Wyoming's rural and frontier makeup; this virtual format was not successful due to a lack of integration with an established provider's office.

Through the Needs Assessment and subsequent strategic planning, WY MCH identified the need to assess the CSHCN system of care and identify gaps before committing to continuing the Wyoming PPP. Thus, WY MCH

allowed the contract with the Hali Project to expire June 30, 2020 but will consider if parent partner models are needed to respond to identified gaps in the system in the future.

The Child Health Program Manager (CHPM) tracked the total number of families served at 274, the number of unique children served at 77, and the number of unique families served at 77.

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 the state. The previous model of genetics services held up to 25 in-person clinics throughout the state each year, and in 2017 WY MCH and stakeholder partners decided to launch a telehealth genetics pilot project blending in-person initial visits with telehealth follow-up visits. Upon review of previous years' clinic enrollment data and county Public Health Nursing office capacity to support genetics clinics, WY MCH selected Casper and Cheyenne as the pilot sites for offering both in-person and telehealth visits. This new model allowed WY MCH to prioritize funding and reduce overall costs for genetics services, while still offering this critical service to families dealing with genetic-related issues.

During the Pilot Year (calendar year 2018), the Wyoming Genetic Program enrolled 69 clients with services provided to 63 individuals at its two pilot locations in Cheyenne and Casper. Of these, 24 patients had a telehealth visit. The 69 clients enrolled in the program averaged 10 years of age, with a range from birth to 45 years, and the majority reported Medicaid enrollment, living in a medically underserved area, and having to take time off work or school for the appointment.

According to a post-visit survey, the 24 patients who received telehealth services 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 24 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.

WY MCH also evaluated the pilot by interviewing front-line providers (i.e. front desk clerks, public health nurses, consulting physicians). The results revealed that assets included excellent relationships between both public health nursing teams and the consulting providers, 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 areas of medical record acquisition prior to the visit and referring them to additional resources after the visit. For all patients, transportation in our rural and frontier state continues to be a barrier to care.

The pilot project identified two primary action steps. First, WY MCH added a third genetic clinic site in Riverton, WY in fall 2019 to meet the needs of several families living in Fremont County in and near the Wind River Indian Reservation. Second, the pilot project identified a gap in provider awareness of available in-state genetic services. During FFY19 and FFY20, the program increased provider engagement and outreach strategies including wide release of a program flyer. To better understand provider awareness and need for speciality services such as genetics, the program is partnering with the Wyoming Institute for Disabilities and the Family to Family Health Information Center grantee to release a provider survey. Results will inform future WY MCH speciality clinic offerings and support.

Due to a successful pilot, WY MCH continues to offer nine in-person and seven telehealth genetics clinics across the three locations annually with plans to consider adding new telehealth sites in future years. In CY2019, the Wyoming Genetic Program scheduled 89 clients with services provided to 75 individuals in Casper, Cheyenne, and Riverton. Of the 14 scheduled but not receiving services, six were due to client cancellations and eight were due to client no-

shows. Of those receiving services, 30 had a telehealth visit. The 89 clients scheduled in the clinics averaged 10 years of age, with a range from birth to 35 years, and the majority reported Medicaid enrollment.

Additional Strategies:

Promote medical home for CSH clients

Public Health Nurses (PHNs) educate Children’s Special Health (CSH) program clients and families on the importance of a medical home. CSH families are strongly encouraged to select a medical home and follow up on all well-visit checks. The CSH program requires all enrolled clients to have a primary care provider; however, 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 PHNs) encourage and support families in maintaining relationships with their child’s primary care provider. There are several national organizations that certify medical practices as patient-centered medical homes. In Wyoming, the Wyoming Primary Care Association, Wyoming Medicaid, and WY MCH have worked in partnership to expand the number of clinics certified as patient centered medical homes (PCMH). The Wyoming Primary Care Association supports clinics in becoming certified through the National Committee for Quality Assurance (NCQA). Wyoming MCH participates in an annual medical home summit hosted by the Wyoming Primary Care association to expand knowledge and understanding around the value of a PCMH as a standard of care for Wyoming Families. According to the Wyoming Primary Care Association and the Wyoming Department of Health, Healthcare Financing Division, Wyoming maintained 14 NCQA Certified PCMH practices. Coordination between a family and their healthcare provider is critical. The CSH program recognizes the complexity and challenge that families face in managing the many facets of their child’s care. Due to this, the CSH Benefits and Eligibility Staff mail appointment letters to families and providers following the AAP Bright Futures periodicity schedule in an effort to remind them of upcoming well visits and scheduled appointments with specialty care providers.

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

The transition of youth to adulthood, including the movement from a child to an adult model of healthcare, was identified as a priority of WY MCH. Based on the increased life expectancy of children with special health care needs, linking this population to adult health care providers early is critical to fostering positive long-term health outcomes. According to the American Academy of Pediatrics, optimal health and access to health care are key barriers impacting successful transition to adult care.

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

In summer 2018, the CSH Program provided a 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. All training included a follow-up survey to better understand the utility of the information provided. The training was recorded and remains a requirement for all new CSH nurses as a component of PHN onboarding. Additionally, CSH staff also have made these training sessions available to Tribal MCH nurses serving CSH clients

on Wind River Indian Reservation.

Transition from pediatric to adult health care for youth with and without special health care needs was identified by Wyoming MCH 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 reviewed definitions of health care transition, health care transition data, best practices, and how to implement newly developed tools and resources. YAYAHP and CSH staff developed the tools using Got Transition resources. The virtual training was offered live in September 2018 and recorded for ongoing use for current and new nurses. This training is required as part of a 13-part CSH training for all new CSH nurses as part of their PHN onboarding process. To date, 34 nurses have completed the training, representing 16 of Wyoming's 23 counties, or 70% of the counties. Training topics 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 (Wyoming Medicaid's case management program), 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.

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

CSH and its partners developed a Wyoming-specific transition toolkit for PHNs to use with youth and parents/caregivers enrolled in the CSH Program. They developed the toolkit through 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). 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 14; it was developed using resources from <https://www.gottransition.org> and customized TA from Got Transition. A fact sheet containing transition issues and community contacts is also sent to CSH clients turning 18 and at age 19, and it is part of the health care transition discussion the PHN has with the youth and parent/caregiver during their annual renewal. CSH has added this information to the CSH Desk Manual ensuring that all CSH clients 14-19 years of age receive standardized transition information and resources.

CSH launched the transition toolkit in January 2019, requiring completion of transition readiness assessments for eligible children during their annual renewal for the program. Between January 1, 2019 and September 30, 2019, 50 CSH clients between the ages of 14 and 19 received transition readiness assessments. CSH and PHN received 49 completed assessments and provided targeted transition education to the parents/caregivers of all 50 clients eligible to receive support for transition.

The MCH Epidemiology Program evaluated the success of the program and reported that parents and youth alike appreciated learning about the importance of health care transition. PHNs interviewed reported that discussion about health care transition adds an interesting dimension to the annual clinical visit.

Response to the CSH transition initiative has been positive. A Sheridan County PHN 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 [...]" The family also expressed that their eldest would have benefitted from this transition assistance and expressed gratitude [that] it is now part of the CSH experience." A Weston County PHN 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 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.”

Other Programmatic Activities

Children’s Special Health Program

The Children’s Special Health (CSH) Program continues to serve CYSHCN and high risk pregnant women and newborns receiving care from an out-of-state provider trained to care for high risk clients. The program includes three sub-programs, CSH, Maternal High Risk (MHR), and Newborn Intensive Care (NBIC), named for the types of populations served. CSH works with eligible families and their provider team to connect families to needed resources. In some cases, CSH also provides financial and travel assistance to families.

In FFY19, the program actively served 640 clients. Of all enrolled clients, 533 were CYSHCN covered by the CSH sub-program, 83 were high risk infants served by the NBIC sub-program, and 24 were high risk pregnant women served by the MHR sub-program.

The CSH Program Manager submitted a formal request for assistance in identifying additional measures of program performance to the Wyoming Department of Health, Quality Improvement and Performance Management Council. Currently program staff and the council are still working to establish appropriate measures.

WY MCH’s overarching priority of supporting continuous quality improvement includes an effort to improve care coordination services for children with special health care needs and their families. This is being accomplished through internal chart audits through the random selection of charts from each Benefits and Eligibility Specialist by the CSHPM. These charts are then assigned to a second Benefits and Eligibility Specialist who completes a chart audit scoring rubric and returns the results to the CSHPM for corrective action. CSH has also established a quality improvement project connected to the establishment and continued measurement of quality and performance standards within CSH.

In addition, in continued support of the MCH core value of health equity, CSH staff worked with the WDH Office of Health Equity to translate all relevant program-related documents and communication materials into Spanish. This effort was intended to support clients, parents, and caregivers in building knowledge and understanding of program services and limitations.

WY MCH continued its collaboration with Wyoming Medicaid to offer emergency travel assistance to eight families in an effort to alleviate barriers to receiving care with out-of-state specialists.

The CSH caseload is distributed among three Benefits and Eligibility Specialists (BES), who 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. The purpose of the desk manual is to have standards documented for how caseloads are worked similarly. The desk manual was completed and put into operation in fall 2019.

Children with Special Health Care Needs - Application Year

Application Year Plan (FFY21): This section presents strategies/activities for 2021-2025 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 (YAYAHP), and Children’s Special Health (CSH)) support the efforts within this domain. See Five-Year State Action Plan Table for more information.

Priority	Performance Measure	ESM (if applicable)
<p>Improve Systems of Care for CYSHCN</p>	<p>NPM 11: % of children with and without special health care needs having a medical home (NSCH)</p> <p>SPM 7: % of adolescents with and without special health care needs who received services necessary to make transitions to adult health care (NSCH)</p>	<p>ESM 11.3: # of family members and providers trained on National Standards for Systems of Care of CYSHCN</p> <p>ESM 11.1: # of CSH advisory council members with lived experience</p> <p>ESM 11.2: % of gaps identified by systems map that the CSHCH Program, Advisory Council, and/or partners are actively addressing</p>

The National Survey of Children’s Health (NSCH, 2017-18) estimates there are 26,977 (19.4%) children with special health care needs (CSHCN) (aged 0-17 years) in Wyoming. In Wyoming, only 9.7% of CSHCN receive care in a well-functioning health care system compared to 13.9% nationally (NSCH, 2017-18). Components of a well-functioning system are the following: family partnership, medical home, early screening, adequate insurance, easy access to services and preparation for adult transition.

Twenty-eight percent of July 2020 public input survey respondents indicated that they believe the health care system in their community works well or very well for children with special health care needs.

WY MCH seeks to leverage diverse partnerships, including those with families and family serving organizations, to understand and improve systems of care for CSHCN. In FY21, CSH will implement the following strategies to improve systems of care for CSHCN and address NPM 11:

1. Conduct a comprehensive gap analysis of Wyoming CSH program and services to understand where gaps exist internally for meeting the National Standards for Systems of care for CYSHCN. This will include developing an outreach plan to reach more families for Gap filling assistance and linking them to needed services.
2. Train internal staff on National Standards for Systems of Care for CYSHCN so they can serve as subject matter experts. Internal staff will support and facilitate the training and education of family members of CYSHCN and providers through Wyoming.
3. Compile a comprehensive Wyoming CSH systems map incorporating the National Standards for Systems of Care for CYSHCN Systems Improvement Alignment Tool.

4. Develop and convene a family-centered CSH Advisory Council to include caregivers with lived experience in compiling a comprehensive Wyoming CSH systems map incorporating the National Standards for Systems of Care for CYSHCN Systems Improvement Alignment Tool. This will also include development of a resource guide and glossary of standard terms and definitions, and continued recruitment of new members to facilitate the goal of more statewide collaboration, including family involvement.
5. Increase collaboration and coordination between State agencies, community-based organizations, families, service providers, and the University of Wyoming supporting the creation of a systems map RFP that will inform the development of the comprehensive CSH resource guide.
6. Increase understanding of certification requirements for a Patient Centered Medical Home (PCMH) by attending annual PCMH trainings hosted by the Wyoming Primary Care Association and/or partners.

Based on these goals CSH will actively engage CYSHCN and families with lived experience to drive the CSH forward.

In FFY21, CSH, YAYAHP, and MCH Epidemiology Program staff will continue to implement the following strategies to address SPM 7 within the Improve Systems of Care for CYSHCN priority:

1. Continue Public Health Nursing (PHN) use of the transition toolkit previously developed as part of the health care transition initiative, which includes a flow chart outlining suggested visit structure and duration; assessment forms to include a plan of care document to be shared between provider and client; talking points for clients and families; a comprehensive resource list; and other supplemental documents contained in the Bright Futures Virtual Toolkit.
2. Continue sending 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.
3. Collaborate with other WY MCH staff to develop a tool to assess parent and youth impressions of the health care transition tools provided by 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.

Seventy-three percent of July 2020 public input survey respondents indicated that they believe CSH's planned work for 2021-2025 fits the needs of their community well or very well, and 87% indicated that they believe it fits at least somewhat well. One July respondent stated, "Families feel completely overwhelmed with follow-through on medical concerns. [The planned work conveyed to survey respondents] fits the needs of our community and ... families' medical needs." Another respondent indicated that the planned CSH work "could increase access to doctors and resources. For example, there are nearly no local resources for children with Type 1 Diabetes in WY. Low-income families really struggle to get the resources they need for T1D."

Other Programmatic Activities

Genetics

WY MCH continues to run genetics clinics in partnership with Public Health Nursing. In FFY21 the Wyoming Genetic Program will work to better understand provider referrals to this program and continue to work on quality

improvement projects through a partnership with the Wyoming Institute for Disabilities.

Cross-Cutting/Systems Building

State Performance Measures

SPM 2 - % of new WY MCH staff completing MCH orientation (including MCH Navigator self-assessment) within first 6 months

Measure Status:	Active
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Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	100.0	100.0	100.0	100.0	100.0

State Action Plan Table

State Action Plan Table (Wyoming) - Cross-Cutting/Systems Building - Entry 1

Priority Need

Strengthen MCH Workforce Capacity to Operationalize MCH Core Values

SPM

SPM 2 - % of new WY MCH staff completing MCH orientation (including MCH Navigator self-assessment) within first 6 months

Objectives

Increase understanding of WY MCH workforce needs related to MCH core values

Strategies

- Develop and improve professional development opportunities to increase competencies related to MCH core values
- Promote and integrate core values across all MCH domains and state priority needs
- Develop understanding of individual and team strengths

Cross-Cutting/Systems Building - 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

Application Year Plan (FFY21): This section presents strategies/activities for 2021-2025 MCH priorities related to the Cross-Cutting/Systems Building Domain. See Five-Year State Action Plan Table for more information.

Priority	Performance Measure	ESM (if applicable)
<p>Strengthen MCH Workforce Capacity to Operationalize MCH Core Values</p>	<ul style="list-style-type: none"> • SPM: % of new WY MCH staff completing MCH orientation (including MCH Navigator self-assessment) within first 6 months 	<p>N/A</p>

In 2015, WY MCH established a vision, mission, and core values to support decision-making and improve programming for the 2016-2020 Title V cycle. In preparation for the 2020 needs assessment and 2021-2025 Title V cycle, unit staff completed a survey on core value implementation and importance. Staff reported engagement, data-driven, and health equity as the most important core values to communicate to stakeholders. Survey results indicated opportunities to improve the degree to which all core values drive programmatic decision-making. Core values were revised in 2018 and include data-driven, engagement, health equity, life course perspective, and systems-level approach. WY MCH staff identified an ongoing need to improve workforce development related to all MCH core values.

Responses to the July 2020 Public Input Survey demonstrate that WY MCH better operationalizing these core values, particularly health equity and engagement, will increase the effectiveness of its work. Respondents cited the need for staff working in health (presumably WY MCH and its partners, with providers and teachers specifically mentioned) to better learn to recognize their own biases and to share health messages “in a way that doesn’t dismiss or diminish ... the family’s cultural beliefs.” Others pointed to the need to “utilize and train up local leaders in the lay community” and engage with non-traditional partners such as law enforcement, local churches and charities, and other local organizations; another respondent emphasized the need to focus on community partners that minorities will trust far more than the government directly. Other respondents indicated that helping community members become aware of services is even more important during COVID-19, when many in-person avenues to information such as birthing classes are unavailable, though many indicated that health information does not reach the communities well in general. As an example, one respondent stated, “Very few people know of the help available. It took me walking into multiple places asking if they knew of anything. I even opened a voluntary case with DFS in hopes that they could help connect me with resources and they could not. I happened to walk into the Department of Health (by) chance hoping to find something before I learned about the Children’s Special Health Program.” Other respondents indicated that families may be embarrassed to ask for help unless directly approached, and emphasized the need to use media to “help them understand that they are empowered when they seek health information/resources. Instill a belief that they are smart, responsible, (and) capable.” One respondent urged, “Actually do it” instead of “just providing lip service,” and this is precisely what WY MCH seeks to fulfill in improving its ability to operationalize its core values.

In FFY21, WY MCH will implement the following strategies to address the priority of strengthening MCH workforce capacity to operationalize MCH core values:

1. Develop and improve professional development opportunities to increase competencies related to MCH core values. Proposed activities include:
 - a. Conduct MCH workforce assessment to identify training needs
 - b. Develop MCH orientation for internal MCH staff and volunteers, including content related to each core value
 - c. Develop MCH orientation for external MCH stakeholders (e.g. contractors), including content related to each core value

2. Promote and integrate core values across all MCH domains and state priority needs. Proposed activities include:
 - a. Develop a plan for strategic plan implementation that integrates core values (e.g. Strategic Plan Implementation Review Meetings held at least quarterly that address degree to which strategies address core values)
 - b. Identify and complete available core value assessment tools (e.g. engagement tool, health equity tool)
 - c. Develop mechanism to measure core value implementation (e.g. develop performance metric to track number/percent of strategies related to a core value)

3. Develop understanding of individual and team strengths. Proposed activities include:
 - a. All MCH staff and volunteers complete Strengthsfinder assessment upon hire/start

III.F. Public Input

Engagement with the public and stakeholders is one of the core values WY MCH is determined to operationalize in the new grant year, but that does not mean WY MCH is waiting until October 1 to make significant changes in how the unit works. Last year WY MCH received minimal public input on its Application/Annual Report with only two survey responses. This year, accessible communication and genuine engagement drove public input efforts.

The central component of WY MCH's public input plan was a public input survey. In determining how to best make the Application/Annual Report available to the public for feedback during its development, WY MCH recognized that exclusively providing the public with a full draft version was, although a common approach, not the most engaging one. The length of the document and public health jargon are not digestible for the average member of the public and could limit how many responses were received and result in only receiving responses from those with higher socioeconomic status. Providing an excerpt, as WY MCH did last year, solves the length problem but retains the literacy level and jargon barriers. Thus, WY MCH chose to convert the content of the application and annual report into plain language and condense it to a more digestible length, then imbed this text directly in the survey itself. The survey was broken up by domain, with the plain language summaries of the Application/Annual Report content followed by six to eight questions per domain. WY MCH worked closely with UPLIFT, Wyoming's Family Voices affiliate, to ensure that the survey was at a length and reading level appropriate for the general public. The survey opened July 1, 2020 and closed July 15, 2020.

WY MCH also recognized the importance of offering an incentive in order to communicate the value of survey respondents' time. UPLIFT, Wyoming's Family Voices affiliate, was able to purchase \$10 Walmart gift cards on WY MCH's behalf for reimbursement, which were then emailed or mailed to all respondents who completed the full survey, live in Wyoming, and are not public employees (WDH's fiscal department defines a public employee as anyone working for a city, county, state, federal, or tribal government, or for an institution of higher learning, and they provided guidance that grant funds should not provide incentives for public employees).

In terms of distribution, WY MCH elected not to rely on a press release as it was feared that Wyoming citizens were oversaturated with WDH press releases regarding COVID-19. WY MCH instead used five approaches to spread the word about the survey:

- Wyoming MCH's quarterly email newsletter
 - The newsletter was sent directly to the 76 subscribers. The newsletter was also forwarded to every MCH PHN across the state (currently there are 77 local MCH PHNs in Wyoming) by the MCH Consultant for PHN. The newsletter providing a link to the survey had an open rate of 74% and a click rate of 16%.
- Wyoming's local MCH PHNs
 - MCH PHNs were asked to tell their clients about the survey via word-of-mouth. During June 22 and July 1, 2020 calls between WY MCH and the MCH PHNs, PHNs offered to put up flyers in their offices and post links to the survey on their Facebook pages. WY MCH created Facebook post content and flyers with a QR code linking to the survey and provided them to the PHNs upon the survey's launch.
- The Wyoming MCH website
- Word-of-mouth through other WDH programs to their clients, initiated by an email blast from the WDH Director's Office announcing the survey
- Word-of-mouth and email blasts through stakeholder groups, including MCH Priority Action Teams, the Wyoming PRAMS listserv, and the WDH Performance Improvement Manager's professional contacts

Once the final survey results were available, staff removed the responses that were deemed to be by bots or scammers, and the responses where the respondent only answered a small fraction of the questions before quitting the survey. After removing these bot, scam, and incomplete responses, MCH determined that it had received 107 responses to its survey, a 5,250% increase in survey responses from the two survey responses in 2019, and a 5,000% increase from the seven survey responses in 2018. Thirty-seven of the 107 respondents were eligible for a gift card; the others were public employees (no respondents indicated that they lived outside Wyoming). Additionally, responses came from 21 of the 23 counties in Wyoming; most of the responses were from Laramie County, but several other counties also had a high number of responses and 17 of the 21 counties that responses came from featured more than one response per county. Of all 107 respondents, 64% reported having a mother or woman aged 15-44 in their household, 12% reported having an infant in their household, 49% reported having a child aged 11 and under in their household, and 36% reported having a teen or young adult aged 12-24 in their household.

As for the nature of the public input, the survey collected both quantitative and qualitative data. Quantitatively, respondents were asked to rank to what degree the past and planned work of each domain impacts their community, to rank how much of a problem certain MCH topics (e.g. child obesity, infant mortality) are in their community, and whether or not they experience barriers related to different domains. Qualitatively, respondents were posed with open-ended questions around barriers, health equity, potential partners in their communities, and any other thoughts they wanted to express.

WY MCH utilized this feedback to solidify which strategies and activities to focus on, identify local community-based partners to convene and collaborate with, and identify which parts of Wyoming the selected priorities are particularly relevant for in order to target attention in those communities.

For those members of the public interested in seeing the full Application/Annual Report document, WY MCH also posted the Application/Annual Report on the home page of its website alongside contact information to provide feedback on August 24, 2020. As of the date of this writing, no comments have been received in this avenue, as respondents opted to provide feedback via the survey featuring the condensed, plain language version of the Application/Annual Report. Upon submission of this Application/Annual Report, the final version will be posted on the WY MCH website along with contact information, should any members of the general public decide to comment at that point.

Earlier in its needs assessment and strategic planning processes, WY MCH also conducted outreach to specific stakeholders through its Priority Action Team (PAT) meetings held March 10-11, 2020 and May 26-27, 2020. WY MCH communicated its plans for its Application/Annual Report and solicited feedback on which priorities and strategies to select. As participants included members of community-based organizations, providers, and tribal health representatives, WY MCH would be remiss not to mention the PAT meetings in the context of both stakeholder engagement and public input.

One additional public input element relevant to WY MCH's planning process was Wyoming's [State Health Assessment](#) (SHIP), based on the 2018 WDH State Health Assessment. The State Health Assessment had over 100 attendees at its open houses and listening sessions held across the state and 447 responses to its online survey from members of the public. The State Health Assessment identified three top health priority recommendations important to Wyoming citizens, highlighted in the SHIP: Behavioral Health, Access to Healthcare, and Unintentional Injury. These overall WDH priorities were used to guide WY MCH's strategic planning. Behavioral Health aligns with WY MCH's planned focus on adolescent suicide and reducing maternal mortality via mental health screening at well woman visits. Access to Healthcare aligns with the CSHCN focus on systems of care. Unintentional Injury aligns with infant safe sleep and adolescent motor vehicle mortality.

Wyoming MCH looks forward to increasing its public input efforts further over the next several years as the unit dives deeper into its core value of engagement. Specific planned efforts include developing a social media communication plan to better reach the public, and the implementation of the Youth Council in order for youth and young adults to provide direct feedback on many WDH and PHD efforts, including those of MCH.

III.G. Technical Assistance

MCH Emergency Preparedness Planning

WY MCH submitted a successful Public Health Associate Program application in 2020 and plans to welcome an associate in October 2020. The associate will help lead efforts to improve WY MCH parent and family partnership activities and develop a statewide MCH Emergency Preparedness Plan informed and reviewed by parents and families. While WY MCH is planning to apply for an Action Learning Collaborative to support WY MCH in building emergency preparedness and response capacity for MCH populations, additional technical assistance may be needed.

New CSHCN Director Mentorship

Plans are underway to reclassify a staff position to become a CSHCN Program Manager and CSHCN Director, ending a nearly ten-year gap in leadership for the program. While this reclassification is not guaranteed due to State processes and needed approvals, the technical assistance need remains. WY MCH leadership requests technical assistance in the form of cross-state mentorship for the new CSHCN leader. The mentor or group of mentors should have experience leading CSHCN activities in a rural/frontier state.

Assessment of National Standards for Systems of Care for CYSHCN

WY MCH's program for CYSHCN has not changed for many years despite reductions in staff/budget and a national shift away from direct services in favor of population-based, public health services for CYSHCN. The program may continue to offer gap-filling financial assistance and care coordination to eligible families but must also shift toward implementation of systems-level strategies. A FFY21 strategy for the "Improve Systems of Care for CYSHCN" priority is to conduct an assessment of the National Standards of Care for CYSHCN in Wyoming. WY MCH is requesting technical assistance in identifying content experts and/or peers in other states who have recently conducted an assessment of the National Standards of Care for CYSHCN to provide guidance and support.

MCH Workforce Development

WY MCH established a new Title V priority dedicated to strengthening MCH workforce development for the 2021-2025 grant cycle. A University of Wyoming social work intern will be assigned to WY MCH beginning August 2020 and will support development of a WY MCH orientation with special emphasis on the MCH core values of data-driven, engagement, health equity, life course perspective, and systems-level approach. Technical assistance may be requested specifically from the National MCH Workforce Development Center and the MCH Evidence Center to identify and vet available trainings and to provide consultation on the development of an evaluation plan for workforce development strategies.

CSHCN Data/Evaluation Support

Due to an inadequate and dated CSH data system, current programmatic efforts lack evaluation capabilities and ongoing quality assurance. WY MCH requests technical assistance 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 technical assistance from the National Center for Care Coordination Technical Assistance and would like to revisit options in the next fiscal year. This technical assistance request is a repeat from the 2019 report; however, this year's technical assistance request adds that any data solution aligns with the National Standards for Systems of Care for CYSHCN.

Provider Associations Engagement

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 the Wyoming Chapter leads are for associations and what their role could/should be. We request TA on engaging provider groups in rural/frontier states.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - [Title V - Medicaid IAA - MOU.pdf](#)

V. Supporting Documents

No Supporting documents were provided by the state.

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - [PHD Org Chart 8.19.20.pdf](#)

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Wyoming

	FY 21 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	\$ 1,078,080	
A. Preventive and Primary Care for Children	\$ 390,000	(36.1%)
B. Children with Special Health Care Needs	\$ 385,000	(35.7%)
C. Title V Administrative Costs	\$ 60,000	(5.6%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	\$ 835,000	
3. STATE MCH FUNDS (Item 18c of SF-424)	\$ 0	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	\$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	\$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	\$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	\$ 0	
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)	\$ 1,078,080	
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)	\$ 1,957,109	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	\$ 3,035,189	

OTHER FEDERAL FUNDS	FY 21 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	\$ 211,677
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	\$ 250,000
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) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant	\$ 12,602
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > ERASE MM	\$ 61,729
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > PRAMS Opioid Supplement	\$ 21,999

	FY 19 Annual Report Budgeted		FY 19 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	\$ 1,100,000		\$ 1,046,625	
A. Preventive and Primary Care for Children	\$ 390,000	(35.5%)	\$ 332,938	(31.8%)
B. Children with Special Health Care Needs	\$ 345,000	(31.4%)	\$ 464,878	(44.4%)
C. Title V Administrative Costs	\$ 45,000	(4.1%)	\$ 107,667	(10.3%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	\$ 780,000		\$ 905,483	
3. STATE MCH FUNDS (Item 18c of SF-424)	\$ 1,736,286		\$ 1,853,637	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	\$ 0		\$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	\$ 639,305		\$ 521,954	
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)	\$ 3,475,591		\$ 3,422,216	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	\$ 1,578,412		\$ 1,445,658	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	\$ 5,054,003		\$ 4,867,874	

OTHER FEDERAL FUNDS	FY 19 Annual Report Budgeted	FY 19 Annual Report Expended
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant	\$ 12,602	\$ 12,602
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	\$ 232,498	\$ 197,478
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	\$ 114,369	\$ 114,367
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	\$ 101,602	\$ 108,248
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Temporary Assistance for Needy Families (TANF)	\$ 1,117,341	\$ 1,012,963

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:	2019
	Column Name:	Annual Report Expended
	Field Note:	Updated 8/21/20
2.	Field Name:	Federal Allocation, B. Children with Special Health Care Needs:
	Fiscal Year:	2019
	Column Name:	Annual Report Expended
	Field Note:	Updated 8/21/20
3.	Field Name:	Federal Allocation, C. Title V Administrative Costs:
	Fiscal Year:	2019
	Column Name:	Annual Report Expended
	Field Note:	Updated 8/21/20
4.	Field Name:	5. OTHER FUNDS
	Fiscal Year:	2019
	Column Name:	Annual Report Expended
	Field Note:	Updated 8/21/20
5.	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:	2021
	Column Name:	Application Budgeted
	Field Note:	GFY20
6.	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:	2021
	Column Name:	Application Budgeted
	Field Note:	GFY20
7.	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:	2021
	Column Name:	Application Budgeted
	Field Note:	GFY20
8.	Field Name:	Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant
	Fiscal Year:	2021
	Column Name:	Application Budgeted
	Field Note:	GFY20
9.	Field Name:	Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > ERASE MM
	Fiscal Year:	2021
	Column Name:	Application Budgeted
	Field Note:	Utah is the awardee. WY is a subrecipient.
10.	Field Name:	Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > PRAMS Opioid Supplement
	Fiscal Year:	2021
	Column Name:	Application Budgeted
	Field Note:	GFY20

Data Alerts:

-
- The value in Line 1C, Title V Administrative Costs, Annual Report Expended is greater than 10% of the Federal Allocation, Annual Report Expended. A field-level note indicating the reason for the discrepancy was provided.

**Form 3a
Budget and Expenditure Details by Types of Individuals Served**

State: Wyoming

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY 21 Application Budgeted	FY 19 Annual Report Expended
1. Pregnant Women	\$ 110,000	\$ 0
2. Infants < 1 year	\$ 110,000	\$ 0
3. Children 1 through 21 Years	\$ 400,000	\$ 0
4. CSHCN	\$ 385,000	\$ 0
5. All Others	\$ 73,000	\$ 0
Federal Total of Individuals Served	\$ 1,078,000	\$ 0

IB. Non-Federal MCH Block Grant	FY 21 Application Budgeted	FY 19 Annual Report Expended
1. Pregnant Women	\$ 150,000	\$ 0
2. Infants < 1 year	\$ 1,400,000	\$ 0
3. Children 1 through 21 Years	\$ 125,000	\$ 0
4. CSHCN	\$ 250,000	\$ 0
5. All Others	\$ 450,591	\$ 0
Non-Federal Total of Individuals Served	\$ 2,375,591	\$ 0
Federal State MCH Block Grant Partnership Total	\$ 3,453,591	\$ 0

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

1.	Field Name:	IA. Federal MCH Block Grant, 1. Pregnant Women
	Fiscal Year:	2019
	Column Name:	Annual Report Expended
	Field Note:	Pending
2.	Field Name:	IA. Federal MCH Block Grant, 2. Infant < 1 Year
	Fiscal Year:	2019
	Column Name:	Annual Report Expended
	Field Note:	Pending
3.	Field Name:	IA. Federal MCH Block Grant, 3. Children 1 through 21 years
	Fiscal Year:	2019
	Column Name:	Annual Report Expended
	Field Note:	Pending
4.	Field Name:	IA. Federal MCH Block Grant, 4. CSHCN
	Fiscal Year:	2019
	Column Name:	Annual Report Expended
	Field Note:	Pending
5.	Field Name:	IA. Federal MCH Block Grant, 5. All Others
	Fiscal Year:	2019
	Column Name:	Annual Report Expended
	Field Note:	Pending
6.	Field Name:	IA. Federal MCH Block Grant, Federal Total of Individuals Served
	Fiscal Year:	2019
	Column Name:	Annual Report Expended

	Field Note: Pending	
7.	Field Name:	IB. Non-Federal MCH Block Grant, 1. Pregnant Women
	Fiscal Year:	2019
	Column Name:	Annual Report Expended
	Field Note: Pending	
8.	Field Name:	IB. Non-Federal MCH Block Grant, 2. Infant < 1 Year
	Fiscal Year:	2019
	Column Name:	Annual Report Expended
	Field Note: Pending	
9.	Field Name:	IB. Non-Federal MCH Block Grant, 3. Children 1 through 21 years
	Fiscal Year:	2019
	Column Name:	Annual Report Expended
	Field Note: Pending	
10.	Field Name:	IB. Non-Federal MCH Block Grant, 4. CSHCN
	Fiscal Year:	2019
	Column Name:	Annual Report Expended
	Field Note: Pending	
11.	Field Name:	IB. Non-Federal MCH Block Grant, 5. All Others
	Fiscal Year:	2019
	Column Name:	Annual Report Expended
	Field Note: Pending	
12.	Field Name:	IB. Non-Federal MCH Block Grant, Non Federal Total of Individuals Served
	Fiscal Year:	2019
	Column Name:	Annual Report Expended

Field Note:
Pending

13. **Field Name:** **FEDERAL-STATE MCH BLOCK GRANT PARTNERSHIP TOTAL**

Fiscal Year: **2019**

Column Name: **Annual Report Expended**

Field Note:
Pending

Data Alerts:

-
- Children 1 through 21 Years, Annual Report Expended does not equal Form 2, Line 1A, Preventive and Primary Care for Children, Annual Report Expended. A field - level note indicating the reason for the discrepancy was provided.
 - CSHCN, Annual Report Expended does not equal Form 2, Line 1B, Children with Special Health Care Needs, Annual Report Expended. A field-level note indicating the reason for the discrepancy was provided.

Form 3b
Budget and Expenditure Details by Types of Services

State: Wyoming

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY 21 Application Budgeted	FY 19 Annual Report Expended
1. Direct Services		
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One		
B. Preventive and Primary Care Services for Children		
C. Services for CSHCN		
2. Enabling Services		
3. Public Health Services and Systems		
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		
Physician/Office Services		
Hospital Charges (Includes Inpatient and Outpatient Services)		
Dental Care (Does Not Include Orthodontic Services)		
Durable Medical Equipment and Supplies		
Laboratory Services		
Direct Services Line 4 Expended Total		\$ 0
Federal Total		

IIB. Non-Federal MCH Block Grant	FY 21 Application Budgeted	FY 19 Annual Report Expended
1. Direct Services		
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One		
B. Preventive and Primary Care Services for Children		
C. Services for CSHCN		
2. Enabling Services		
3. Public Health Services and Systems		
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		
Physician/Office Services		
Hospital Charges (Includes Inpatient and Outpatient Services)		
Dental Care (Does Not Include Orthodontic Services)		
Durable Medical Equipment and Supplies		
Laboratory Services		
Direct Services Line 4 Expended Total		
Non-Federal Total		

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

None

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

State: Wyoming

Total Births by Occurrence: 5,923

Data Source Year: 2019

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	5,827 (98.4%)	4	4	4 (100.0%)

Program Name(s)		
Classic Galactosemia	Medium-Chain Acyl-Coa Dehydrogenase Deficiency	Primary Congenital Hypothyroidism

2. Other Newborn Screening Tests

None

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

The WY Newborn Screening Program does not currently perform long term follow up.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

1.	Field Name:	Total Births by Occurrence
	Fiscal Year:	2019
	Column Name:	Total Births by Occurrence Notes
	Field Note:	VSS
2.	Field Name:	Core RUSP Conditions - Receiving At Least One Screen
	Fiscal Year:	2019
	Column Name:	Core RUSP Conditions
	Field Note:	NBS Program Data

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 2019

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

Types Of Individuals Served	(A) Title V Total Served	Primary Source of Coverage				
		(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	1,209	33.3	0.0	58.8	7.9	0.0
2. Infants < 1 Year of Age	1,990	34.8	0.0	57.5	7.7	0.0
3. Children 1 through 21 Years of Age	1,016	62.6	1.6	29.4	5.1	1.3
3a. Children with Special Health Care Needs	610	86.2	2.6	6.3	2.8	2.1
4. Others	2,695	9.0	0.0	79.0	12.0	0.0
Total	6,910					

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	6,562	Yes	6,562	100	6,562	1,209
2. Infants < 1 Year of Age	5,989	Yes	5,989	100	5,989	1,990
3. Children 1 through 21 Years of Age	157,511	Yes	157,511	19	29,927	1,016
3a. Children with Special Health Care Needs	31,313	Yes	31,313	21	6,576	610
4. Others	413,403	Yes	413,403	7	28,938	2,695

Form Notes for Form 5:

None

Field Level Notes for Form 5a:

1.	Field Name:	Pregnant Women Total Served
	Fiscal Year:	2019
	Field Note:	PHNI Prenatal; MHR
2.	Field Name:	Infants Less Than One YearTotal Served
	Fiscal Year:	2019
	Field Note:	NBIC; PHNI Infants
3.	Field Name:	Children 1 through 21 Years of Age
	Fiscal Year:	2019
	Field Note:	PHNI Family Visits; Genetics
4.	Field Name:	Children with Special Health Care Needs
	Fiscal Year:	2019
	Field Note:	CSH; Parent Partner
5.	Field Name:	Others
	Fiscal Year:	2019
	Field Note:	PHNI Family Visits (adults); PHNI Postpartum Visits (adults); Parent Partner (families)

Field Level Notes for Form 5b:

1.	Field Name:	Pregnant Women
	Fiscal Year:	2019
	Field Note:	Home Visitation, Maternal Mortality, PQC (all women), Breastfeeding in hospitals (4), CLC training for breastfeeding (21), AIM hospitals (4), Quitline, IPP LARC (1)
2.	Field Name:	InfantsLess Than One Year
	Fiscal Year:	2019
	Field Note:	Home Visitation, FIMR (1 county), PQC (all), Breastfeeding Hospitals (4), CLC training (21), LOCATe, NBS
3.	Field Name:	Children 1 Through 21 Years of Age
	Fiscal Year:	2019
	Field Note:	HMG (2 counties), Family Home Visitation, Genetics
4.	Field Name:	Children With Special Health Care Needs
	Fiscal Year:	2019
	Field Note:	Parent Partner, CSH, Transition Education
5.	Field Name:	Others
	Fiscal Year:	2019
	Field Note:	Family Visits, Parent Partner

Data Alerts: None

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

State: Wyoming

Annual Report Year 2019

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	6,566	5,100	68	837	213	50	26	179	93
Title V Served	1,209	1,209	0	0	0	0	0	0	0
Eligible for Title XIX	2,147	1,340	29	364	158	10	3	221	22
2. Total Infants in State	6,823	5,334	174	1,011	85	0	219	0	0
Title V Served	1,990	1,990	0	0	0	0	0	0	0
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. Title V Served
	Fiscal Year:	2019
	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.

2.	Field Name:	2. Total Infants in State
	Fiscal Year:	2019
	Column Name:	Total
	Field Note:	Infants in State for Form 6 is more than 10% different than occurrent births in Form 4.

3.	Field Name:	2. Title V Served
	Fiscal Year:	2019
	Column Name:	Total
	Field Note:	This represents the number of infants served through the Newborn Intensive Care Programs and the Healthy Baby Home Visitation Program. Data on race and ethnicity are not reliably collected.

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

State: Wyoming

A. State MCH Toll-Free Telephone Lines	2021 Application Year	2019 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 438-5795	(800) 438-5795
2. State MCH Toll-Free "Hotline" Name	WY Maternal and Child Health Toll Free Hotline	WY Maternal and Child Health Toll Free Hotline
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"		185

B. Other Appropriate Methods	2021 Application Year	2019 Annual Report Year
1. Other Toll-Free "Hotline" Names		n/a
2. Number of Calls on Other Toll-Free "Hotlines"		0
3. State Title V Program Website Address	https://health.wyo.gov/public/health/mch/	https://health.wyo.gov/public/health/mch/
4. Number of Hits to the State Title V Program Website		3,574
5. State Title V Social Media Websites		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	122 West 25th Street
Address 2	3rd Floor West
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	122 West 25th Street
Address 2	3rd Floor West
City/State/Zip	Cheyenne / WY / 82002
Telephone	(307) 777-6326
Extension	
Email	danielle.marks@wyo.gov

3. State Family or Youth Leader (Optional)

Name	Susie Markus
Title	WY Youth Council Coordinator
Address 1	122 West 25th Street
Address 2	3rd Floor West
City/State/Zip	Cheyenne / WY / 82002
Telephone	(307) 274-6292
Extension	
Email	smarkussowk@gmail.com

Form Notes for Form 8:

None

Form 9
State Priorities – Needs Assessment Year

State: Wyoming

Application Year 2021

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five- year reporting period)
1.	Prevent Maternal Mortality	New
2.	Prevent Infant Mortality	Continued
3.	Promote Healthy and Safe Children	New
4.	Promote Adolescent Motor Vehicle Safety	New
5.	Prevent Adolescent Suicide	New
6.	Improve Systems of Care for Children and Youth with Special Health Care Needs	New
7.	Strengthen MCH Workforce Capacity to Operationalize MCH Core Values	New

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.

None

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
2018	76.4 %	0.5 %	4,917	6,439
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
2017	46.3	8.8	28	6,051
2016	73.1	10.7	47	6,430
2015	44.1	9.4	22	4,992
2014	77.1	10.4	55	7,131
2013	73.4	10.1	53	7,218
2012	62.5	9.4	45	7,196
2011	73.9	10.2	53	7,175
2010	53.7	8.6	39	7,257
2009	53.6	8.4	41	7,643
2008	42.7	7.6	32	7,502

Legends:

- Indicator has a numerator ≤ 10 and is not reportable
- Indicator has a numerator < 20 and should be interpreted with caution

NOM 2 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014_2018	NR 	NR 	NR 	NR 

Legends:

-  Indicator has a numerator <10 and is not reportable
-  Indicator has a numerator <20 and should be interpreted with caution

NOM 3 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	9.4 %	0.4 %	614	6,559
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
2018	9.8 %	0.4 %	646	6,561
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
2018	27.4 %	0.6 %	1,798	6,561
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
2018/Q2-2019/Q1	2.0 %			
2018/Q1-2018/Q4	2.0 %			
2017/Q4-2018/Q3	1.0 %			
2017/Q3-2018/Q2	1.0 %			
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:

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
2017	4.5	0.8	31	6,919
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
2017	4.6	0.8	32	6,903
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
2017	2.9	0.7	20	6,903
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
2017	1.7 ⚡	0.5 ⚡	12 ⚡	6,903 ⚡
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
2017	NR 	NR 	NR 	NR 
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
2017	NR 	NR 	NR 	NR 
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
2018	3.3 %	0.9 %	208	6,378
2017	8.0 %	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
2017	4.4	0.9	26	5,874
2016	5.5	0.9	36	6,531
2015	3.3 ⚡	0.8 ⚡	17 ⚡	5,089 ⚡
2014	4.2	0.8	28	6,670
2013	2.5 ⚡	0.6 ⚡	17 ⚡	6,726 ⚡
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
- ⚡ 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
2017_2018	12.5 %	1.4 %	16,551	132,767
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
2018	17.9	5.2	12	66,936
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
2018	31.8	6.5	24	75,417
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
2016_2018	20.1	4.3	22	109,359
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
2016_2018	25.6	4.8	28	109,359
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
2017_2018	19.4 %	1.5 %	26,977	138,786
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
2017_2018	9.7 %	2.6 %	2,609	26,977
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
2017_2018	3.4 %	0.8 %	3,997	116,027
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
2017_2018	7.9 %	1.2 %	9,060	114,958
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
2017_2018	58.4 % ⚡	5.2 % ⚡	10,033 ⚡	17,176 ⚡
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
2017_2018	90.9 %	1.2 %	125,792	138,372
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
2016	9.1 %	0.5 %	315	3,458
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 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: 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
2017_2018	11.8 %	2.3 %	7,114	60,360
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
2018	8.1 %	1.3 %	10,693	131,647
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
2018	68.2 %	3.5 %	6,494	9,527
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 width/estimate >1.2
-  Estimates with 95% confidence interval widths >20 or that are inestimable 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
2018_2019	46.0 %	2.1 %	59,126	128,480
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 because the relative standard error is >0.3.
- ⚡ 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
2018	53.5 %	3.8 %	19,622	36,657
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 width/estimate > 1.2
- Estimates with 95% confidence interval widths > 20 or that are inestimable 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
2018	89.1 %	2.2 %	32,648	36,657
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 width/estimate > 1.2
- ⚡ Estimates with 95% confidence interval widths > 20 or that are inestimable 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
2018	65.1 %	3.6 %	23,851	36,657
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 width/estimate >1.2
- ⚡ Estimates with 95% confidence interval widths > 20 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
2018	20.8	1.1	362	17,379
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
2018	15.7 %	1.9 %	995	6,336
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
2017_2018	3.5 %	0.8 %	4,799	137,617
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 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Federally Available Data	
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)	
	2019
Annual Objective	
Annual Indicator	64.8
Numerator	61,481
Denominator	94,822
Data Source	BRFSS
Data Source Year	2018

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective					

Field Level Notes for Form 10 NPMs:

None

NPM 5A - Percent of infants placed to sleep on their backs

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2019
Annual Objective	
Annual Indicator	85.7
Numerator	5,251
Denominator	6,130
Data Source	PRAMS
Data Source Year	2018

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective					

Field Level Notes for Form 10 NPMs:

None

NPM 5B - Percent of infants placed to sleep on a separate approved sleep surface

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2019
Annual Objective	
Annual Indicator	29.6
Numerator	1,775
Denominator	5,999
Data Source	PRAMS
Data Source Year	2018

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective					

Field Level Notes for Form 10 NPMs:

None

NPM 5C - Percent of infants placed to sleep without soft objects or loose bedding

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2019
Annual Objective	
Annual Indicator	32.6
Numerator	1,928
Denominator	5,918
Data Source	PRAMS
Data Source Year	2018

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective					

Field Level Notes for Form 10 NPMs:

None

NPM 7.2 - Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19

Federally Available Data	
Data Source: HCUP - State Inpatient Databases (SID)	
	2019
Annual Objective	
Annual Indicator	276.4
Numerator	207
Denominator	74,890
Data Source	SID-ADOLESCENT
Data Source Year	2017

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective					

Field Level Notes for Form 10 NPMs:

None

NPM 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - CHILD		
	2016	2019
Annual Objective		
Annual Indicator		30.2
Numerator		14,688
Denominator		48,676
Data Source		NSCH-CHILD
Data Source Year		2017_2018

i 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					
	2021	2022	2023	2024	2025
Annual Objective					

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	2019
Annual Objective			76	78
Annual Indicator		75.7	78.2	78.2
Numerator		34,569	35,814	35,814
Denominator		45,669	45,789	45,789
Data Source		NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2016_2017

i 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						
	2020	2021	2022	2023	2024	2025
Annual Objective	78.0	78.0	80.0	80.0	80.0	

Field Level Notes for Form 10 NPMs:

None

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - Children with Special Health Care Needs

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - CSHCN		
	2016	2019
Annual Objective		
Annual Indicator		38.1
Numerator		10,270
Denominator		26,977
Data Source		NSCH-CSHCN
Data Source Year		2017_2018

i 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					
	2021	2022	2023	2024	2025
Annual Objective					

Field Level Notes for Form 10 NPMs:

None

**Form 10
National Performance Measures (NPMs) (2016-2020 Needs Assessment Cycle)**

State: Wyoming

2016-2020: NPM 4A - Percent of infants who are ever breastfed

Federally Available Data				
Data Source: National Immunization Survey (NIS)				
	2016	2017	2018	2019
Annual Objective	90	92	93	93
Annual Indicator	89.7	88.3	90.0	89.6
Numerator	5,817	5,853	6,269	4,671
Denominator	6,486	6,628	6,963	5,216
Data Source	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016

State Provided Data				
	2016	2017	2018	2019
Annual Objective	90	92	93	93
Annual Indicator	91	90.7		
Numerator				
Denominator				
Data Source	PRAMS	PRAMS		
Data Source Year	2014	2016		
Provisional or Final ?	Final	Final		

Field Level Notes for Form 10 NPMs:

None

2016-2020: NPM 4B - Percent of infants breastfed exclusively through 6 months

Federally Available Data				
Data Source: National Immunization Survey (NIS)				
	2016	2017	2018	2019
Annual Objective	26	29	32	32
Annual Indicator	27.0	32.0	28.8	31.4
Numerator	1,693	2,049	1,959	1,578
Denominator	6,263	6,412	6,790	5,027
Data Source	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016

Field Level Notes for Form 10 NPMs:

None

2016-2020: 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	2019
Annual Objective			29	29
Annual Indicator		27.6	27.0	22.5
Numerator		4,900	4,651	3,759
Denominator		17,751	17,226	16,730
Data Source		NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018

i 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.

Field Level Notes for Form 10 NPMs:

None

2016-2020: 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	2019
Annual Objective			19	17
Annual Indicator		17.9	16.5	13.4
Numerator		2,073	2,119	1,872
Denominator		11,609	12,855	13,940
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018

i 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.

Field Level Notes for Form 10 NPMs:

None

2016-2020: NPM 14.1 - Percent of women who smoke during pregnancy

Federally Available Data				
Data Source: National Vital Statistics System (NVSS)				
	2016	2017	2018	2019
Annual Objective	15	14	14	13.5
Annual Indicator	15.2	14.6	14.4	13.4
Numerator	1,148	1,043	968	859
Denominator	7,540	7,152	6,735	6,404
Data Source	NVSS	NVSS	NVSS	NVSS
Data Source Year	2015	2016	2017	2018

State Provided Data				
	2016	2017	2018	2019
Annual Objective	15	14	14	13.5
Annual Indicator	13.5	11.2		
Numerator				
Denominator				
Data Source	PRAMS	PRAMS		
Data Source Year	2015	2016		
Provisional or Final ?	Final	Final		

Field Level Notes for Form 10 NPMs:

None

Form 10
State Performance Measures (SPMs)

State: Wyoming

SPM 1 - Percent of women who smoke during pregnancy

Measure Status:	Active
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Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective					

Field Level Notes for Form 10 SPMs:

None

SPM 2 - % of new WY MCH staff completing MCH orientation (including MCH Navigator self-assessment) within first 6 months

Measure Status:	Active
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Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	100.0	100.0	100.0	100.0	100.0

Field Level Notes for Form 10 SPMs:

None

Form 10
State Performance Measures (SPMs) (2016-2020 Needs Assessment Cycle)

2016-2020: 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	2019
Annual Objective		54	70	80
Annual Indicator	51.9	68	80.6	73.6
Numerator	42	68	50	53
Denominator	81	100	62	72
Data Source	Wyoming Vital Statistics Services			
Data Source Year	2015	2016	2017	2018
Provisional or Final ?	Final	Final	Final	Final

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.
4.	Field Name:	2019
	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.

2016-2020: 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	2019
Annual Objective		20	30	30
Annual Indicator	25.3	32.2	13	14.5
Numerator	22	28	11	12
Denominator	86,903	86,855	84,348	83,015
Data Source	Wyoming Hospital Discharge Data			
Data Source Year	FY 2015	CY 2016	CY17	CY18
Provisional or Final ?	Final	Final	Final	Final

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 calculate 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 calculate 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.

2016-2020: 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	2019
Annual Objective		70	70	70
Annual Indicator	68.4	68.4	66.3	66.3
Numerator				
Denominator				
Data Source	Prevention Needs Assessment	Prevention Needs Assessment	Prevention Needs Assessment	Prevention Needs Assessment
Data Source Year	2016	2016	2018	2018
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional

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

2016-2020: SPM 5 - Percent of children (6-11 years) who are physically active at least 60 minutes per day.

Measure Status:		Active		
State Provided Data				
	2017	2018	2019	
Annual Objective			32	
Annual Indicator			30.2	
Numerator			14,688	
Denominator			48,676	
Data Source			NSCH	
Data Source Year			2017-2018	
Provisional or Final ?			Provisional	

Field Level Notes for Form 10 SPMs:

None

2016-2020: SPM 6 - Use of most/moderately effective contraception by postpartum women

Measure Status:		Active		
State Provided Data				
	2017	2018	2019	
Annual Objective			66	
Annual Indicator			66.4	
Numerator			3,517	
Denominator			5,296	
Data Source			PRAMS	
Data Source Year			2018	
Provisional or Final ?			Provisional	

Field Level Notes for Form 10 SPMs:

None

2016-2020: SPM 7 - Percent of children with and without special health care needs having a medical home

Measure Status:	Active
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Baseline data was not available/provided.

Field Level Notes for Form 10 SPMs:

None

Form 10
Evidence-Based or –Informed Strategy Measure (ESM)

State: Wyoming

ESM 1.1 - Number of women ages 18-44 enrolled in the My 307 Wellness App

Measure Status:	Active
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Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	10.0	12.0	14.0	16.0	18.0

Field Level Notes for Form 10 ESMs:

None

ESM 1.2 - Number of women who interact with developed messaging on the well woman visit

Measure Status:	Active
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Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective					

Field Level Notes for Form 10 ESMs:

None

ESM 11.1 - Percent of CSH Advisory Council members with lived experience

Measure Status:	Active
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Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	50.0	50.0	50.0	50.0	50.0

Field Level Notes for Form 10 ESMs:

None

Form 10
Evidence-Based or -Informed Strategy Measures (ESMs) (2016-2020 Needs Assessment Cycle)

2016-2020: ESM 4.4 - Number of Hospitals Participating in the Wyoming 5-Steps to Breastfeeding Success Program

Measure Status:		Active		
State Provided Data				
	2017	2018	2019	
Annual Objective	4	4	0	
Annual Indicator	4	4	0	
Numerator				
Denominator				
Data Source	Women and Infant Program	Women and Infant Health Program	Women and Infant Health Program	
Data Source Year	2017	2018	2019	
Provisional or Final ?	Final	Final	Final	

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:	State Provided Data
	Field Note:	The program ended before the start of FFY19.

2016-2020: 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		
State Provided Data				
	2017	2018	2019	
Annual Objective			100	
Annual Indicator			100	
Numerator			4	
Denominator			4	
Data Source			Program Data (self report from hospitals)	
Data Source Year			CY 2018	
Provisional or Final ?			Final	

Field Level Notes for Form 10 ESMs:

1.	Field Name:	2019
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Column Name:	State Provided Data
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Field Note:

This program has not continued.

2016-2020: ESM 4.7 - Percent of counties that have at least one public health nurse trained as a Certified Lactation Consultant (CLC)

Measure Status:		Active		
State Provided Data				
	2017	2018	2019	
Annual Objective			90	
Annual Indicator			100	
Numerator			23	
Denominator			23	
Data Source			Public Health Nursing Program Data	
Data Source Year			SFY 2020	
Provisional or Final ?			Provisional	

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 6.3 - 211 Referrals to Help Me Grow

Measure Status:		Active		
State Provided Data				
	2017	2018	2019	
Annual Objective	30	45	60	
Annual Indicator	39	49	14	
Numerator				
Denominator				
Data Source	HMG Reports	HMG Reports	HMG Reports	
Data Source Year	2017	2018	2019	
Provisional or Final ?	Final	Final	Final	

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:** 2019
-
- Column Name:** State Provided Data
-
- Field Note:**
October 1, 2018 - June 30, 2019 (9 months due to contract termination as of June 30th 2019)

2016-2020: ESM 6.6 - Number of referrals from HMG to community resources resulting in services

Measure Status:		Active	
State Provided Data			
	2017	2018	2019
Annual Objective			50
Annual Indicator			41
Numerator			
Denominator			
Data Source			HMG Reports
Data Source Year			2019
Provisional or Final ?			Final

Field Level Notes for Form 10 ESMs:

1.	Field Name:	2019
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	Column Name:	State Provided Data
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Field Note:

October 1, 2018 - June 30, 2019 (9 months due to contract termination as of June 30th 2019)

2016-2020: ESM 6.7 - Number of providers trained on Bright Futures

Measure Status:	Active
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Baseline data was not available/provided.

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 10.2 - # QI cycles completed by participating practices

Measure Status:		Active		
State Provided Data				
	2017	2018	2019	
Annual Objective			4	
Annual Indicator			4	
Numerator				
Denominator				
Data Source			Program Data	
Data Source Year			2019	
Provisional or Final ?			Final	

Field Level Notes for Form 10 ESMs:

1.	Field Name:	2019
	Column Name:	State Provided Data

Field Note:

Contract executed and work began- June 2018; year-end data reports shared with WDH- February 2020; year-end data collection conducted through Dec. 2019

2016-2020: ESM 12.4 - # of parent or youth completed transition readiness assessments completed by PHN in CSH program

Measure Status:		Active	
State Provided Data			
	2017	2018	2019
Annual Objective			45
Annual Indicator			49
Numerator			
Denominator			
Data Source			CSH Program Data
Data Source Year			FFY19
Provisional or Final ?			Final

Field Level Notes for Form 10 ESMs:

1.	Field Name:	2019
	Column Name:	State Provided Data

Field Note:

CSH launched the transition toolkit in January 2019, requiring completion of transition readiness assessments for eligible children during their annual renewal for the program. Between January 1, 2019 and September 30, 2019, 50 CSH clients between the ages of 14 and 19 received transition readiness assessments. CSHP and PHN received 49 completed assessments and provided targeted transition education to the parents/caregivers of all 50 clients eligible to receive support for transition.

2016-2020: ESM 14.1.1 - # of pregnant women referred to the WY Quitline services from Healthy Baby Home Visitation

Measure Status:		Active		
State Provided Data				
	2017	2018	2019	
Annual Objective			25	
Annual Indicator			16	
Numerator				
Denominator				
Data Source			WY Quitline	
Data Source Year			2019	
Provisional or Final ?			Provisional	

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 14.1.2 - # of providers trained on SCRIPT implementation

Measure Status:		Active		
State Provided Data				
	2017	2018	2019	
Annual Objective			7	
Annual Indicator			7	
Numerator				
Denominator				
Data Source			Program Data	
Data Source Year			FFY19	
Provisional or Final ?			Final	

Field Level Notes for Form 10 ESMs:

None

Form 10
State Performance Measure (SPM) Detail Sheets

State: Wyoming

SPM 1 - Percent of women who smoke during pregnancy
Population Domain(s) – Women/Maternal Health, Perinatal/Infant Health

Measure Status:	Active									
Goal:	Decrease the percent of women who smoke during pregnancy									
Definition:	<table border="1" style="width: 100%;"> <tr> <td style="background-color: #1f4e79; color: white;">Numerator:</td> <td>Number of women who report smoking during pregnancy</td> </tr> <tr> <td style="background-color: #1f4e79; color: white;">Denominator:</td> <td>Number of live births</td> </tr> <tr> <td style="background-color: #1f4e79; color: white;">Unit Type:</td> <td>Percentage</td> </tr> <tr> <td style="background-color: #1f4e79; color: white;">Unit Number:</td> <td>100</td> </tr> </table>		Numerator:	Number of women who report smoking during pregnancy	Denominator:	Number of live births	Unit Type:	Percentage	Unit Number:	100
Numerator:	Number of women who report smoking during pregnancy									
Denominator:	Number of live births									
Unit Type:	Percentage									
Unit Number:	100									
Healthy People 2020 Objective:	Related to Tobacco Use (TU) Objective 6: Increase smoking cessation during pregnancy (Target: 30.0%)									
Data Sources and Data Issues:	National Vital Statistics System (NVSS)									
Significance:	A 2019 Pediatrics article (Anderson, et. al) found that women who smoke double the risk of their infants dying suddenly. Infants exposed to secondhand smoke also have a higher risk of sudden unexplained infant death (SUID), as well as a higher risk of developing chronic diseases like asthma as they grow older.									

SPM 2 - % of new WY MCH staff completing MCH orientation (including MCH Navigator self-assessment) within first 6 months

Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active	
Goal:	Increase % of WY MCH staff completing MCH orientation (including MCH Navigator self-assessment) within first 6 months	
Definition:	Numerator:	# of WY MCH staff completing MCH orientation (including MCH Navigator self-assessment) within first 6 months
	Denominator:	# of WY MCH staff beginning after October 1, 2020
	Unit Type:	Percentage
	Unit Number:	100
Healthy People 2020 Objective:	n/a	
Data Sources and Data Issues:	Program data	
Significance:	Assessing MCH workforce needs early in tenure is important for identifying and procuring adequate training resources.	

SPM 3 - Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19
Population Domain(s) – Adolescent Health

Measure Status:	Active								
Goal:	To decrease the rate of hospital admissions for non-fatal injury among children ages 0 through 19								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of hospital admissions with a primary diagnosis of unintentional or intentional injury among adolescents, ages 10 through 19 (excludes in-hospital deaths)</td> </tr> <tr> <td>Denominator:</td> <td>Number of adolescents, ages 10 through 19</td> </tr> <tr> <td>Unit Type:</td> <td>Rate</td> </tr> <tr> <td>Unit Number:</td> <td>100,000</td> </tr> </table>	Numerator:	Number of hospital admissions with a primary diagnosis of unintentional or intentional injury among adolescents, ages 10 through 19 (excludes in-hospital deaths)	Denominator:	Number of adolescents, ages 10 through 19	Unit Type:	Rate	Unit Number:	100,000
Numerator:	Number of hospital admissions with a primary diagnosis of unintentional or intentional injury among adolescents, ages 10 through 19 (excludes in-hospital deaths)								
Denominator:	Number of adolescents, ages 10 through 19								
Unit Type:	Rate								
Unit Number:	100,000								
Healthy People 2020 Objective:	Related to Injury and Violence Prevention (IVP) Objective 1.2: Reduce hospitalizations for nonfatal injuries. (Baseline: 617.6 per 100,000. Target: 555.8 per 100,000.)								
Data Sources and Data Issues:	Healthcare Cost and Utilization Project (HCUP) - State Inpatient Database (SID) Population estimates come from the U.S. Census Bureau								
Significance:	<p>Unintentional injury is the leading cause of child and adolescent mortality, from age 1 through 19. Homicide and suicide, violent or intentional injury, are the second and third leading causes of death for adolescents ages 15 through 19. For those who suffer non-fatal severe injuries, many will become children with special health care needs. Effective interventions to reduce injury exist but are not fully implemented in systems of care that serve children and their families. Reducing the burden of nonfatal injury can greatly improve the life course trajectory of infants, children, and adolescents resulting in improved quality of life and cost savings.</p> <p>Heron M. Deaths: Leading Causes for 2014. National Vital Statistics Reports. 2016 June 30. 65(5). https://www.cdc.gov/nchs/data/nvsr/nvsr65/nvsr65_05.pdf</p>								

SPM 4 - Percent of children receiving at least 1 EPSDT visit as noted within CMS 416 report
Population Domain(s) – Child Health, Adolescent Health

Measure Status:	Active								
Goal:	Increase percent of children receiving at least 1 EPSDT visit as noted within CMS 416 report								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td># of children receiving at least 1 EPSDT visit as noted within CMS 416 report</td> </tr> <tr> <td>Denominator:</td> <td># of children eligible for EPSDT visit</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	# of children receiving at least 1 EPSDT visit as noted within CMS 416 report	Denominator:	# of children eligible for EPSDT visit	Unit Type:	Percentage	Unit Number:	100
Numerator:	# of children receiving at least 1 EPSDT visit as noted within CMS 416 report								
Denominator:	# of children eligible for EPSDT visit								
Unit Type:	Percentage								
Unit Number:	100								
Data Sources and Data Issues:	CMS 416 Report								
Significance:	The CMS 416 Report provides data on how WY compares to other states for well visit rates.								

SPM 5 - Percent of youth participating in Sources of Strength programming who report increased youth-adult connectedness

Population Domain(s) – Adolescent Health

Measure Status:	Active								
Goal:	Increase percent of youth participating in Sources of Strength programming who report increased youth-adult connectedness								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td># of youth participating in Sources of Strength programming who report increased youth-adult connectedness</td> </tr> <tr> <td>Denominator:</td> <td># of youth participating in Sources of Strength programming</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	# of youth participating in Sources of Strength programming who report increased youth-adult connectedness	Denominator:	# of youth participating in Sources of Strength programming	Unit Type:	Percentage	Unit Number:	100
Numerator:	# of youth participating in Sources of Strength programming who report increased youth-adult connectedness								
Denominator:	# of youth participating in Sources of Strength programming								
Unit Type:	Percentage								
Unit Number:	100								
Healthy People 2020 Objective:	n/a								
Data Sources and Data Issues:	Program data/Sources of Strength data								
Significance:	Sources of Strength is an evidenced-based strategy to reduce youth suicide.								

Form 10
State Performance Measure (SPM) Detail Sheets (2016-2020 Needs Assessment Cycle)

2016-2020: 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:	<table border="1" style="width: 100%;"> <tr> <td style="background-color: #cccccc;">Numerator:</td> <td>Number of VLBW infants born in a hospital with a Level III+ NICU</td> </tr> <tr> <td style="background-color: #cccccc;">Denominator:</td> <td>Number of VLBW infants</td> </tr> <tr> <td style="background-color: #cccccc;">Unit Type:</td> <td>Percentage</td> </tr> <tr> <td style="background-color: #cccccc;">Unit Number:</td> <td>100</td> </tr> </table>	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
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:	<p>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.</p>								
Significance:	<p>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)</p>								

2016-2020: 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:	<table border="1"> <tr> <td>Numerator:</td> <td>Inpatient hospitalizations for non-fatal injuries in Wyoming hospitals for children aged 1 through 11</td> </tr> <tr> <td>Denominator:</td> <td>Children aged 1 through 11 in Wyoming</td> </tr> <tr> <td>Unit Type:</td> <td>Rate</td> </tr> <tr> <td>Unit Number:</td> <td>100,000</td> </tr> </table>	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
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:	<p>Numerator: Hospital Discharge Data (HDD) Denominator: Census population estimates</p> <p>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.</p>								
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.								

2016-2020: 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:	<table border="1"> <tr> <td>Numerator:</td> <td>total # of high school students reporting 0 occasions of alcohol use in the past 30 days</td> </tr> <tr> <td>Denominator:</td> <td>total # of high school students</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>		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
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.									

2016-2020: 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:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of children (6-11 years) who are physically active at least 60 minutes per day.</td> </tr> <tr> <td>Denominator:</td> <td>Number of children (6-11 years)</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	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
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.								

2016-2020: 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.	

2016-2020: 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:	<table border="1"> <tr> <td>Numerator:</td> <td>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)</td> </tr> <tr> <td>Denominator:</td> <td>Number of children, ages 0 through 17</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	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
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:	<p>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%)</p> <p>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%)</p>								
Data Sources and Data Issues:	National Survey of Children's Health (NSCH)								
Significance:	<p>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</p>								

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 1.1 - Number of women ages 18-44 enrolled in the My 307 Wellness App

NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active								
Goal:	Increase the # of women learning about the well woman visit through the My 307 Wellness App								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>n/a</td> </tr> <tr> <td>Denominator:</td> <td>n/a</td> </tr> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>10,000</td> </tr> </table>	Numerator:	n/a	Denominator:	n/a	Unit Type:	Count	Unit Number:	10,000
Numerator:	n/a								
Denominator:	n/a								
Unit Type:	Count								
Unit Number:	10,000								
Data Sources and Data Issues:	My 307 Wellness App monthly enrollment data provided by Wildflower Health								
Significance:	It is important to connect with adult women of reproductive age (18-44) to educate them on what the well woman visit is and what takes place during the well woman visit.								

ESM 1.2 - Number of women who interact with developed messaging on the well woman visit
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active								
Goal:	Increase the # of women who access well woman visit information.								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>n/a</td> </tr> <tr> <td>Denominator:</td> <td>n/a</td> </tr> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>10,000</td> </tr> </table>	Numerator:	n/a	Denominator:	n/a	Unit Type:	Count	Unit Number:	10,000
Numerator:	n/a								
Denominator:	n/a								
Unit Type:	Count								
Unit Number:	10,000								
Data Sources and Data Issues:	My 307 Wellness App monthly click rate provided by Wildflower Health								
Significance:	After engaging adult women of reproductive age through social media it is important to ensure they are reading accurate literature at a basic health literacy level to better understand and gain knowledge of what the well woman visit consists of and questions to ask their provider about any blood draws, immunizations and exams.								

ESM 5.1 - Among PRAMS respondents reporting having had a home visit, % who report their baby sleeps on a separate approved sleep surface

NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active								
Goal:	Increase the % of PRAMS respondents who received a home visit, who put their infants to sleep on a separate, approved surface.								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of women who respond to PRAMS survey, who reported having a home visit, and reported that they put their infants to sleep on a separate, approved surface.</td> </tr> <tr> <td>Denominator:</td> <td>Number of women who respond to PRAMS survey and who reported having a home visit</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	Number of women who respond to PRAMS survey, who reported having a home visit, and reported that they put their infants to sleep on a separate, approved surface.	Denominator:	Number of women who respond to PRAMS survey and who reported having a home visit	Unit Type:	Percentage	Unit Number:	100
	Numerator:	Number of women who respond to PRAMS survey, who reported having a home visit, and reported that they put their infants to sleep on a separate, approved surface.							
	Denominator:	Number of women who respond to PRAMS survey and who reported having a home visit							
	Unit Type:	Percentage							
Unit Number:	100								
Data Sources and Data Issues:	PRAMS								
Significance:	This will help us better understand the impact of the home visitation program on safe sleep behaviors as well as better understanding who is participating in the home visitation program.								

ESM 5.2 - Among PRAMS respondents reporting having had a home visit, % who report their baby sleeps without soft objects or loose bedding.

NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active	
Goal:	Increase the percent of PRAMS respondents, who report a home visit, who put infant to sleep without soft objects or loose bedding.	
Definition:	Numerator:	Number of women who respond to PRAMS survey, who reported having a home visit, and who reported that they put their infant sleeps without soft objects or loose bedding
	Denominator:	Number of women who respond to PRAMS survey AND had a home visit
	Unit Type:	Percentage
	Unit Number:	100
Data Sources and Data Issues:	PRAMS	
Significance:	This will help us better understand the impact of the home visitation program on safe sleep behaviors as well as better understanding who is participating in the home visitation program.	

ESM 5.3 - Percent of PRAMS respondents reporting their provider spoke to them about safe sleep
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active								
Goal:	Increase the percentage of moms who have a provider discuss safe sleep with them.								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of PRAMS respondents who answer 'Yes' to question about provider discussing safe sleep</td> </tr> <tr> <td>Denominator:</td> <td>Number of total PRAMS respondents</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	Number of PRAMS respondents who answer 'Yes' to question about provider discussing safe sleep	Denominator:	Number of total PRAMS respondents	Unit Type:	Percentage	Unit Number:	100
	Numerator:	Number of PRAMS respondents who answer 'Yes' to question about provider discussing safe sleep							
	Denominator:	Number of total PRAMS respondents							
	Unit Type:	Percentage							
Unit Number:	100								
Data Sources and Data Issues:	PRAMS								
Significance:	A strategy for our safe sleep work is to educate providers on the need to have safe sleep discussions with their clients, whether a first time mom or a mom with several children. This will help us better understand a change, over time, in provider discussions with moms about safe sleep protocols and see where we still need to improve our efforts.								

ESM 7.2.1 - # of schools/organizations/SADD chapters providing teen driver safety programs (e.g. Teen in the Driver Seat) with teens

NPM 7.2 – Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19

Measure Status:	Active								
ESM Subgroup(s):	Children 10 through 19								
Goal:	Increase the # of schools/organizations/SADD chapters providing teen driver safety programs (e.g. Teen in the Driver Seat) with teens								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td># of schools/organizations/SADD chapters providing teen driver safety programs (e.g. Teen in the Driver Seat) with teens</td> </tr> <tr> <td>Denominator:</td> <td>n/a</td> </tr> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	# of schools/organizations/SADD chapters providing teen driver safety programs (e.g. Teen in the Driver Seat) with teens	Denominator:	n/a	Unit Type:	Count	Unit Number:	100
Numerator:	# of schools/organizations/SADD chapters providing teen driver safety programs (e.g. Teen in the Driver Seat) with teens								
Denominator:	n/a								
Unit Type:	Count								
Unit Number:	100								
Data Sources and Data Issues:	Program data collected from schools/organizations								
Significance:	The program can directly increase # of evidence-based teen driver safety programs implemented in WY through the Child Safety Learning Collaborative and partnership with community prevention specialists and other partners in communities. Teens in the Driver Seat is one evidence-based program example.								

ESM 8.1.1 - Number of childcare facilities reporting adoption of one or more model policies from the WY Healthy Policies Toolkit

NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Measure Status:	Active	
ESM Subgroup(s):	Children 6 through 11	
Goal:	Increase # of childcare facilities reporting the adoption of one or more model policies from the Wyoming Healthy Policies Toolkit	
Definition:	Numerator:	# of childcare facilities reporting the adoption of one or more model policies from the Wyoming Healthy Policies Toolkit
	Denominator:	N/A
	Unit Type:	Count
	Unit Number:	500
Data Sources and Data Issues:	Wyoming Department of Workforce Services Data	
Significance:	Childhood obesity remains a focus as does increasing physical activity among children 6-11 years old. This is a priority among many state-level agencies and community-based partners. The Health Policies Toolkit was developed to incorporate Wyoming resources with national evidence-based or informed strategies to reduce and prevent childhood obesity.	

ESM 10.1 - Number of clinics trained on Bright Futures and youth friendliness through the Adolescent Health Initiative

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 clinics trained on Bright Futures and youth friendliness through participation in the ACE-AP								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of clinics trained on Bright Futures and youth friendliness through participation in the ACE-AP</td> </tr> <tr> <td>Denominator:</td> <td>n/a</td> </tr> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>50</td> </tr> </table>	Numerator:	Number of clinics trained on Bright Futures and youth friendliness through participation in the ACE-AP	Denominator:	n/a	Unit Type:	Count	Unit Number:	50
Numerator:	Number of clinics trained on Bright Futures and youth friendliness through participation in the ACE-AP								
Denominator:	n/a								
Unit Type:	Count								
Unit Number:	50								
Data Sources and Data Issues:	University of Michigan ACE-AP data								
Significance:	The Adolescent Health Program will continue to partner with the University of Michigan to implement the Adolescent Centered Environment Assessment Process (ACE-AP) in 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. Training will also include aspects of Bright Futures guidelines for providers to implement. By increasing the knowledge of providers and their staff on adolescent centered care, more adolescents will receive their recommended annual well visit.								

ESM 10.2 - Number of clinics implementing Bright Futures guidelines (including youth-related assessments)
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 clinics implementing Bright Futures guidelines (including youth-related assessments)								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td># of clinics implementing Bright Futures guidelines (including youth-related assessments)</td> </tr> <tr> <td>Denominator:</td> <td>n/a</td> </tr> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>50</td> </tr> </table>	Numerator:	# of clinics implementing Bright Futures guidelines (including youth-related assessments)	Denominator:	n/a	Unit Type:	Count	Unit Number:	50
Numerator:	# of clinics implementing Bright Futures guidelines (including youth-related assessments)								
Denominator:	n/a								
Unit Type:	Count								
Unit Number:	50								
Data Sources and Data Issues:	University of Michigan and/or Program Data								
Significance:	The Adolescent Health Program will continue to partner with the University of Michigan to implement the Adolescent Centered Environment Assessment Process (ACE-AP) in 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. Training will also include aspects of Bright Futures guidelines for provides to implement. By increasing the knowledge of providers and their staff on adolescent centered care, more adolescents will receive their recommended annual well visit.								

ESM 10.3 - Percentage of ACE-AP participating clinics who receive Adolescent Centered Environment certification
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Measure Status:	Active								
Goal:	Increase the percentage of ACE-AP participating clinics who receive Adolescent Centered Environment certification								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of clinics certified as Adolescent-Centered Environment</td> </tr> <tr> <td>Denominator:</td> <td>Total number of clinics participating in the ACE-AP</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	Number of clinics certified as Adolescent-Centered Environment	Denominator:	Total number of clinics participating in the ACE-AP	Unit Type:	Percentage	Unit Number:	100
Numerator:	Number of clinics certified as Adolescent-Centered Environment								
Denominator:	Total number of clinics participating in the ACE-AP								
Unit Type:	Percentage								
Unit Number:	100								
Data Sources and Data Issues:	University of Michigan and program data								
Significance:	The Adolescent Health Program will continue to partner with the University of Michigan to implement the Adolescent Centered Environment Assessment Process (ACE-AP) in 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. Training will also include aspects of Bright Futures guidelines for providers to implement. By increasing the knowledge of providers and their staff on adolescent centered care, more adolescents will receive their recommended annual well visit.								

ESM 10.4 - Number of clinics showing improvement in at least 50% of selected topics through the ACE-AP
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 clinics showing improvement in at least 50% of selected topics	
Definition:	Numerator:	Number of clinics showing improvement in at least 50% of selected topics
	Denominator:	n/a
	Unit Type:	Count
	Unit Number:	50
Data Sources and Data Issues:	University of Michigan and program data	
Significance:	The Adolescent Health Program will continue to partner with the University of Michigan to implement the Adolescent Centered Environment Assessment Process (ACE-AP) in 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. Training will also include aspects of Bright Futures guidelines for providers to implement. By increasing the knowledge of providers and their staff on adolescent centered care, more adolescents will receive their recommended annual well visit.	

ESM 10.5 - Number of Youth Council recommendations developed

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 Youth Council recommendations								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td># of youth council recommendations developed</td> </tr> <tr> <td>Denominator:</td> <td>n/a</td> </tr> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	# of youth council recommendations developed	Denominator:	n/a	Unit Type:	Count	Unit Number:	100
Numerator:	# of youth council recommendations developed								
Denominator:	n/a								
Unit Type:	Count								
Unit Number:	100								
Data Sources and Data Issues:	Program data								
Significance:	The council will provide opportunities for youth and young adults to share their expertise and experiences to help inform and guide Wyoming Department of Health programs that target youth and young adults by making program specific recommendations. The council's presence and activities will help adults better understand youth and young adult culture and needs.								

ESM 10.6 - Number of resources developed based on Youth Council recommendations
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 resources developed based on Youth Council recommendations	
Definition:	Numerator:	Number of resources developed based on Youth Council recommendations
	Denominator:	n/a
	Unit Type:	Count
	Unit Number:	100
Data Sources and Data Issues:	Program data	
Significance:	The council will provide opportunities for youth and young adults to share their expertise and experiences to help inform and guide Wyoming Department of Health programs that target youth and young adults by making program specific recommendations. The council's presence and activities will help adults better understand youth and young adult culture and needs.	

ESM 10.7 - Number of schools/organizations implementing Sources of Strength
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Measure Status:	Active								
Goal:	Increases the number of schools/organizations implementing Sources of Strength								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of schools/organizations implementing Sources of Strength</td> </tr> <tr> <td>Denominator:</td> <td>n/a</td> </tr> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	Number of schools/organizations implementing Sources of Strength	Denominator:	n/a	Unit Type:	Count	Unit Number:	100
Numerator:	Number of schools/organizations implementing Sources of Strength								
Denominator:	n/a								
Unit Type:	Count								
Unit Number:	100								
Data Sources and Data Issues:	Program data								
Significance:	Sources of Strength is an evidence-based strategy for reducing youth suicide.								

ESM 11.1 - Percent of CSH Advisory Council members with lived experience

NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active	
ESM Subgroup(s):	CSHCN, CSHCN and non-CSHCN	
Goal:	Develop CSH advisory council with at least 50% of members having lived experience (e.g. being a parent of a child with special health care needs)	
Definition:	Numerator:	Number of advisory council members with lived experience
	Denominator:	Total number of advisory council members
	Unit Type:	Percentage
	Unit Number:	100
Data Sources and Data Issues:	CSHCN Program Data	
Significance:	This ESM (and associated activity) helps the program to prioritize family partnership in improving systems of care for CSHCN.	

ESM 11.2 - Percent of gaps identified by systems map that the CSHCN Program, Advisory Council, and/or partners are actively addressing

NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active								
ESM Subgroup(s):	CSHCN, CSHCN and non-CSHCN								
Goal:	Increase the number of gaps identified by the systems map that lead to actionable strategies to improve systems of care for CSHCN and improve the percent of children with and without special health care needs who have a medical home.								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td># of gaps identified by systems map that are addressed</td> </tr> <tr> <td>Denominator:</td> <td># of gaps identified by systems map</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	# of gaps identified by systems map that are addressed	Denominator:	# of gaps identified by systems map	Unit Type:	Percentage	Unit Number:	100
Numerator:	# of gaps identified by systems map that are addressed								
Denominator:	# of gaps identified by systems map								
Unit Type:	Percentage								
Unit Number:	100								
Data Sources and Data Issues:	CSHCN Program Data								
Significance:	After completing a gap assessment, it is important that the Program, Advisory Council, and partners identify and target gaps within the system of care to focus improvement efforts.								

ESM 11.3 - Number of family members, providers, and/or partners trained on National Standards for Systems of Care for CYSHCN

NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active									
ESM Subgroup(s):	CSHCN, CSHCN and non-CSHCN									
Goal:	Increase the number of people trained on National Standards for Systems of Care for CYSHCN									
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>Number family members, providers, and/or partners trained on National Standards for Systems of Care for CYSHCN</td> </tr> <tr> <td>Denominator:</td> <td>n/a</td> </tr> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>250</td> </tr> </table>		Numerator:	Number family members, providers, and/or partners trained on National Standards for Systems of Care for CYSHCN	Denominator:	n/a	Unit Type:	Count	Unit Number:	250
Numerator:	Number family members, providers, and/or partners trained on National Standards for Systems of Care for CYSHCN									
Denominator:	n/a									
Unit Type:	Count									
Unit Number:	250									
Data Sources and Data Issues:	Program data									
Significance:	HRSA and AMCHP developed national standards to evaluate success of CYSHCN programs and services. Program alignment with these standards is critical to evaluate Wyoming CSH success and identify needed improvement.									

Form 10

Evidence-Based or -Informed Strategy Measure (ESM) (2016-2020 Needs Assessment Cycle)

2016-2020: ESM 4.4 - Number of Hospitals Participating in the Wyoming 5-Steps to Breastfeeding Success Program
2016-2020: 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:	<table border="1"> <tr> <td>Numerator:</td> <td>N/A</td> </tr> <tr> <td>Denominator:</td> <td>N/A</td> </tr> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>26</td> </tr> </table>	Numerator:	N/A	Denominator:	N/A	Unit Type:	Count	Unit Number:	26
Numerator:	N/A								
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.								

2016-2020: ESM 4.6 - Percent of hospitals demonstrating an increase in at least one step from baseline based on hospital self-reported assessment

2016-2020: 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:	<table border="1"> <tr> <td>Numerator:</td> <td># of hospitals with a self-reported increase in steps implemented in their hospital</td> </tr> <tr> <td>Denominator:</td> <td># of hospitals participating in 5 Steps program</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	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
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								

2016-2020: ESM 4.7 - Percent of counties that have at least one public health nurse trained as a Certified Lactation Consultant (CLC)

2016-2020: 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:	<table border="1"> <tr> <td>Numerator:</td> <td># of counties with at least one CLC</td> </tr> <tr> <td>Denominator:</td> <td># of counties</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	# of counties with at least one CLC	Denominator:	# of counties	Unit Type:	Percentage	Unit Number:	100
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.								

2016-2020: ESM 6.3 - 211 Referrals to Help Me Grow

2016-2020: 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:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of referrals from 211 to HMG</td> </tr> <tr> <td>Denominator:</td> <td>N/A</td> </tr> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	Number of referrals from 211 to HMG	Denominator:	N/A	Unit Type:	Count	Unit Number:	100
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.								

2016-2020: ESM 6.6 - Number of referrals from HMG to community resources resulting in services
2016-2020: 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:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of referrals from HMG that result in a connection to services</td> </tr> <tr> <td>Denominator:</td> <td>N/A</td> </tr> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>500</td> </tr> </table>	Numerator:	Number of referrals from HMG that result in a connection to services	Denominator:	N/A	Unit Type:	Count	Unit Number:	500
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.								

2016-2020: ESM 6.7 - Number of providers trained on Bright Futures

2016-2020: 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:	<table border="1"> <tr> <td>Numerator:</td> <td>Number of providers trained on Bright Futures</td> </tr> <tr> <td>Denominator:</td> <td>N/A</td> </tr> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	Number of providers trained on Bright Futures	Denominator:	N/A	Unit Type:	Count	Unit Number:	100
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:	<p>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.</p> <p>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.</p>								

2016-2020: 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:	<table border="1"> <tr> <td>Numerator:</td> <td>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)</td> </tr> <tr> <td>Denominator:</td> <td>N/A</td> </tr> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>		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
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:	<p>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.</p>									

2016-2020: ESM 12.4 - # of parent or youth completed transition readiness assessments completed by PHN in CSH program

2016-2020: 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.	

2016-2020: ESM 14.1.1 - # of pregnant women referred to the WY Quitline services from Healthy Baby Home Visitation

2016-2020: 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:	<table border="1"> <tr> <td>Numerator:</td> <td># of smoking HB clients referred to the Quitline</td> </tr> <tr> <td>Denominator:</td> <td>N/A</td> </tr> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	# of smoking HB clients referred to the Quitline	Denominator:	N/A	Unit Type:	Count	Unit Number:	100
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.								

2016-2020: ESM 14.1.2 - # of providers trained on SCRIPT implementation

2016-2020: NPM 14.1 – Percent of women who smoke during pregnancy

Measure Status:	Active								
Goal:	Increase the number of providers trained in SCRIPT								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td># of providers trained in SCRIPT</td> </tr> <tr> <td>Denominator:</td> <td>N/A</td> </tr> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	# of providers trained in SCRIPT	Denominator:	N/A	Unit Type:	Count	Unit Number:	100
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](#)