Maternal and Child Health Services Title V Block Grant

Wyoming

FY 2022 Application/ FY 2020 Annual Report

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I. General Requirements

I.A. Letter of Transmittal

Wyoming Department of Health

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Stefan Johansson
Interim Director

Mark Gordon
Governor

August 4, 2021

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

Ref: JJ-2021-015

Dear Ms. Kelly:

Letter of Transmittal

The DUNS number for Wyoming Maternal and Child Health (MCH) Services Block Grant is 809915796, as requested in the Terms and Conditions issued on November 16, 2004. The core grant number for Wyoming's Title V Block Grant is B04MC33877.

If you need additional information, please contact me by phone at 307-777-3733, or by e-mail at jamin.johnson1@wyo.gov.

Sincerely,

Jamin Johnson, MS, CHES
Interim Maternal and Child Health Unit Manager
Public Health Division

JJ/jj

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

I.B. Face Sheet

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

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix F of the 2021 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: January 31, 2024.

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: January31, 2024.

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, 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 assure 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 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 Women, Infants, and Children), other State agencies (including the Department of Education, Department of Family Services, and Department of Workforce Services), the University of Wyoming, the partner who administers the Title X grant (Wyoming Health Council), and the current partner who administers the federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) grant (Parents as Teachers National Center) and the Wyoming Department of Family Services (DFS) which is the agency overseeing comprehensive early childhood home visiting in Wyoming. .

WY MCH and Public Health Nursing (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 the 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 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 MIECHV grants; however, WY MCH staff partner closely with the grantees.

FFY20 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 FFY20.

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

WY MCH partnered with Wyoming Medicaid and the Wyoming Primary Care Association to ensure that federally qualified health center (FQHC) and rural health center (RHC) providers became aware of the newly unbundled outpatient long-acting reversible contraception (LARC) insertions. The Wyoming Perinatal Quality Collaborative, the LARC working group, and the Wyoming Health Council (the Wyoming Title X grantee) worked together to bring trainers from the Reproductive Health National Training Center to Wyoming. The LARC workgroup also created a draft LARC toolkit, which it will resume progress on following the COVID-19 pandemic. From 2016 to 2019, 19.7% of women in Wyoming reported LARC use after pregnancy (WY PRAMS).

2 - Prevent infant mortality

In FFY20, WY MCH sought to prevent infant mortality through reducing the percentage of women who smoke during pregnancy, given its impact on low birth weight, increased risk of premature birth, and increased risk of sudden unexplained infant death (SUID). 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. WY MCH continues to promote the Wyoming Quitline through distribution of marketing materials in PHN home visiting and PHN offices. WY MCH also partnered with the Wyoming Quit Tobacco Program to market the Quitline to pregnant women, including by updating the incentives provided to pregnant and postpartum callers. In 2019, 13.6% of women in Wyoming smoked during pregnancy compared to 19.3% in 2009 (NVSS).

3 - Improve breastfeeding duration

WY MCH provided financial support to assure that each of Wyoming's 23 counties had a PHN trained as a Certified Lactation Consultant (CLC). 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. WY MCH provided further support to the Wyoming Women, Infants and Children (WIC) Program to provide CLC certifications for their staff. In 2019, 90.0% of infants in Wyoming were reported to have been breastfed, compared to 84.1% in the U.S. the same year (The National Immunization Surveys).

4 - Promote preventive and quality care for children and adolescents

In the Child Health domain, WY MCH provided training in Ages and Stages and Bright Futures to Wyoming providers to increase developmental screenings. WY MCH also promoted lead screening and applied for further lead funding through the CDC.

In the Adolescent Health domain, WY MCH continued partnering with the University of Michigan to implement pilot clinics 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. WY MCH also executed a contract for a Youth Council Coordinator, recruited members, and began holding meetings with 14 adolescent members aged 18-24, representing diverse backgrounds and identities, in order to promote youth voice in the development of Wyoming organizations' and agencies' strategies, materials, and activities. In 2019, 79.2% of Wyoming adolescents ages 12-17 were reported to have a preventative medical visit in the past year, compared to only 69.1% in the U.S. (NSCH).

In the CYSHCN domain, WY MCH continued to provide gap-filling financial assistance and travel assistance to Wyoming families and identified new barriers to care brought about by the COVID-19 pandemic. WY MCH also continued to focus efforts on providing care coordination services and increasing the number of children and families receiving care in a medical home, supported knowledge sharing between PHN and WY MCH and training of new PHNs, and provided transition readiness assessments and transition letters to teenage CSH clients. Of Wyoming CYSHCN ages 0-17, 37.9% received care in a medical home, and 19.0% of CYSHCN ages 12-17 received the services necessary to transition to adult health care (NSCH, 2018/2019).

5 - Reduce and prevent childhood obesity

In FFY20, WY MCH continued to promote and actively support the Healthy Policies Toolkit and provided TA and training to the University of Wyoming Cent$ible Nutrition Program, and presented at a statewide conference encouraging and supporting Wyoming early childhood education providers to adopt physical activity priorities from the toolkit. The Children and Youth with Special Health Care Needs Program Manager (CYSHCNPM) also actively participated in the state-level nutrition collaborative, in which he applied a Title V lens to the collective areas of work on hunger, obesity, food sustainability, access, and the promotion of physical activity. In 2018 and 2019, 35.8% of Wyoming children ages 6-11 were reported by their parents to be physically active at least 60 minutes everyday in the past week, an increase from 27.3% in 2016 and 2017 (NSCH).

6 - Prevent injury in children

In FFY20, WY MCH implemented community-based grants with targeted evidence-based strategies to address the major causes of childhood injury/hospitalizations in Wyoming. WY MCH placed particular focus on adolescent motor vehicle safety and adolescent suicide prevention. The CYSHCNPM also continued to serve as an active member of the Child Safety Network Childhood Injury Learning Collaborative. In 2018, 230.7/100,000 adolescent ages 10-19 were hospitalized for non-fatal injuries, compared to 200.9/100,000 in the U.S (HCUP-SID). The Wyoming adolescent (ages 15-19) suicide rate continues to increase and was 32.1/100,000 from 2017 to 2019, compared to 11.2/100,000 in the U.S. The Wyoming adolescent motor vehicle mortality has decreased in the past ten years and was 22.0/100,000 adolescents ages 15-19 from 2017 to2019, but still higher than the U.S. rate of 11.2/100,000 (NVSS).

7 - Promote healthy and safe relationships in adolescents

In FFY20, WY MCH leveraged non-Title V funding to support this priority. WY MCH selected two Rape Prevention and Education (RPE) Program pilot communities to implement strategies using a Collective Impact Model; one community taught at least 50 students about healthy masculinity and creating cultures of safety and respect, and the community (which includes the Wind River Reservation) focused on supporting culturally-specific youth engagement activities. WY MCH also built statewide capacity for sexual violence prevention among youth and young adults through the Wyoming Sexual Violence Prevention Council (WSVPC), including developing ways to continue to engage in prevention work online and in socially-distanced environments during COVID-19. Additionally, the YAYAHPM serves as the Wyoming Personal Responsibility Education Program (WyPREP) Project Director, providing training, curricula, and support for implementation of evidence-based, medically accurate curricula in school and community-based settings; from the 2017-2018 school year to present, WyPREP and its partners reached over 2,250 Wyoming youth. An RPE Dashboard was created to visualize indicators and data sources that measure overarching risk and protective factors that impact sexual violence in Wyoming. In 2018, 21% of students reported being a victim of rape or attempted rape at any time during their time at the University of Wyoming (UW Sexual Misconduct Climate Survey), and in 2019, 7.1% of new moms reported being physically abused before their pregnancy (WY PRAMS).

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, the NSCH, Vital Statistics Services, and PRAMS, in consultation with the MCH Epidemiology Program, in the development of National Outcome Measures (NOM) and National Performance Measure (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.

Examination of Wyoming MCH data helped to drive the chosen MCH priorities. High rates of adolescent suicide and

motor vehicle rates, especially compared to U.S. rates, highlighted the need to focus more on teen driving safety, as well as strengthening adolescent preventative care, especially in providing mental health services. A current Maternal Mortality Review helped to drive the work on promoting well-women visits and preventative care, again with a focus on improving upon mental health services for women of reproductive age. PRAMS data demonstrated that improvements in safe sleep environments in Wyoming could be made, as a leading cause of death of post neonatal infants is sudden unexpected infant death (SUID) (VSS). Examination of the NSCH showed that Wyoming was most lacking in the coordinative care component of CSHCN receiving care in a medical home. While NSCH showed rates of physical activity among children were better in Wyoming compared to the U.S., increasing trends in childhood obesity indicated the need to continue to focus on physical activity promotion.

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

FFY21-FFY25 Priorities and FFY22 Proposed Strategies

WY MCH's seven priorities for FFY21-FFY25, along with key examples of related strategies and performance measures for FFY22, are listed below.

1 - Promote healthy and safe children
Key strategies will include continuing to promote Bright Futures guidelines and expanding outreach to additional childcare facilities, supporting state-level expansion of early childhood mental health services, and continuing involvement in statewide childhood blood lead surveillance and prevention efforts. Measures will include the percent of children ages 6-11 who are active at least one hour per day, the percent of children receiving at least one Early and Periodic Screening, Diagnosis, and Treatment visit as noted within the Centers for Medicare and Medicaid Services 416 Report, and an ESM on the number of providers receiving training and TA on the Wyoming Healthy Policies Toolkit.

2 - Improve systems of care for CYSHCN
Key strategies will include completing a comprehensive gap analysis, utilizing internal staff knowledge to address national standards of care, developing and convening a CSH Advisory Council, and continuing to coordinate and collaborate with multiple partners to create a comprehensive CSH resource guide. Measures will include the percent of children ages 0-17 with a medical home, the percent of CSH Advisory Council members with lived experience, and other ESMs.

3 - Prevent maternal mortality
Key strategies will include conducting virtual focus groups; developing a culturally appropriate communication campaign based on focus group findings, incorporating the My 307 Wellness App; and standing up a joint Utah-Wyoming maternal mortality review committee to create Wyoming-specific protocols and recommendations. Measures will include the percentage of women ages 18-44 with a preventative medical visit in the last year, and ESMs around My 307 Wellness app usage and well woman visit content engagement on the app.

4 - Prevent infant mortality
Key strategies will include conducting virtual focus groups, providing education and resources to providers and PHNs on safe sleep practices with an equity lens, monitoring QuitKit use driving home-visiting pregnant/postpartum mothers' usage of the Wyoming Quitline, and developing 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. 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; the percent of women who smoke during pregnancy; the percent of children ages 0-17 who live in households where someone smokes, and several ESMs.

5 - Promote adolescent motor vehicle safety
Key strategies will include facilitating collaborative efforts to strengthen partnerships with a focus on implementing evidence-based strategies, implementing Teens in the Driver's Seat in a high school setting, and developing motor vehicle traffic

safety guidelines and materials for adolescent well visits. Measures will include the rate of hospitalization for non-fatal injury per 100,000 adolescents ages 10-19 and the number of schools providing teen driver safety programs with teens.

6 - Prevent adolescent suicide

Key strategies will include improving the ability and capacity of Wyoming clinics to provide mental health screening and care to adolescents, developing a campaign encouraging adolescent well-visits in partnership with the state Youth Council, and implementing Sources of Strength in Wyoming junior high and high schools. Measures will include the percent of adolescents ages 12-17 with a preventative medical visit in the last year, of Sources of Strength-participating youth reporting increased youth-adult connectedness, and several ESMs.

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 and team strengths. The primary measure will be the percent of new WY MCH staff completing MCH orientation (including MCH Navigator self-assessment) within their first six months.

III.A.2. How Federal Title V Funds Complement State-Supported MCH Efforts

WY MCH receives an annual Title V award of $1,078,080 to complement its $2,375,591 in State match and Trust & Agency funds. Title V funds provide WDH with the workforce capacity, expertise, and infrastructure to address MCH priority needs:

- Title V partially or fully funds eight MCH staff and Title V match partially funds two MCH epidemiologists; Title V direct assistance also funds a CDC-assigned MCH epidemiologist.
- Title V funds enable support staff capacity to develop, implement, and evaluate strategies within each domain.
    - The grant provides for distinct staff in the following leadership roles: Title V Director/Unit Manager, CYSHCN Director/Children's Special Health Program Manager/Child Health Program Manager, Women and Infant Health Program Manager, and Youth and Young Adult Program Manager.
    - The grant provides for a workforce development/strategic planning contractor, who utilizes StrengthsFinder assessments to maximize WY MCH's effectiveness, and who will largely help WY MCH with strategic plan implementation in the coming year.
- In Wyoming, 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, RPE, PREP, and ERASE MM. WY MCH also receives MCHB technical assistance funding for a national consultant on CYSHCN standards.

WY MCH's Title V-funded specialty genetics services and State-funded gap-filling CYSHCN services directly benefit from the Title V-provided staff, leadership, and infrastructure. This year's success story highlights how the CSH program addresses all levels of the service pyramid, again made possible through Title V-funded staff, leadership, and infrastructure.

Title V funds further enable WY MCH to leverage partnerships critical to Title V activities. Recent and ongoing contractors include a Youth Council Coordinator, the University of Michigan to implement youth-friendly practices in clinics, and the University of Colorado to bring in genetics clinic specialists. WY MCH is also recruiting for a new Perinatal Quality Collaborative Coordinator, to be funded primarily through Title V with supporting ERASEMM funds. In addition, we are currently formalizing an agreement with Wyoming's Family Voices affiliate, UPLIFT, using Title V funds, and establishing a new five-year relationship with our existing workforce development/strategic planning contractor, Lolina, Inc.

III.A.3. MCH Success Story

WY MCH proudly features the success of its CSH Program in representing all three tiers of the MCH Pyramid of Services. Many frontier states lean heavily toward direct services (DS), but CSH is successfully filling critical DS needs while also prioritizing enabling services (ES) and public health services and systems (PHSS).

Exemplifying its DS impact, CSH provided the funding for a $5,000 activity chair which Medicaid and CSH identified was necessary but was not a qualified expense under Medicaid. Wyoming Medicaid and CSH recognized that the child had outgrown her high chairs and strollers, and worked together to locate and purchase the appropriate activity chair enabling her family to move her between rooms to support daily tasks like feed her. Bridging DS and ES, CSH supported Wyoming Medicaid in reducing structural barriers due and provided valuable gap-filling assistance to Wyoming residents (e.g. providing a stipend to a family for out-of-state hospital travel expenses since they could not afford to wait for reimbursement) and COVID-19 (e.g. funding a family's hotel stay closer to a hospital when the Ronald McDonald House closed and other hotels in the area presented a transportation barrier). Another ES highlight was providing care coordination to a family facing incredible financial hardship due to difficulty navigating applications and fees for other assistance, enabling the family to obtain coverage for their twins' birth and NICU stay at an out-of-state hospital. The bidirectional supportive relationship between Wyoming Medicaid and CSH expands opportunities for Wyoming Families to access high-quality care.

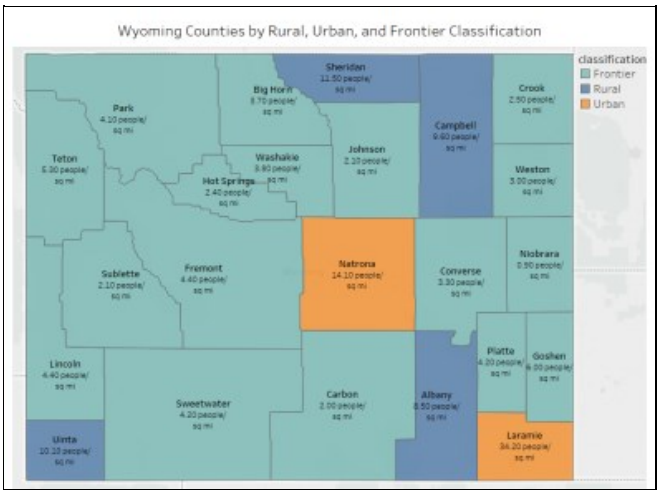
In the PHSS realm, WY MCH separated its Title V and CYSHCN Director roles between two managers, making room for more dedicated, consistent CYSHCN thought leadership. CSH also began meeting with a CYSHCN national consultant to evaluate and expand systems of care and make data-driven decisions, in accordance with the National Standards for Systems of Care for CYSHCN, and expanded these meetings to the entire WY MCH staff to spread the CYSHCN vision and mission and demonstrate the domain's cross-cutting nature. WY MCH also began working with a national family engagement consultant to draft a project work plan, which will culminate in the creation of a Wyoming CYSHCN advisory group.

Notably, CSH has accomplished the feat of incorporating the entire MCH Pyramid of Services into its critical work with a staff of only 3.5 FTEs. Wyoming CYSHCN families have a full spectrum of support from this small, dedicated team.

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 fewer than six people 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% from July 2018 (U.S. Census Quick Facts, 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 2019, 92.6% of the population aged five years and older spoke only English at home and 7.4% 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 Quick Facts, 2020).

Nearly one quarter (23.1%) of the population is under the age of 18, and 17.1% is over the age of 65. Ninety-three point two percent of people over the age of 25 have a high school education or higher, with 27.4% of this group having at least a bachelor's degree. The median household income in 2019 was $65,003, just slightly less than the median household income in the U.S. of $65,712. Persons in poverty are estimated to be 10.1% of the population, compared to 10.5% nationally (U.S. Census Quick Facts, 2020).

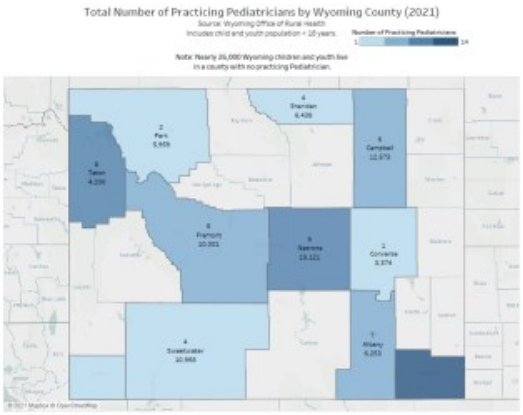
During the spring and summer of 2020, Wyoming's economy faced a significant downturn due to the COVID-19 pandemic and lessened value of its natural resources, and the long-term impacts are uncertain. Employment in Wyoming decreased 7.0% (20,820 jobs) along with the U.S. decline of 7.0%. The unemployment significantly decreased to 6.6%, which is lower than the national average (Wyoming Economic Analysis Division, 2020). Data on 2020 population estimates were not available when this report was completed.

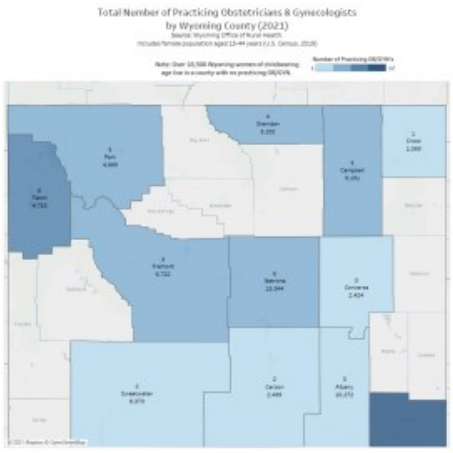
Strengths and Challenges

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 in adult physical inactivity (25.7% in 2018 to 21.7% in 2019, Behavioral Risk Factor Surveillance System). 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, a high rate of uninsured persons, 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 (HRSA) Designated Health Provider Shortage Areas (HPSA) Quarterly Summary Report, Wyoming had a total of 48 Primary Care HPSA designations, with 187,903 residents residing in primary care shortage areas. There were 32 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 an HPSA for mental health. Per HRSA's Designated HPSA Quarterly Summary (3/31/21), 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 2021 there are currently 55 physicians practicing obstetrics and gynecology (OB/GYN) in Wyoming and 63 practicing pediatricians. Eleven counties have no OB/GYN and 12 counties have no pediatrician. Over 18,500 Wyoming women of childbearing age (15-44) live in a county with no practicing OB/GYN and approximately 26,000 Wyoming children and youth (<18 years of age) live in a county with no practicing pediatrician (Centers for Disease Control and Prevention (CDC) Wonder, 2020).

There are 166 family practice physicians in the state. Twenty-six individuals practice in Natrona County, 22 in Laramie County, 18 in Park County, and 9 in Fremont County. Nine counties have fewer than five family practice physicians (Wyoming Office of Rural Health, 2020).

Results from the CDC-developed Levels of Care Assessment Tool (LOCATe) piloted in 2016 found that Wyoming lacks Level III facilities for both neonatal and maternal levels of care. This requires families to travel long distances for health care, miss work, and coordinate care for children left at home. In many cases, families must cross state boundaries to receive care. The LOCATe tool has since been revised and may be administered again with Wyoming 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 2019, 14.8% of Wyoming residents under the age of 65 years had no health insurance coverage, down slightly from the previous year, but still making Wyoming ranked as sixth highest in the nation. compared to 9.5% of the population nationally (U.S. Census Quick Facts, 2020). Wyoming is one of twelve states that has not expanded Medicaid. During the 2021 Wyoming legislative session, a Medicaid expansion bill that passed the Wyoming House for the first time subsequently failed a vote in the Senate Labor, Health, and Social Service Committee. The bill would expand Medicaid contingent on the state continuing to receive a 90% federal match assistance percentage for the expansion population and at least 55% for the traditional Medicaid population (a five percentage point increase from the traditional match rate of 50%, which is an incentive included in the American Rescue Plan Act (ARPA) for adopting expansion). Prior to the new ARPA incentive, the Wyoming legislature had voted against multiple Medicaid expansion bills during the 2020 and other previous legislative sessions. Health insurance options in the Federal

Health Insurance Marketplace for Wyoming include Blue Cross Blue Shield and Mountain Health co-op.

According to the 2020 Robert Wood Johnson County Health Rankings & Roadmaps, Wyoming fares better than 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 5.7% (Teton County) to 18.9% (Niobrara County) (Small Area Income and Poverty Estimates, 2020).

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 Four-Year Graduation Rates). Educators report that the four-year graduation rate for Native American youth increased substantially from the previous period but recognize that more work needs to be done.

The definition used for health equity by the Robert Wood Johnson foundation is: "Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care." Due to the unique nature of Wyoming, a number of barriers to measuring health equity exist. Small population numbers (particularly for minorities) at the state and county levels make stratification by geographic region, race, and ethnicity challenging. Wyoming continually monitors MCH outcomes for minority populations 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, WY MCH established a Title V priority to build workforce capacity to operationalize all of its core values with specific emphasis on health equity. The operationalization of health equity will consider ways in which we can increase our capacity to present data through a health equity lens.

In 2018, the Wyoming Department of Health (WDH), Public Health Division (PHD) completed a State Health Assessment (SHA) in pursuit of public health accreditation. The SHA identified Behavioral Health, Access to Healthcare, and Unintentional Injury as top health priorities.

Agency Organizational Structure and Role

The Maternal and Child Health Services Title V Block Grant is managed by the Maternal and Child Health Unit (WY MCH) within the Community Health Section (CHS) and Public Health Division (PHD) of the Wyoming Department of Health (WDH). WDH's mission is to "promote, protect, and enhance the health of all Wyoming residents." PHD's mission 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 organizational chart for a visualization of PHD's 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.

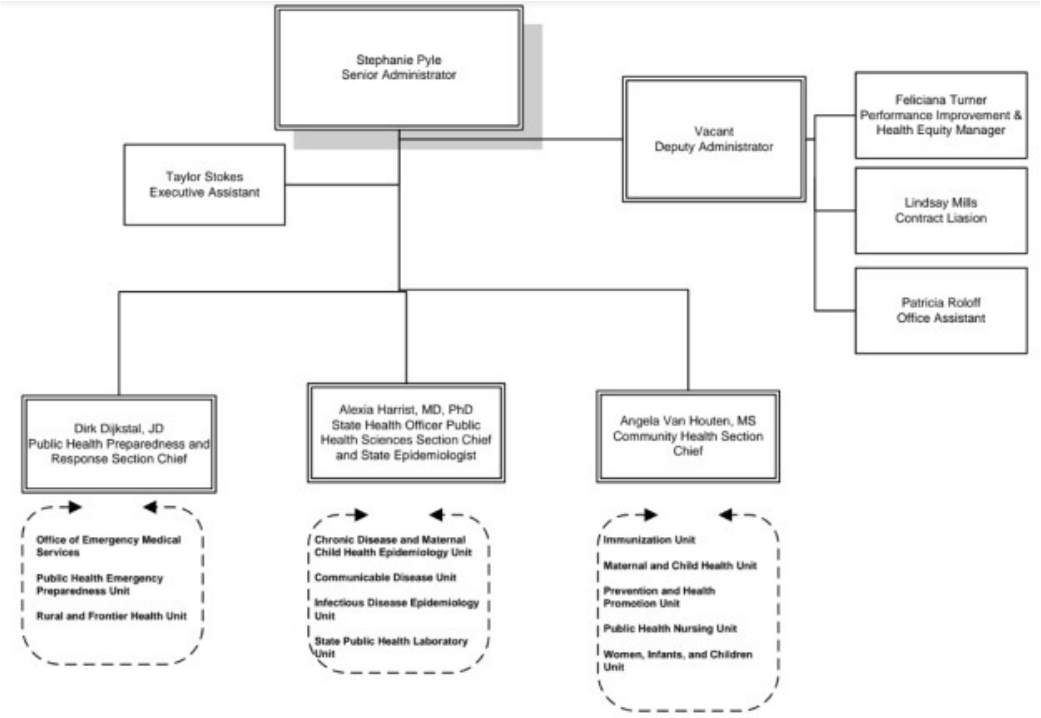
PHD employs approximately 265 staff in a mostly-centralized public health system. With 19 of the states 23 Public Health Nursing (PHN) offices are administered through a State-county partnership. The remaining four are independent local health departments.

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*
  - Immunizations
  - Maternal and Child Health
  - Prevention and Health Promotion
  - PHN
  - 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 Laboratory

A summary of the PHD organizational structure is included below.



PHD is working toward public health accreditation and completed a State Health Assessment (SHA) in 2018. A member of the MCH Epidemiology Program is on the SHA Leadership Team. Efforts to develop a State Health Improvement Plan (SHIP) 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 workgroups continue to address each of these PHD strategic priorities. For example, the workgroup working to foster a competent, flexible workforce facilitates the completion of an assessment of the Core Competencies for Public Health Professionals by all PHD 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 MCH population and administers the Title V MCH Services Block Grant. Structurally, the unit's programs are divided according to the population groups they serve. This structure aligns well with the Title V population domain framework and assures dedicated resources within each domain. Programs strive to collaborate to ensure consideration of the life course perspective in program planning and decision making. WY MCH programs include:

- **Women and Infant Health Program**, focusing on women of reproductive age and infants through age one (*Women/Maternal Health and Perinatal/Infant Health domains*)
- **Children and Youth with Special Health Care Needs (CYSHCN) Program**, focusing on all children one through 21 years, including those with special health care needs (*Child Health and Children with Special Health Care Needs (CSHCN) domains*)
- **Youth and Young Adult Health Program**, focusing on the unique needs of youth and young adults ages 12-24 (*Adolescent Health domain*)

WY MCH's vision is a Wyoming where all families and communities are healthy and thriving. 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 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. Promote Adolescent Motor Vehicle Safety (Adolescent Domain)
5. Prevent Adolescent Suicide (Adolescent Domain)
6. Improve Systems of Care for Children and Youth with Special Health Care Needs (CYSHCN Domain)
7. Strengthen MCH Workforce Capacity 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 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

CYSHCN Program Overview and Population Served

In 2018-2019, approximately 24,350 (18.1%) of Wyoming children ages 0-17 had a special health care need. The prevalence of CSHCN whose parents reported receiving care in a well-functioning system in Wyoming is 8.6% , compared to 14.1% of CSHCN in the U.S. overall, and a continued decrease from 16.6% in 2016-2017 and 9.7% in 2017-2018 (National Survey of Children's Health). Currently, WY MCH's CYSHCN program activities are limited in systems-level scope and serve a small proportion of the overall CSHCN population in Wyoming. Beginning in FFY21, the CYSHCN program will focus on assessing and improving systems of care for all CSHCN.

WY MCH's CYSHCN program (also known as the Children's Special Health (CSH) Program) offers care coordination and limited gap-filling financial assistance as the payer of last resort for enrolled clients (CYSHCN ages 0-18 and high-risk pregnant women and infants requiring Level III care) 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 FFY20, CSH actively served 540 clients. Of all enrolled clients, 449 were CYSHCN, 74 were high-risk infants, and 17 were high-risk pregnant women. Of those served, 93% were on Medicaid during the reporting year.

In 2021, a planned organizational structure change will bring the newborn screening and genetic specialty clinic services (currently under the Women and Infant Health Program) under the CYSHCN Program, a consolidation that aligns with a new systems-level focus for CYSHCN activities in 2021-2025 and one that will better align CYSHCN workforce development efforts under Title V CYSHCN Director's leadership. This change will also expand the population served by the CYSHCN Program to include all infants born in Wyoming.

WY MCH works with partners such as PHN, Medicaid, and Kid Care CHIP (Child Health Insurance Program), in-state and out-of-state primary care and specialty providers, early intervention providers, and home visiting providers to assure vulnerable populations, especially CYSHCN, have access to health insurance, a primary care provider or ideally a certified medical home, specialty care services, and other supports and services based on identified family needs.

Strengthening partnerships with out-of-state providers and neighboring Title V agencies helps to build Wyoming's health services infrastructure. For example, the Wyoming Newborn Screening and Genetics Programs contract with the Colorado Department of Public Health and the Environment (CDPHE) for newborn screening laboratory and short-term follow-up services, and the University of Colorado Medicine for in-person and telehealth genetics services and consultation. Additionally, WY MCH partnered with the Utah Department of Health to apply for a CDC Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM) grant to expand the scope of the well-established Utah Perinatal Mortality Review Committee to include review of Wyoming cases.

Health Services Infrastructure and Integration of Services

Wyoming lacks a children's hospital and has a significant shortage of pediatric specialists in the state, leading families to rely heavily on bordering states' infrastructure for Level III hospital care and pediatric specialty care. WY MCH maintains an updated map of pediatric specialty clinics offered in Wyoming and directly funds in-person and telehealth genetic clinic services due to an absence of an in-state geneticist and long wait times for out-of-state appointments.

The CSH Program requested MCHB technical assistance in 2020. The program began work with a national CYSHCN leader to complete an assessment of Wyoming implementation of the National Standards for Systems of Care for CSHCN; this assessment helps identify further gaps and opportunities for improvement to assure CSHCN have access to a comprehensive, coordinated, and family-centered system of care.

Financing of Services

Wyoming is one of two remaining states whose Medicaid payments are based on fee for service. Overall, children make up 67% of Wyoming residents covered by Medicaid and KidCare CHIP. Wyoming Medicaid and KidCare CHIP serve a large portion of Wyoming's vulnerable populations, including 100% of children in foster care, 55% of children who live in or near poverty, 34% of children with disabilities or special health care needs, and 29% of infants, toddlers, and preschoolers (Georgetown University Health Policy Institute Wyoming Snapshot 2019). As of October 1, 2020, the Wyoming Medicaid and KidCare CHIP eligibility was 154% federal poverty level (FPL) for children ages 0-5 and pregnant women; 133% FPL for children ages 6-18; and 200% FPL for Kid Care CHIP.

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 NBS and Genetics Programs fulfill this statutory requirement in partnership with families, providers (including midwives), hospitals, CDPHE (laboratory services and short-term follow up contractor), and a contracted courier service. The Wyoming NBS and Genetics Coordinator is funded by both Title V and State Trust and Agency funding (comprised of hospital fees charged for NBS services), demonstrating the partnership between Title V and WDH to assure access to newborn screening statewide.

Wyo. Stat. § 35-27-101, 102, 103, 104, Public Health Nurses Infant Home Visitation Services, was passed in 2000. This statute directs PHN to contact eligible women to offer home visitation services. 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 implementation in Wyoming reduced from statewide implementation to zero sites over the course of twenty years. In 2021, the statute requirement will be met by a new evidence-based home visitation model, Maternal Early Childhood Sustained Home-Visiting, a model selected for its fit for Wyoming's unique characteristics and needs. The newly named program, Wyoming Hand in Hand, launched in Spring 2021 and is funded by Temporary Assistance for Needy Families (TANF) funding and State General Funds that count toward the required Title V match.

During the 2020 legislative session, Wyo. Stat. § 21-2-202 was updated to authorize the State Superintendent of Public Instruction to employ a state school nurse if/when non-State funds were available. Together, the Wyoming Department of Education and WY MCH agreed to contribute funding for this position. The selected candidate started in June 2021.

III.C. Needs Assessment
FY 2022 Application/FY 2020 Annual Report Update

Ongoing Needs Assessment Activities

WY MCH leadership and MCH Epidemiology Program (MCH Epi) staff will work closely to identify and implement interim activities to occur between 5 year needs assessments (NA).

Current and planned ongoing NA activities include:

- The CYSCHN Director is receiving MCHB-funded technical assistance (TA) to support completion of the National Standards for Systems of Care for CYSHCN assessment. Assessments will be completed from the perspective of WY MCH and other agencies/organizations involved in WY's CYSHCN systems of care. Assessment findings will help the CYSHCN Program to select standards for action and revise the state action plan for the CSHCN domain.
- WY MCH is partnering with the OMNI Institute to hold focus groups on well woman visit, safe sleep, child well visit, and systems of care for CYSHCN. Results will inform state action plan strategies and activities, ensuring that voices of community members are included.
- In 2020 MCH Epi created dashboards to monitor key WY MCH indicators from birth certificate data, PRAMS, and all Title V National Outcome Measures (NOM) and Performance Measures (NPM). The dashboards allow for identification of trends and examination of disparities and MCH data are more accessible to partners.
- MCH Epi is creating data briefs on the selected MCH priorities, focusing on the chosen NPMs. These are snapshots of where WY stands in the priority and highlight the data that helped drive the process for priority selection.
- WY MCH will convene the MCH/Title V Steering Committee annually to gather feedback on state action plan progress and address challenges/barriers. The meetings offer an opportunity to connect with other statewide assessments (e.g. State Health Assessment, MIECHV) that could inform ongoing needs assessment efforts for MCH.
- In spring 2021, WY MCH released an online public input survey to gather input on recent and planned activities and identify emerging needs. The survey asked, "What are the unmet needs in your community?" for each of the five primary domains. WY MCH is using the results to inform action planning.

Health Status and Needs Update

Women's/Maternal Health

Maternal Mortality and Morbidity

Due to WY's small population and small numbers of maternal deaths, maternal death rates fluctuate. Aggregated data suggests that the WY maternal mortality rate is similar to the national rate. 2020 was the first year of MMRC review of cases, we completed case reviews for 3 2018 3 maternal deaths, 2 were found to be pregnancy related.

From 2016-2020, WY's severe maternal morbidity rate was 91.5 per 10,000 delivery hospitalizations. The most common severe maternal morbidity in WY is transfusion, followed by eclampsia.

Maternal Mental Health

As suicide and drug overdoses are among the leading causes of maternal mortality in WY, maternal mental health is an area of focus.

In WY, 18% of new moms reported depression prior to pregnancy, 17% reported depression during pregnancy, and 14% reported postpartum depression (PPD). PPD was highest among women ages 15-24 years and was also significantly higher for women in the lowest Federal Poverty Levels. A majority (86%) of women reported their providers discussed

depression with them at a postpartum visit (PRAMS, 2016-2019).

Preconception Health

According to the 2018 Behavioral Risk Factor Surveillance System (BRFSS), 65% of WY women reported having a preventive medical visit in the past year, significantly less than the U.S. prevalence of 73%. While the prevalence in WY has increased over the past few years, it has been significantly less than the U.S. prevalence since 2009. In 2019, the prevalence of women reporting having a well women visit in the past year was highest for those with a college degree or more (78%), and those with a household income of $75,000 or more (75%). In addition, a higher prevalence of women with health insurance (73%) compared to uninsured women (35%) reporting having a preventive medical visit in the past year.

Maternal Smoking

Significant reductions in the prevalence of women smoking during pregnancy have been seen in both the U.S. and in WY. While decreases in smoking have been seen, the 2019 WY prevalence (13.6%) is significantly higher than the U.S. prevalence of 6.0% (NVSS). The prevalence of smoking during pregnancy was significantly higher among WY women with less than a high school education (32.0%) compared to those with at least a high school education (25.7), those some college education (11.1%) and those who graduated from college (1.0%) and significantly higher among women on Medicaid (29%) compared to those who are uninsured (16%) and those with private insurance (6.2%) (NVSS). To reach the HP2030 goal of 95.7% of women giving birth not reporting smoking during pregnancy, WY needs to increase the percentage of women giving birth who did not smoke during pregnancy by 10.7%.

Family Planning

In 2019, 22% of women reported having an unintended pregnancy, which is a significant decrease from 33% in 2012. The rate of unintended pregnancies did not differ by race, but differences were seen by income level. Women living with incomes ≤100% FPL reported having an unintended pregnancy significantly more (38%) compared to women living with incomes 201-300% FPL (17%) and 301%+ FPL (13%).

In 2019, 69% of WY women at risk of pregnancy/not actively trying to become pregnant reported use of the most/moderately effective form of contraception. The prevalence has not changed significantly since 75% in 2012. No differences were seen by race/ethnicity, income or Medicaid status. Although no longer a Title V priority, MCH Epi will continue to monitor and conduct analysis around contraceptive use (PRAMS).

Perinatal/Infant Health

Infant Mortality

WY's 2015-2019 infant mortality rate (IMR) was 5.6 deaths/1,000 live births; with a majority of deaths occurring 63% among neonatal infants (VSS). The WY IMR was lower than the 2018 national rate of 5.7 deaths/1,000 live births and both met the HP2020 objective (6.0 deaths/1,000 live births) but not the HP2030 objective of 5.0 deaths per 1,000 live births. From 2009-20019, the WY IMR among white women was 6.3/1,000 and was 7.9/1,000 among American Indian women (VSS 2009-2019).

Both the neonatal and postneonatal mortality rates in WY have been similar to U.S. rates over the past 10 years. From 2015-2019, the leading causes of death among WY neonates were congenital malformation, deformations, and chromosomal abnormalities followed by disorders related to short gestation and low birth weight. The leading causes of postneonatal infant death were sudden unexpected infant death (SUID), congenital malformation, deformations, and chromosomal abnormalities (WY VSS).

Preterm and Low Birth Weight (LBW) Births

In 2019, 10% of WY infants were born preterm, which was not significantly different from the 2019 U.S. prevalence (10%). Since 2009, WY's preterm rate has fluctuated; the highest prevalence was 11% in 2014 and the lowest at 9% in 2017. The 2019 rate was the same as the 2009. The prevalence of LBW births in WY has increased since 2009; the 2019 prevalence

of 10% was significantly higher than the 2009 prevalence (8%). The 2019 WY prevalence was significantly higher than the 2019 U.S. prevalence 8%. In 2019, WY had not met the HP2020 preterm goal of 9.4%, or the HP2020 LBW goal of 7.8%. MCH Epi will continue to monitor changes in preterm and LBW deliveries and will examine the LBW increase in more detail.

Infant Sleep Environment

The leading cause of postneonatal infant death in WY from 2015 to 2019 was SUID, which includes sudden infant death syndrome (SIDS). Over 84% of WY women reported their infants are put to sleep on their backs only (PRAMS, 2016-2019), exceeding the HP2020 goal of 75.8%. However, less than one third of women reported their infants always or often were placed to sleep on a separate approved sleep surface and 31% reported their infants were usually placed to sleep with *no* soft bedding. Disparities in sleep environments were seen by race and ethnicity, as well as by income. Planned program activities include conducting focus groups to better be able to understand the observed disparities in sleep environments.

Breastfeeding

The WY breastfeeding initiation rate (90.9%) exceeds the HP2020 Goal (81.9%) (PRAMS, 2016-2019). In 2017, 31.4% of infants in WY were breastfeed exclusively through six months, exceeding the HP2020 Goal of 25.5%, and significantly higher than the 20.0% in 2007(National Immunization Survey, 2016). WY continues to monitor breastfeeding rates, however, as WY has met the HP2020 and HP 2030 goals and has maintained high breastfeeding rates, breastfeeding is not a Title V priority

Child Health

Child Mortality

In 2019, the mortality rate for WY children ages 1-9 (CMR) was 16.8/100,000, similar to the 2019 US rate of 16.7/100,000. The WY CMR has not changed significantly since 2009. Similar to the US, the 2017-2019 CMR is higher for children ages 1-4 (25.3/100,000) than for children ages 5-9 (20.3/100,000), but unlike the US the difference in the rates between the two age groups was significant.

Unintentional Injury

Between 2009 and 2019, unintentional injury (UI) accounted for 40% of the deaths among WY children ages 1-9 and UI is the second-leading cause of death in this age group. Among UI related deaths, drowning (21.3%) and motor vehicle traffic injuries (19.1%) were the most common mechanisms of fatal injuries (VSS).

According to the Healthcare Cost and Utilization Project - State Inpatient Database (HCUP-SID), there were no significant changes in the WY child injury hospitalization rates from 2016-2018. Since 2016, the WY child injury hospitalization rate has been lower than the U.S. rate and the 2018 WY rate (82.7/100,000 children 0-9 years) was significantly lower than the U.S. (122.1/100,000). Childhood mortality and injury hospitalization are no longer a WY Title V priority, but MCH Epi will continue to monitor this topic.

Overall Health and Preventive Care

According to the 2018-2019 NSCH, 94% of WY children ages 0-11 were reported to be in excellent or very good health, 48% received care in a medical home, 58% had adequate and continuous insurance, and 19% received care in a well-functioning system. Data indicated that a significantly higher prevalence of children who received care in a medical home were reported to be in excellent or very good health, compared to children who did not receive care in a medical home.

In 2019, 64.6% 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. WY continues to see an increase in the percent of eligible children receiving at least one EPSDT screening, and this has increased by 17.9% since 2013 (WY Centers for Medicare and Medicaid Services 416 Report).

Obesity and Physical Activity

In 2018-2019, 14.3% of WY children ages 10-13 were reported as being obese, compared to 16.4% in the U.S. (NSCH). In 2018-2019 36% of WY children ages 6-11 were active for 60 minutes every day. This prevalence was significantly higher than the US prevalence of 28%, for the first time since 2016-2017 (NSCH). Small numbers continue to make any noted disparities in physical activity between different groups of children difficult to evaluate. The Child Health program is currently focusing efforts addressing policies around obesity and physical activity with licensed childcare facilities in WY.

Adolescent Health

Adolescent Mortality

The WY adolescent (ages 10-19) mortality rate (AMR) decreased significantly from the 2009 rate of 66.8/100,000 adolescents to 31.8 per 100,000 adolescents in 2018. In 2019 the AMR increased 52.7/100,000, but was not significantly different from the 2009 rate. The 2019 WY AMR was significantly higher than the 2019 US AMR of 32.1/100,000. From 2009-2019, he leading cause of death among 10-19 year olds in WY was unintentional injury (42% of deaths) and suicide (32% of deaths) (WY VSS). WY MCH Epi will continue to monitor this rate, and adolescent health program priorities include prevention of adolescent suicide and motor vehicle injury.

The 2017-2019 AMR was significantly higher among ages 15-19 (72.5/100,000) compared to ages 10-14 (11.1/100,000), males (54.6/100,000) compared to females (25.7/100,000) and Non-Hispanic American Indians/Alaska Natives (166.1/100,000) compared to Non-Hispanic Whites (39.2/100,000). The AMR among WY youth ages 15-19 is higher than the US AMR among the same age group (49.8/100,000) (NVSS).

Motor Vehicle Mortality

The 2017-2019 adolescent (ages 15-19) motor vehicle mortality rate (AMVMR) in WY has decreased from the 2007-2009 rate of 37.8/100,000 to 22.0/100,000 (NVSS, 2017-2019). However, the WY rate has been significantly higher than the US rate since 2007.

The YAYAHP plans to implement *Teens in the Driver's Seat* as a strategy to tackle motor vehicle mortality by focusing on seat belt use among adolescents. In partnership with MCH Epi, the YAYAHP is proposing a new question around seatbelt use to be added to the WY Prevention Needs Assessment (PNA), as the YRBSS is no longer administered in WY.

Suicide, Self-Harm, and Risk and Protective Factors

Over the last decade, the WY adolescent suicide rate has increased by more than two-thirds the rate it was from 2007-2009, while the US rate has increased by half of what it was from 2007-2009 to 2017-2019. The 2017-2019 WY rate (32.1/100,000) was almost triple the U.S. rate of 11.2/100,000. Suicides made up 32% of all deaths among adolescents ages 10-19 in WY from 2009 to 2019 (VSS). From 2015 to 2019, adolescent males in WY died by suicide at a significantly higher rate (48.5/100,000) than females (11.5/100,000). This difference is also seen in national data (NVSS).

The YAYAP is working to increase adolescent well-visit rates and promote mental health screenings during adolescent well-visits. In 2019, 69% of adolescents, 12-17 years, had a preventative medical visit in the past year, significantly less than the 80% in the US, and down from 78% in 2016/2017 (NSCH). According to 2019 WY Medicaid data, 34% of adolescents (ages 10-20 years) eligible to receive at least one screening received a screening, an increase from 24% in 2015 when, the lowest rate observed in the past 10 years (WY Centers for Medicare and Medicaid Services 416 report).

Children with Special Health Care Needs (CSHCN)

Approximately 18% of WY children ages 0-17 years (24,351) have special health care needs. In 2018-2019, 57% of WY CHSCN had insurance that was considered adequate for a child's health needs, and 8.6% of WY CSHCN reported receiving care in a well-functioning system compared to 14% of CSHCN in the US. While the 2018-2019 prevalence in WY is not significantly less than the 2016-2017 prevalence of 17% this is a decrease of almost 50% in the percent of children who received care in a well-functioning system (NSCH, 2018-2019).

In 2018-2019, 38% WY CSHCN reported having a medical home, compared to the 49.7% of non-CSHCN children in WY, and 42% of CSHCN in the US. WY's CSHCN Program has chosen to work on increasing the prevalence of CSHCN in WY receiving care in a medical home over the next five years, with a specific focus on the need to improve the care-coordination component of a medical home for the WY CSHCN population. The prevalence of WY CSHCN receiving care-coordination when needed (55%) is the lowest among all the components of a medical home (NSCH, 2018-2019).

Emerging Needs Update

Childhood Lead Poisoning Prevention

The WDH-PHD does not currently fund a dedicated lead program and has lacked capacity for ones since 2014. Blood lead test results are a reportable disease/condition in WY. In 2018, only 5% (1,958) of WY children under the age of six had been tested for lead, significantly less than the national average of 19%. Of the children who were tested in 2018, 3% (49) had elevated blood lead levels, which was higher than the national average of 2%. In early 2020, WY MCH partnered with the State Epidemiologist/State Health Officer to submit an application for the CDC Childhood Lead Poisoning Prevention grant. If funded, the grant will fund one FTE to implement activities to improve lead screening, reporting, surveillance, follow-up, and linkages to services for children with elevated blood lead levels.

COVID-19 and MCH Emergency Preparedness and Response

During the past year, all MCH Epi staff and some WY MCH staff assisted with the State's COVID-19 response, temporarily shifting capacity away from MCH efforts. Support included staffing COVID-19 call lines, case investigation, contact tracing, and COVID-19 data. MCH staff contributed subject matter expertise related to the impact of COVID-19 on pregnant women and children.

WY PRAMS added two COVID-19 supplements. The general COVID-19 supplement began Oct 2020 with the July 2020 births. The COVID-19 Vaccine Supplement, asking about vaccine administration and hesitancy, began data collection in April 2021 with the January 2021 births.

MCH Epi is conducting a linkage of COVID-19 cases in women of reproductive age to birth/fetal death records 2020 to describe the pregnant population who also had COVID-19 and monitor the outcomes to both the infant and mother. MCH Epi is monitoring for potential maternal mortality cases who also were diagnosed with COVID-19. To date, there have been no maternal mortality cases linked to COVID-19 cases.

In 2020, WY MCH submitted a CDC PHAP application to expand capacity to address the unique needs of MCH populations and MCH systems of care in times of emergency, not limited to COVID-19. In addition, a team of stakeholders currently participate in an AMCHP Emergency Preparedness and Response Action Learning Collaborative.

Oral Health

The WDH-PHD Oral Health Program was eliminated in 2016 due to budget reductions, therefore the role of WY MCH in oral health activities is limited. WY MCH participates in a statewide WY Oral Health Coalition co-led by the WY Primary Care Association. WDH-PHD also serves on the Rocky Mountain Network of Oral Health Steering Committee, a HRSA-funded oral health integration project focused on children 0-40 months and pregnant women.

MCH Epi continues to monitor oral health data. In 2018-2019, 14% of WY children ages 1-17 had decayed teeth/cavities in the past year, which was slightly higher than the prevalence of 10% in 2016-2017, and higher than the U.S. prevalence of 12% in 2018-2019. WY children had a slightly higher prevalence of children ages 1-17 (81%) who had dental visits in the past year compared to the US (80%) (NSCH).

In 2020 the WY Oral Health Coalition received funding from the WY Office of Rural Health to update a statewide oral health needs assessment. WY MCH will use results to monitor oral health among MCH populations and will continue to address oral health through active participation in WY Oral Health Coalition activities and through the Title V Priority - Promote

Healthy and Safe Children.

Child and Adolescent Health Insurance

In 2018-2019, the prevalence of children ages 0-17 who were adequately insured in the past year in WY (57%) was significantly less than the U.S. prevalence (67%). According to the 2019 American Community Survey (ACS), 10% of WY children (ages 0-17) were not currently insured, which is significantly more than the US prevalence (5%). When examined by race, the highest prevalence of uninsured children was among non-Hispanic American Indian/Alaska Native (31%) (ACS, 2019). In 2018-2019, uninsured children (ages 1-17) had the lowest prevalence (67%) of having a preventive dental visit in the past year, as well as the lowest prevalence (23%) of receiving care within a medical home (NSCH). These numbers coupled with the uninsured statistics from the CYSHCN population show it is clear there is much work left to do in these areas.

While child health insurance (NOM 21) was identified as an emerging need during the 2020 NA, it was not selected as a priority due to capacity challenges and concerns over the impact WY MCH is actually positioned to make. WY MCH will continue to monitor child health insurance measures and will work to promote access to health insurance among clients served through WY MCH programs.

Capacity Update

Between 2012 and 2020, the WY MCH Unit Manager assumed the dual role of Title V and CSHCN Director due to limited leadership capacity in the CYSHCN program. To strengthen leadership capacity for CYSHCN services after this initial transition, the former Child Health Program and CYSHCN Program were consolidated to form an expanded CYSHCN Program overseeing the Child Health and CSHCN population domains, and is now led by one program manager who also assumes the role of Title V CSHCN Director. The WY Newborn Screening and Genetics Program will transfer to the CYSHCN program in 2021 to consolidate all CYSHCN services and workforce capacity.

WY MCH continues to allocate State funding to each of WY's 23 local PHN offices to support local MCH programming. Due to the economic downturn, future State funding may be reduced; however, no significant cuts are expected for the current State biennium (2021-2022). WY MCH will integrate Title V 2021-2025 priorities and strategies into contracts with local PHN offices as early as summer 2022, when current contracts are up for renewal.

Title V Partnerships and Collaborations Update

WY MCH partners with MCH Epi 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; Department of Workforce Services; Department of Family Services; Department of Education; WDH Behavioral Health Division; WDH PHD ; the University of WY; WY Health Council (Title X grantee); the federal Maternal, Infant, Early Childhood Home Visiting (MIECHV) grant, administered by an out-of-state, non-profit partner; and other statewide organizations and associations (WY Medical Society, Uplift, WY Primary Care Association, WY American Academy of Pediatrics Chapter, WY American College of Obstetricians and Gynecologists Chapter, WY Kids First, WY Afterschool Alliance, WY 211, WY Community Foundation).

WY MCH representatives sit on the following statewide councils:

- WY Governor's Council on Developmental Disabilities
- WY Governor's Early Childhood State Advisory Council
- WY Early Intervention Council
- WY Preschool Development Grant Executive Leadership Committee
- WY Citizen Review Panel

In July 2020, WY MCH executed new two-year contracts with all 23 county PHN offices with TANF and State General Funds

provided for reimbursement of MCH services. These funds support an estimated 47 full-time employees across WY in support of MCH services. Although no formal funding agreements exist yet, WY MCH also works with the Northern Arapaho and Eastern Shoshone Tribes to promote and provide gap-filling financial assistance and care coordination services as part of the CYSHCN Program. CYSHCN staff provide training and support to tribal nurses to improve and sustain programming.

Efforts to Operationalize Five-Year Needs Assessment Findings

The WY MCH NA framework was not designed to be static or time-defined; many elements will persist throughout the five-year grant cycle.

Steering Committee and MCH Priority Action Team Involvement
The WY MCH/Title V Steering Committee formed in 2019 to drive NA activities, approve priorities, and hold WY MCH accountable to its developed State Action Plan (SAP)and met in January 2020 to approve draft Title V priorities. Due to COVID-19 the committee did not meet again to approve the final WY MCH SAP until June 2021. The committee will meet annually to receive updates on implementation of WY MCH's SAP and to offer expert feedback and recommendations, in order to improve WY MCH accountability, increase leadership buy-in, and provide opportunities for ongoing feedback and quality improvement.

In spring 2020, WY MCH convened MCH Priority Action Teams (PATs) to gather input on the selected priorities and strategies for the 2021-2025 NA, and to establish consistent engagement of stakeholders in the Title V SAP planning, development, implementation, and evaluation. Due to COVID-19, the PATs have not met as planned to formally launch the 2021-2025 five-year cycle. Program managers plan to convene a PAT per priority topic twice a year to monitor progress on the SAP and offer support in implementation of MCH activities, with the support of Uplift, the WY Family Voices affiliate.

Strategic Plan Implementation
In January 2021, WY MCH released a Request for Proposal for strategic planning, strategic implementation, workforce development, and leadership consultation services. Seven proposals were received and Lolina, Inc. was selected for an initial two-year contract with options for renewals throughout the 2021-2025 Title V cycle, as needed.

In late 2020, WY MCH began holding weekly 30-30 meetings to check in on SAP, successes, and challenges experienced over the past 30 days and planned commitments for the upcoming 30 days. Designed to improve individual and team accountability for implementation of strategies, the 30-30 schedule rotates by domain to ensure each MCH population domain is highlighted and how the core values are operationalized in the work.

WY MCH continues efforts in two key areas of its original NA framework - program and policy development and resource allocation - throughout FFY21. This provides staff an opportunity to revisit original plans and make adjustments based on new information, changing community needs and/or capacity. WY MCH plans to revisit and revise its SAP and ESMs/SPMs ahead of the start of FFY22 and will receive technical assistance from the MCH Evidence Center and from Lolina, Inc. throughout summer 2021.

WY MCH will then focus on resource allocation and will revise its budget to align with updates to the SAP and consider revising county MCH funding allocations and contract deliverables to assure each county is working towards at least one MCH priority area and/or strategy in their next contract renewal.

Organizational Structure and Leadership Updates

WY MCH administers the Title V MCH Services Block Grant (BG) and provides leadership for state and local efforts that improve the health of MCH populations. The table below outlines MCH and MCH Epi staff.

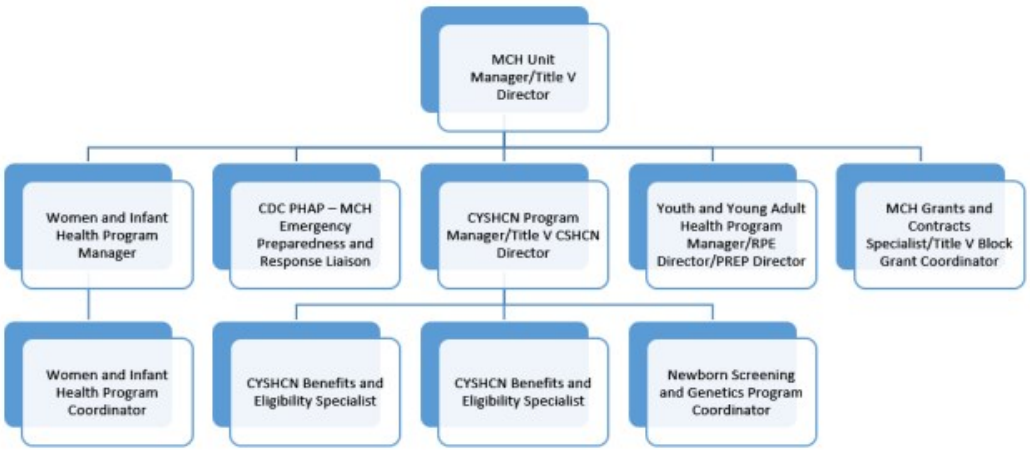
Staff Member	Title/Role	Unit/ Program	FTE	Title V Domain	Tenure with WY MCH/ MCH Epi (Tenure with State of WY)
MCH Unit Staff					
Danielle Marks, MSW, MPH*	MCH Unit Manager, Title V Director	MCH	1	All	7 (7)
Jamin Johnson, MS, CHES	CYSHCN Program Manager, Title V CSHCN Director	MCH	1	Child; CYSHCN; Cross-Cutting	3 (5)
Megan Selheim, BS, MFA	Youth and Young Adult Health Program Manager	MCH	1	Adolescent; Cross-Cutting	<1 (<1)
Vacant as of May 28, 2021	Women and Infant Health Program Manager	MCH	1	Women/Maternal; Perinatal/Infant; Cross-Cutting	N/A
Sapphire Heien, BA	MCH Grants and Contracts Specialist, Title V BG Coordinator	MCH	1	All	2 (6)
Carleigh Soule, MS	Newborn Screening and Genetics Coordinator	MCH	1	Perinatal/Infant; CSHCN; Cross-Cutting	15 (15)
Natalie Hudanick	Women and Infant Health Program Coordinator	MCH	1	Women/Maternal; Perinatal/Infant; Child; Cross-Cutting	<1 (<1)
Denise Robinson	Children's Special Health Benefits and Eligibility Specialist	MCH	1	CSHCN; Cross-Cutting	1 (14)
Sheli Gonzales	Children's Special Health Benefits and Eligibility Specialist	MCH	1	CSHCN; Cross-Cutting	15 (19)
Eleana Dubreus	CDC Public Health Associate and MCH Emergency Preparedness and Response Liaison	MCH	1	All	<1 (<1)
MCH Epidemiology Program Staff					

Ashley Busacker, PhD	Senior Epidemiology Advisor	MCH Epi	1	All	11 (11)
Joseph Grandpre, PhD	Chronic Disease/Maternal and Child Health Epidemiology Unit Manager	MCH Epi		All	8 (19)
Moira Lewis, MPH	MCH Epidemiology Program Manager	MCH Epi	1	All	2 (2)
Neva Ruso	PRAMS Coordinator/MCH Epidemiologist	MCH Epi	1	All	<1 (<1)
** Between July and September 2021, the Title V Director will be out on maternity leave with interim duties to be transferred to the Title V CSHCN Director and Community Health Section Chief.*					

Key organizational/staffing changes since last report's submission include:

- Hiring of YAYAHPM to fill position left vacant in August 2020
- Hiring of MCH Epidemiologist/WY PRAMS Coordinator to fill a position left vacant in February 2020
- Reclassification of a former CYSHCN Benefits and Eligibility Specialist position (vacant due to retirement) to Women and Infant Health Program Coordinator position (hired June 2021)
- Consolidation of the Child Health Program and CYSHCN Program to include programmatic activities and leadership oversight;
- Assignment of Title V CSHCN Director duties to the new CYSHCN Program Manager who now oversees both Child Health and CYSHCN domains;
- Movement of the Newborn Screening and Genetics Program from the Women and Infant Health Program to CYSHCN Program
- Welcoming of a CDC Public Health Associate, who serves as the MCH Emergency Preparedness and Response Liaison

See below for an updated WY MCH organizational chart as of summer 2021.



WY MCH partners closely with PHN Unit leadership and two full-time PHN staff (MCH Consultant and MCH Data Coordinator) to implement a statewide home visiting program and support local MCH services implementation, including CYSHCN care coordination services. The MCH Consultant and MCH Data Coordinator were recently filled due a retirement and promotion.

WY MCH benefits from a strong MCH Epidemiology Program housed within the Public Health Sciences Section of the WDH-PHD. Program staff include a Program Manager, MCH Epidemiologist/PRAMS Coordinator, CDC-Assigned Senior MCH Epidemiologist, and Chronic Disease/MCH Epidemiology Unit Manager (0.25 FTE support for MCH Epidemiology). A fifth MCH epidemiology position, a MCH/Injury Epidemiologist, is vacant and may be eliminated in budget cuts.

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

III.C.2.a. Process Description

I. Goals, Framework, Methodology

The goal of the Wyoming Maternal and Child Health Unit's (WY MCH) Five-Year Needs Assessment (NA) was to determine maternal and child health (MCH) priorities that reflect stakeholder input, are supported by evidence, and which WY MCH has the capacity to address. WY MCH based its 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

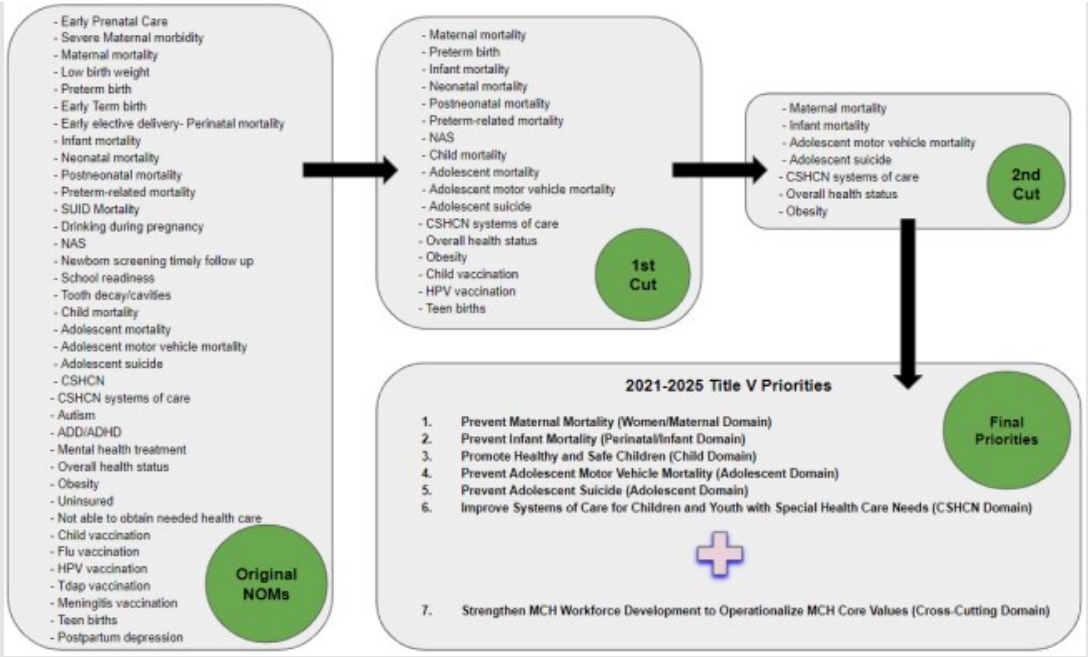
Systems-Level Approach:
WY MCH prioritizes work that addresses community structures, social norms, environment, and policies to maximize impact

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 (PMs), 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 Priority Action Teams (PATs) (whose membership would be further defined after narrowing potential priorities and a survey of state partners), reviewed qualitative data during State Health Assessment (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 National Outcome Measure (NOM) Tableau dashboard using the Federally Available Document produced by the Health Resources and Services Administration as well as additional state survey data (e.g. National Survey of Children's Health (NSCH), Pregnancy Risk Assessment Monitoring System PRAMS)) and Vital Statistics Services (VSS) 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.



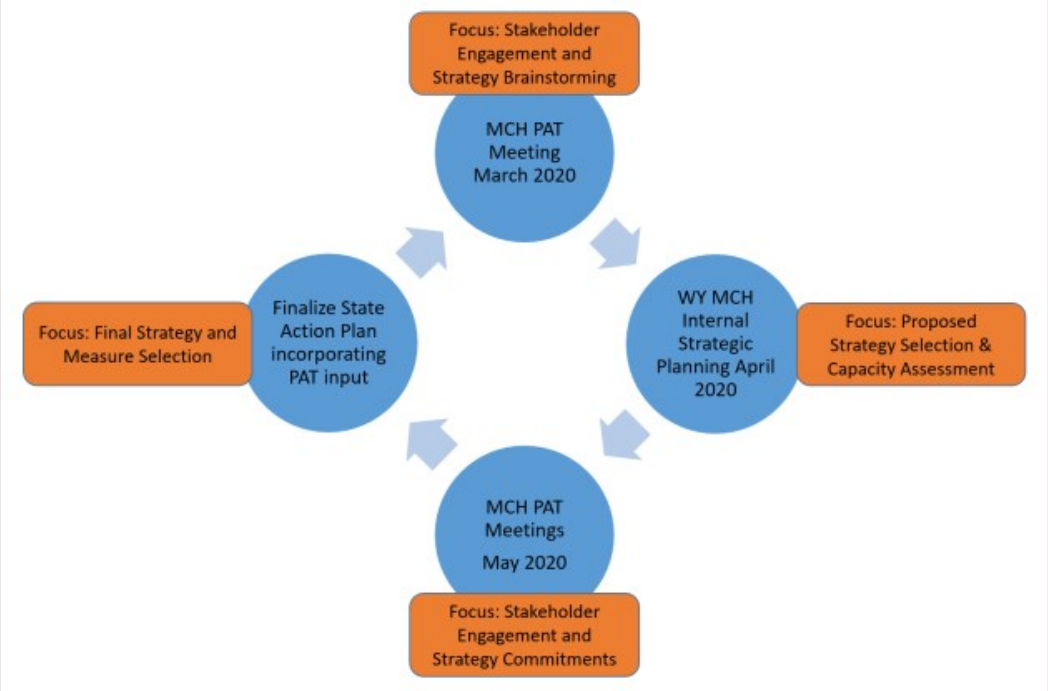
WY MCH staff conducted an initial assessment of each NOM on their perception of its magnitude/burden, MCH leadership role, internal capacity and feasibility, and political leverage. MCH epidemiologists evaluated each indicator for data availability, relation to national indicators, and alignment with 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 PMs conducted a feasibility assessment for each potential priority topic to evaluate NOMs and national performance measures (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 PMs presented their recommendations to the planning group, then finalized a narrowed list of NOMs for consideration (i.e. “2nd Cut”) 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 or 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

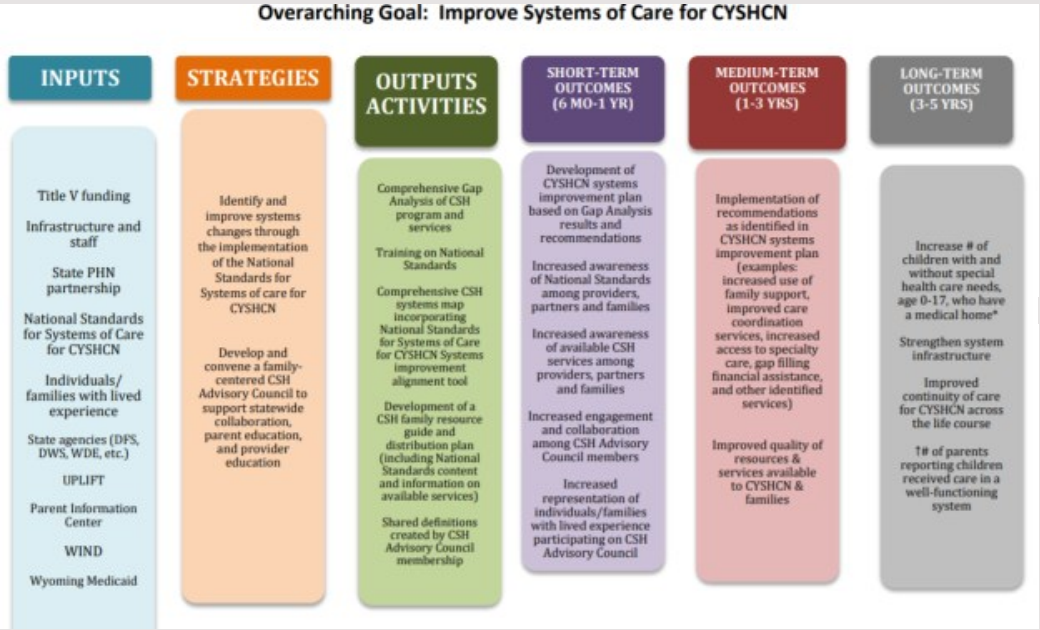
At each meeting, the Title V Director provided background on Title V and the NA process to date, followed by brief presentations by the lead WY MCH PM on information contained in their respective priority briefs. Then, a contracted facilitator led an interactive dialogue among participants to reflect 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 WY MCH PM to assist in strategy selection.

PMs 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- to 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, PMs proposed associated NPMs or state performance measures (SPMs) and draft evidence-based or -informed strategy measures (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.



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, Wyoming Medicaid, Wyoming 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, and 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 that 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 its 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, 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 VSS 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

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 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 in Wyoming 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 Pregnancy Risk Assessment Monitoring System (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 ages 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 ≤100% of the Federal Poverty level (FPL) (17.9%) and 101-200% FPL (16.1%) compared to women reporting incomes ≥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 by 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 (BRFSS), 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 System (NVSS) 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 regard 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 ≤100% FPL reported having an unintended pregnancy significantly more (40.0%, 95%C 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/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/1,000 live births in 2017 and meets the Healthy People 2020 (HP2020) objective (6.0 deaths/1,000 live births). Both the neonatal and postneonatal mortality rates have been similar to 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

(Vital Statistics Services (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, or 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 birthweight 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 of age 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 ≥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 breastfeed 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 causes, 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 HCUP-SID, 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 Centers for Medicare and Medicaid Services 416 report).

Obesity and Physical Activity
In 2016, Women, Infants, and Children (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 (Wyoming Hospital Discharge Data). According to the Wyoming Prevention Needs Assessment (WYPNA), in 2018 18.5% of students reported ever seriously considering attempting suicide in the past 12 months, compared to 15.3% in 2012.

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 (WYPNA, 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 (VSS).

Overall Health and Preventative Care

For adolescents ages 12-17, 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% (WYPNA). 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 (WYPNA, 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 (WYPNA).

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 (WYPNA, 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).

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 Wyoming CHSCN population. 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-CSCHN (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-CSHCH 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%) than 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

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 Personal Responsibility Education Program (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 assure 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

Capacity to Provide and Assure Services within Six MCH Domains

WY MCH manages the Title V MCH Services Block Grant (BG) and provides leadership for state and local efforts that improve the health of the MCH population. WY MCH employs 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 that 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 Wyoming physicians.

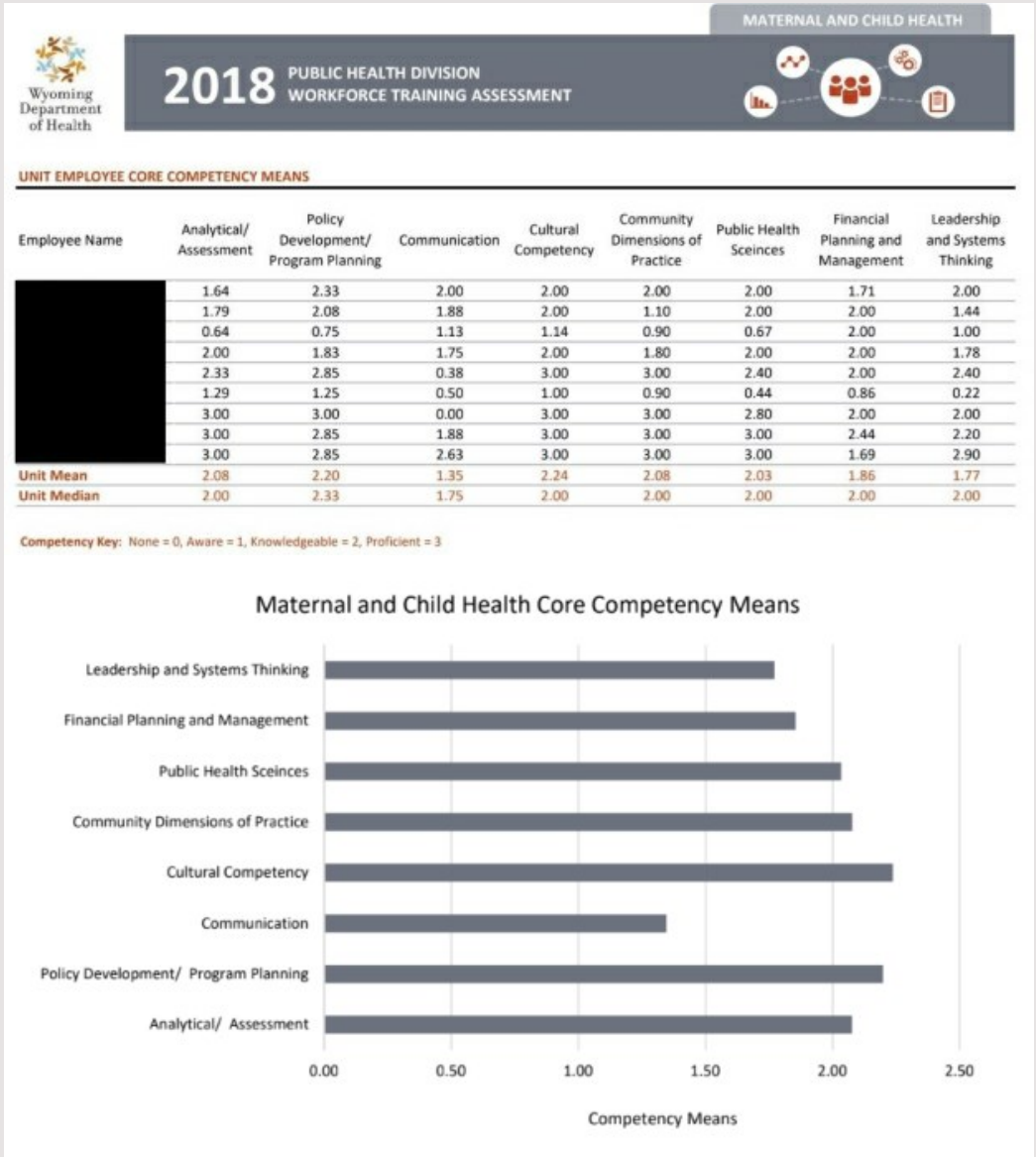
CSH partners with organizations such as the Wyoming Institute for Disabilities, Uplift, Early Intervention and Education programs, and Wyoming Medicaid, among others, to assure CSHCN and their families receive comprehensive, community-based, and family-centered care. In 2021-2025, WY MCH will work to 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

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.



Employee Name	Analytical/ Assessment	Policy Development/ Program Planning	Communication	Cultural Competency	Community Dimensions of Practice	Public Health Sceinces	Financial Planning and Management	Leadership and Systems Thinking
[redacted]	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

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

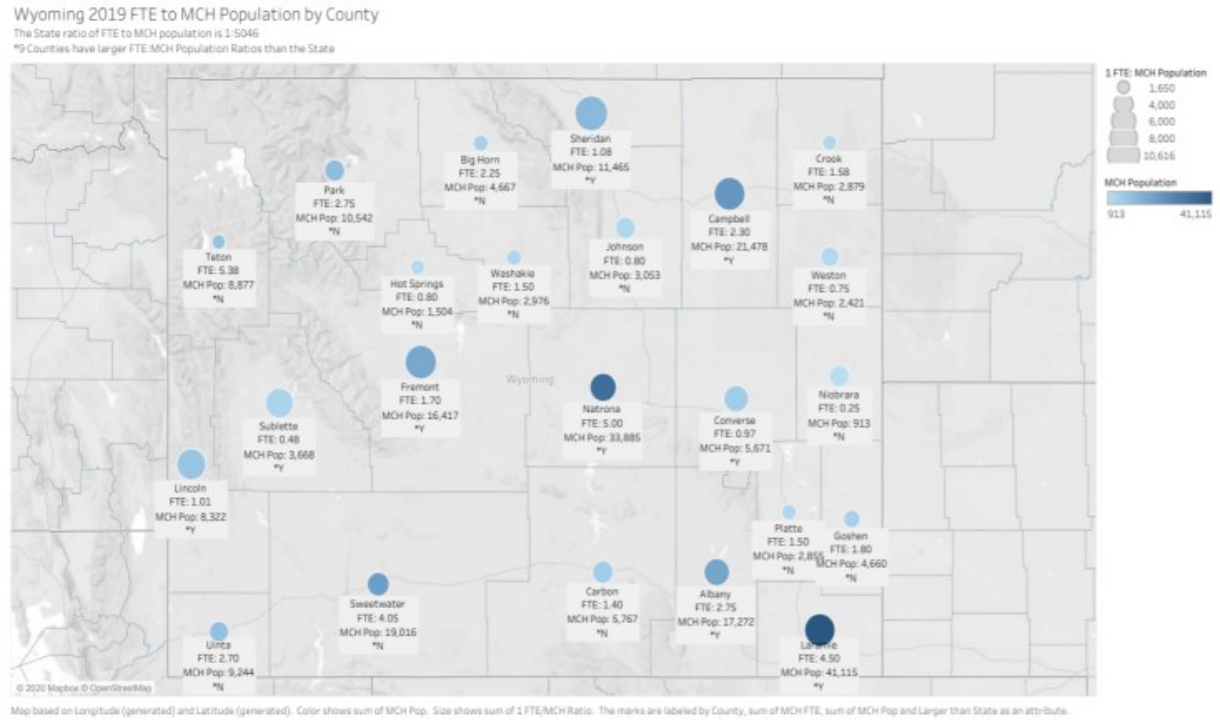
assist the Title V Director and staff in developing a comprehensive workforce development plan for MCH staff and contractors.

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 WYMCH 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).



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 the Association of Maternal and Child Health Programs. 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 MCH 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 totaling 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

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, WIC, 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 (MIECHV) 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 AmeriCorps Vista member assigned to the Performance Improvement Program.

Other Maternal and Child Health Bureau 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 and 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 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 NAs. Finalization of an 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 NA Steering Committee and the Wyoming MIECHV Director sits on the Title V/MCH NA 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 an 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 PREP.

WY MCH meets monthly with Wyoming Health Council (WHC), the Wyoming 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 State General Funds provided for reimbursement of MCH services, such as home visitation and care coordination for CYSCHN. These funds fully or partially support an estimated 47 full-time employees across Wyoming in support of MCH services.

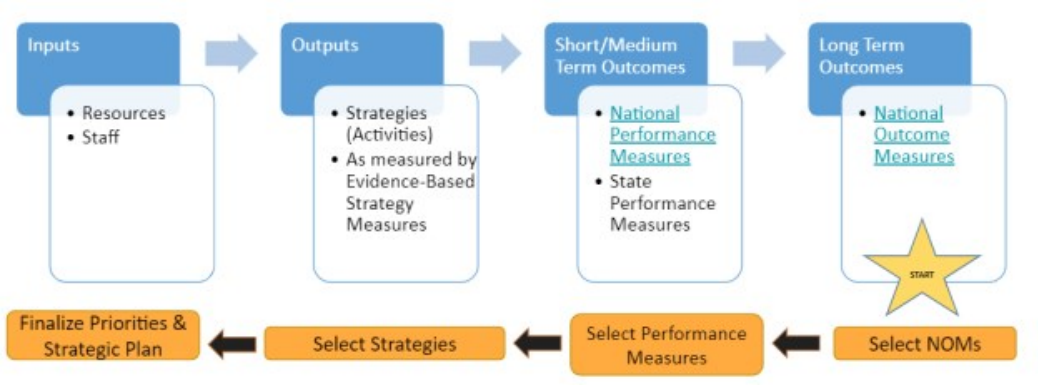
Tribes, Tribal Organizations, and Urban Indian Organizations
MCH tribal nurses serving both the Northern Arapaho and Eastern Shoshone tribes offer gap-filling financial assistance and care coordination services as part of CSH. CSH Benefits and Eligibility Specialists provide training and support to the 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.

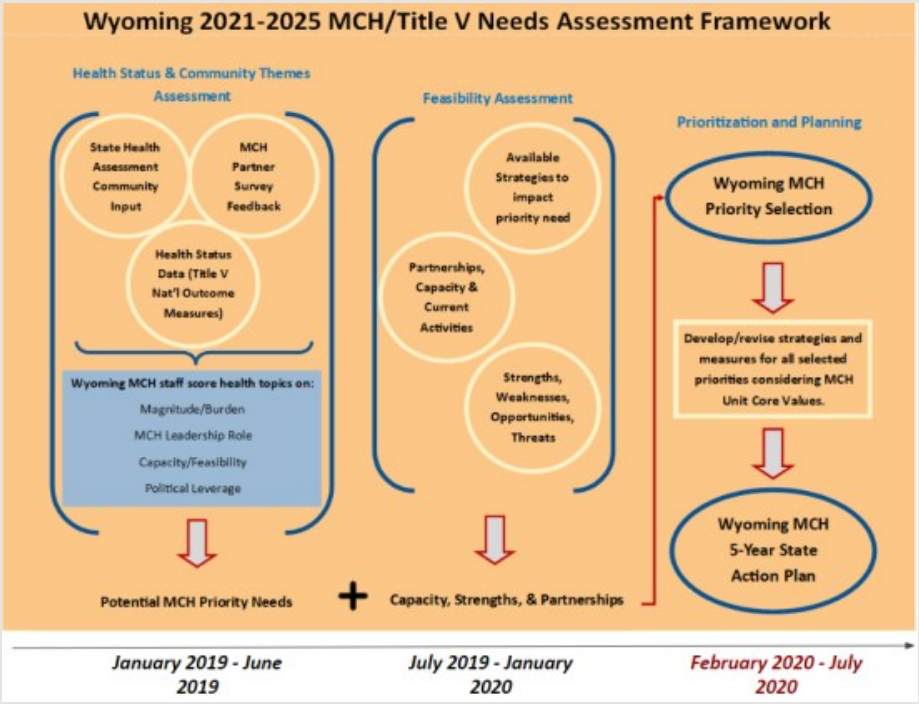
III.C.2.c. Identifying Priority Needs and Linking to Performance Measures

The image below shows the process of selecting 2021-2025 priorities beginning with selecting 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 assure alignment with the Title V performance measure framework and assure a limited number of resources were allocated to addressing priorities important both nationally and in Wyoming.

The figure below 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 Wyoming when compared nationally (suicide and motor vehicle mortality) and for momentum due to new grants and capacity (maternal mortality).

III.D. Financial Narrative

	2018		2019	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$1,125,000	$1,083,689	$1,100,000	$1,076,672
State Funds	$1,825,591	$1,948,353	$1,736,286	$1,853,637
Local Funds	$0	$0	$0	$0
Other Funds	$550,000	$427,238	$639,305	$0
Program Funds	$0	$0	$0	$521,954
SubTotal	$3,500,591	$3,459,280	$3,475,591	$3,452,263
Other Federal Funds	$1,600,234	$1,559,910	$1,578,412	$1,539,667
Total	$5,100,825	$5,019,190	$5,054,003	$4,991,930

	2020		2021	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$1,100,000	$1,078,080	$1,078,080	
State Funds	$1,825,591	$1,825,591	$1,850,000	
Local Funds	$0	$0	$0	
Other Funds	$550,000	$550,000	$0	
Program Funds	$0	$0	$525,591	
SubTotal	$3,475,591	$3,453,671	$3,453,671	
Other Federal Funds	$1,877,176	$1,877,176	$1,957,109	
Total	$5,352,767	$5,330,847	$5,410,780	

	2022	
	Budgeted	Expended
Federal Allocation	$1,078,080	
State Funds	$1,850,000	
Local Funds	$0	
Other Funds	$0	
Program Funds	$525,591	
SubTotal	$3,453,671	
Other Federal Funds	$653,000	
Total	$4,106,671	

III.D.1. Expenditures

In FFY20, Wyoming received $1,078,080 in Title V federal funding. Wyoming's Title V allocation is based on the total numbers of women of childbearing age (ages 15-44), infants and children ages 0-18, and individuals ages 0-44 living in poverty.

Wyoming's MCH Block Grant expenditures ($1,078,080) for FFY20 were categorized into the following categories:

- Preventive and Primary Care Services for Children (32.5%)
- Services for Children with Special Health Care Needs (34.9%)
- Administrative (9.7%)
- Other (Family) (13%)

The Wyoming Maternal and Child Health Unit (WY MCH) met the 30% requirement for both Preventive and Primary Care Services for Children and Services for Children with Special Health Care Needs and spent less than the maximum 10% of funds on administrative costs. The Other, or Family, category supports salary/benefits and key activities of the Women and Infant Health Program.

The majority of Wyoming's Title V funding supports the State-level workforce and contracts with partner organizations to address Wyoming's seven state MCH priority needs. Specifically, Title V funding supports 2.5 full-time program manager positions, which are organized according to the population groups they serve, two full-time Children's Special Health Benefits and Eligibility Specialists, and 1.5 health program coordinator positions. This funding structure aligns well with the Title V population domain framework and assures dedicated resources within each domain. Title V direct assistance funding also supports 1 full-time CDC-assigned MCH epidemiologist who provides technical assistance and scientific guidance supportive of all MCH programs, with a specific emphasis on support for the Women and Infant Health Program.
The partnership between WY MCH and MCH Epidemiology is essential to assure the unit is continually assessing and monitoring the needs of Wyoming communities, as well as the success of programming. State matching funds and other federal funds are leveraged to fund the remaining WY MCH and MCH Epidemiology staff. Title V funding also supports a portion of one staff position in the Injury and Violence Prevention Program.

WY MCH contracts with a leadership coach and strategic planning consultant to support staff professional development and strategic planning and implementation efforts.

In FFY20, Title V funds supported the following Wyoming programs/projects, each aligned with the state priority need it addresses:

- Adolescent-Centered Environment Assessment Process (ACE-AP) facilitated by the University of Michigan and provided to four pediatric/family practice clinics (promote preventive and quality care for adolescents)
- Genetics clinics (promote preventive and quality care for children/adolescents, including those with special health care needs)
- Youth Council coordination services (promote preventive and quality care for adolescents; promote healthy and safe relationships)
- Breastfeeding training scholarships (promote breastfeeding duration)
- Telehealth technical assistance (promote preventive and quality care for children/adolescents, including those with special health care needs)
- My 307 Wellness app support (all priorities)
- Data system improvements for home visiting and CSH programs (promote breastfeeding duration; promote preventive and quality care for children/adolescents; improve access to and use of effective family planning)

WY MCH benefits from $2,375,591 in State and Trust and Agency funds (newborn screening fees) required to meet the 1989 Maintenance of Effort (MOE) and State match. State funds support the delivery of home visitation services and Children's Special Health (CSH) care coordination services by Public Health Nursing (PHN) in all 23 Wyoming counties and limited gap-filling financial assistance to eligible families served by the CSH Program, including high-risk pregnant women and infants cared for by Level III providers. CSH is a payer of last resort for enrolled clients who meet medical and financial eligibility criteria. In order to be eligible for assistance, families must first apply for Medicaid, KidCare Child Health Insurance Program (CHIP), and the Federal Marketplace. Trust and Agency funds support operations of the statute required newborn screening program.

State General Funds used for the infant immunization Prevnar also assist with meeting the required MOE and match.

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

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

III.D.2. Budget

The 2021-2025 Title V Needs Assessment and strategic planning processes provide the Wyoming Maternal and Child Health Unit (WY MCH) with direction for leveraging available resources to impact the health and wellness of Wyoming's families across all population domains. Title V funding, in combination with other federal funds (e.g. Personal Responsibility Education Program, Rape Prevention Education Program), will continue to fund WY MCH positions, including a direct assistance-funded, CDC-assigned MCH epidemiologist. Three positions - the MCH Grants & Contracts Specialist/Title V Block Grant Coordinator, MCH Unit Manager, and two epidemiologists - are funded fully or partially (over 75%) with State Match/Maintenance of Effort (MOE) funds.

Wyoming's required MOE is greater than the federally-required match. Several programs assist in maintaining this level of funding effort: Newborn Screening (NBS), Public Health Nursing Home Visitation Program, Children's Special Health, and Immunizations. WY MCH's FFY21 budget includes $1,850,000 in State General Funds and $525,591 in program income from NBS. WY MCH remains able to meet the required MOE of $2,375,591.

WY MCH's proposed budget for FFY22, as reflected in Form 2, includes the following budget items:

- Prevention and Primary Care for Children: $323,424 (30%)
- Children with Special Health Care Needs: $323,424 (30%)
- Other/Family: $228,080 (21.1%)
- Administrative Costs: $60,000 (5.6%)
- State MCH Funds: $1,850,000
- Program Income (NBS): $525,591
- State MOE: $2,375,591

III.E. Five-Year State Action Plan

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

State: Wyoming

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

State Action Plan Table - Entry View

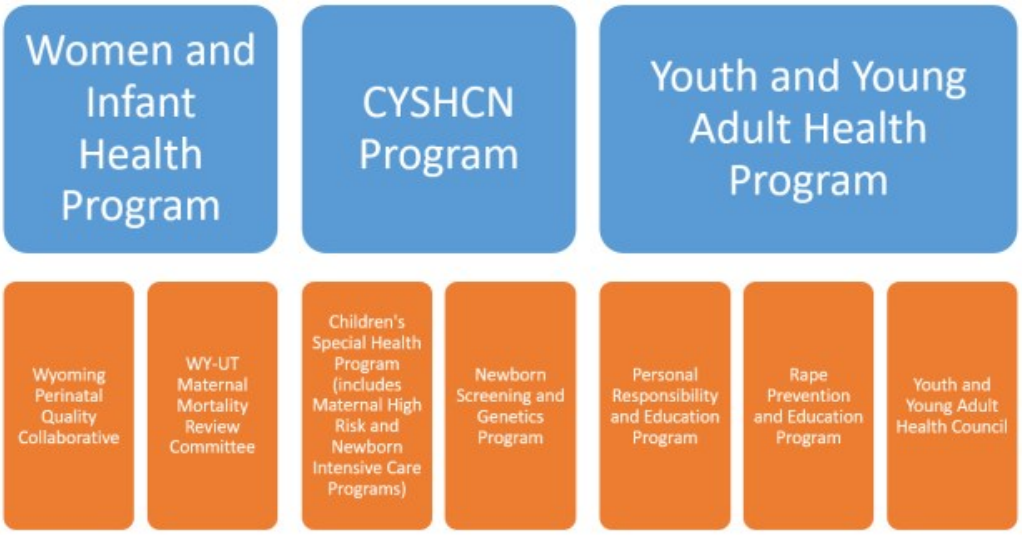
State Action Plan Table - Legal Size Paper View

III.E.2. State Action Plan Narrative Overview

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

The Wyoming Title V Program, known as the Wyoming Maternal and Child Health (MCH) Unit (WY MCH), is organized within the Community Health Section (CHS) of the Public Health Division (PHD). Structurally, the unit's programs are divided according to the population groups they serve. This structure aligns well with the Title V population domain framework and assures dedicated resources within each domain. Programs strive to collaborate to ensure consideration of the life course perspective in program planning and decision making. WY MCH programs include:

- Women and Infant Health Program, focusing on women of reproductive age and infants through age one (Women/Maternal Health and Perinatal/Infant Health domains)
- Children and Youth with Special Health Care Needs (CYSHCN) Program, focusing on all children one through 21 years, including those with special health care needs (Child Health and Children with Special Health Care Needs (CSHCN) domains)
- Youth and Young Adult Health Program, focusing on the unique needs of youth and young adults ages 12-24 (Adolescent Health domain)



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. COVID-19 has interrupted plans to consistently engage PATs in Year 1; however, plans are underway to reconvene PATs by priority ahead of Year 2.

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 WY MCH to determine its most appropriate role in priority-related work.

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.

III.E.2.b. State MCH Capacity to Advance Effective Public Health Systems

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

Recruitment and Retention of Staff

WY MCH and MCH Epidemiology have current staff sizes of ten and three, respectively. Staff turnover is common with both programs collectively losing approximately one to three staff members per year. Sixty-one percent of staff have been with WY MCH or MCH Epidemiology for two years or less. WDH-PHD tracks turnover and vacancy data for its 266 positions. As of May 21, 2021, the vacancy percentage for PHD was 14% (37 vacant positions). The turnover rate (number of separations in the past year divided by the number of positions) is 20.3%, representing 54 separations in the past year. WDH collects confidential exit interview data but current data are not available.

The WY MCH Unit Manager participates on the WDH-PHD Workforce Development Workgroup (WFD WG). The WFD WG identified workforce needs and challenges including compensation and recruitment/retention, and a shrinking and unstable Wyoming economy. One in five WDH PHD staff reported they are considering leaving for a reason other than retirement, and for those who left and completed an exit survey, “culture” was the top reason for their separation. It is important to note that these barriers were identified before the COVID-19 pandemic. Additional workforce interviews and data collection are needed to understand the full impact of the pandemic on workforce needs, as well as on recruitment and retention.

In 2020, the WFD WG received technical assistance and training from the Association of State and Territorial Health Officials (ASTHO) on topics related to Public Health 3.0, an approach to public health practice that emphasizes cross-sectorial environmental, policy- and systems-level actions that directly affect the social determinants of health.

Assessment of Training and Professional Development Needs

WY MCH established a workforce capacity-building 2021-2025 Title V Priority under the Cross-Cutting/Systems Building Domain: Strengthen MCH Workforce Capacity to Operationalize MCH Core Values. This survey was established in response to a staff survey identifying training opportunities related to knowledge and skills related to MCH core values. Identified strategies under this priority will increase staff assessment of professional development needs by requiring all new staff to complete the MCH Navigator self assessment within six months of hire as part of the WY MCH orientation. WY MCH leadership will request technical assistance from the MCH Workforce Development Center to develop the WY MCH orientation and evaluate increased knowledge and/or skills related to key MCH competencies and WY MCH core values.

WY 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.

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.

WDH-PHD administers a PHD Workforce Training Assessment every two years to assist staff and leadership in

developing annual performance goals and to understand strengths and opportunities for workforce development. 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. The assessment was adapted by WDH-PHD WFD WG to include questions related to WDH-PHD policies & procedures training needs. The last assessment was completed in summer 2020. The WFD WG will pay particular attention to training needs related to strategic skills necessary for the evolving role of governmental public health.

Training Needs of MCH Partners

In 2019, WY MCH and Public Health Nursing partnered to revise a quarterly performance report completed by county governments that receive WY MCH funding. The quarterly performance report now asks about technical assistance and training needs related to MCH services. WY MCH program managers serve as subject matter experts and provide training as needed and/or requested. In some cases, training opportunities are driven by Title V priorities. For example, a 2016-2020 Title V priority focused on improving breastfeeding duration led WY MCH to provide annual funding opportunities for Certified Lactation Consultant (CLC) training and certification for Public Health Nurses and Women, Infants, and Children (WIC) staff.

Innovations in Staffing Structures

While a small staff size presents capacity and resource challenges, it also allows for increased collaboration across population areas and improved 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.

Since 2012, CSH has lacked direct leadership with the Title V Director/MCH Unit Manager overseeing the CSH 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 Wyoming's Title V program. To strengthen leadership capacity for CSHCN services in Wyoming, the Title V Director restructured the unit to combine the Child Health and CSH Programs under one program manager's responsibilities. This program manager was promoted to Title V CSHCN Director in late 2020.

Following the retirement of a CSH Benefits and Eligibility Specialist in 2019, WY MCH restructured again, this time shifting workforce capacity to address unmet needs such as oversight of 23 MCH contracts with county governments and coordination of strategies related to women/maternal, perinatal/infant, and child health domains and strategies that cut across multiple domains (e.g. Bright Futures implementation efforts). The result of the restructure was the creation of a Women and Infant Health Program Coordinator position, which was filled in June 2021.

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 hosted three consecutive masters-level social work students to the team between 2018 and 2020 and plans to onboard a bachelors-level social work student in fall 2021 to support Youth and Young Adult Health Program activities due to identified capacity challenges. The WY MCH Unit Manager typically provides required Master of Social Work-level supervision for students; however, due to maternity leave, a fellow WDH-PHD Unit Manager will take over this role in 2021.

- Title V Internship Program: In 2018 and 2020, WY MCH welcomed two pairs of masters-level public health

students to the team as part of the National MCH Workforce Development Center's Title V Internship Program. The 2020 internship application focused on increasing MCH involvement in emergency preparedness planning and response 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. 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. WY MCH used the finalized communications plan to request approval from WDH, which was granted, to develop and maintain a WY MCH Facebook page; it launched in early 2021.

WY MCH recognized that while an intern may need in-person support to work on emergency preparedness, a PHAP would have the experience necessary to succeed in this area even with WY MCH leadership's limited capacity to provide support due to the pandemic, and the work very much still needed accomplished. In spring 2020, WY MCH submitted a successful PHAP application to enhance parent/family engagement efforts and establish an MCH emergency preparedness and response plan. The associate joined WY MCH in October 2020 and works closely with family-run organizations and the PHD Public Health Preparedness and Response Unit, among other partners.

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

"Family partnership is defined as patients, families, their representatives, and health professionals working in active partnership at various levels across the health care system—direct care, organizational design and governance, and policy making—to improve health and health care. This partnership is accomplished through the intentional practice of working with families for the ultimate goal of positive outcomes in all areas through the life course." (Carman et al., 2013).

WY MCH's core value of engagement, established in 2015 and updated in 2018, demonstrates a commitment to cultivating authentic collaboration and trust with families and community partners to improve outcomes for all MCH populations.

In 2019, WY MCH convened a group of over 20 engaged stakeholders 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), the Wyoming Institute for Disabilities (Wyoming Family to Family Health Information Center [F2FHIC]), the Wyoming Parent Information Center, and a representative from the Wyoming Department of Education. The workgroup continues to meet monthly to share updates on parent/family engagement activities and identify collaboration opportunities. During the COVID-19 pandemic, discussions centered on better understanding families' challenges and needs during the crisis and sharing about each organization's efforts to maintain engagement and provide support. This workgroup also agreed to lead implementation of consumer education strategies to promote well visits as part of the Bright Futures Implementation Task Force; however, COVID-19 and diminished leadership capacity has slowed progress on this effort.

Wyoming received the Preschool Development Birth through Five (PDG B-5) and received a renewal grant to continue efforts for the next three years. Grant activities related to parent/family partnership include the development of a family engagement framework, an annual family survey, and administration of "empowering families" sub-grants. The WY MCH CSH Program currently participates on the PDG B-5 Executive Leadership Team, and efforts are underway to better align parent/family engagement efforts led by this grant with Title V family partnership activities.

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 lead this work, WY MCH leverages partnerships (e.g. Wyoming Family Voices, Wyoming F2FHIC) and other workforce capacity building opportunities such as internships and other temporary employee assignments. In fall 2020, WY MCH welcomed a CDC PHAP Associate 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. Emergency preparedness and response activities are well underway and include participation from WY MCH and partners, including the Wyoming Family Voices affiliate and Wyoming F2FHIC, in the Association of Maternal and Child Health Programs (AMCHP) Emergency Preparedness and Response Action Learning Collaborative (EPR ALC). Efforts to specifically address parent/family/community engagement outside of the context of emergency preparedness and response are on hold until Year 2 as COVID-19 and a CDC deployment have limited the PHAP Associates's ability to take on more than leading the AMCHP EPR ALC efforts in Year 1. In Year 2, beginning in fall 2021, the Associate will complete an environmental scan on best practices related to parent/family/community engagement, current engagement activities, and work with partners to develop and implement a sustainable parent/family engagement strategy that provides meaningful opportunities for parents and families to participate in program planning and improvement

activities within WY MCH and WDH, and across State agencies and organizations.

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 2020 and 2021 virtual AMCHP conference. In late 2020, WY MCH and Uplift began planning for a partnership agreement to include Uplift's provision of technical assistance to WY MCH staff to engage parents and families in MCH program planning, implementation, and evaluation. In addition, Uplift will identify and recruit parent, family, and youth representatives to serve on each WY MCH Priority Action Team (PAT). Uplift also supported efforts to improve the public input process in summer 2020 and 2021 and will continue to do so in subsequent years under the new partnership agreement. Their involvement, paired with leadership from a new Title V Block Grant Coordinator, has led to a significant increase in public input responses, jumping from just two in 2019 to 107 in 2020, sustained at 101 responses in 2021. One success noted in 2021 was that a higher percentage of respondents (60%) were members of the general public, whereas 2020 saw a majority of respondents be public employees with only 35% of respondents being members of the general public; WY MCH believes this may be due to marketing the survey through more directly engaging means, such as the new WY MCH Facebook page and Uplift's social media pages. Eighteen of Wyoming's 23 counties were represented in the survey responses. Also in 2021, Uplift piloted a virtual family feedback forum on the CYSHCN domain, in which Uplift staff solicited verbal feedback on the same types of content and questions included in the survey; four parents of CYSHCN participated. Uplift intends to expand the virtual family feedback forum in future years to obtain public input on all MCH domains.

Family-to-Family Health Information Center Partnership
WY MCH established monthly meetings with the Wyoming Institute for Disabilities (Wyoming F2FHIC) in 2020, primarily focusing collaborative efforts on needs assessment coordination. In summer 2020, both organizations jointly released a provider survey on the level and type of care provided to CSHCN in their practices. Survey results revealed a lack of knowledge among providers on WY MCH genetics clinics, Bright Futures guidelines, and Wyoming F2FHIC programs and services. A document describing all programs and resources was developed and sent to all providers who requested more information. WY MCH continues to meet with Wyoming F2FHIC to request additional data from Medicaid on CYSHCN care and needs. Wyoming F2FHIC will also support WY MCH in the completion of an assessment of the National Standards for Systems of Care for CYSHCN.

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. A consultant recommended by MCHB began working with the CYSHCN Director in 2020 to begin completion of the assessment, and a second consultant, a national leader in family engagement, will begin to provide support to WY MCH in summer 2021 to establish a framework for a Wyoming CSHCN Advisory Council. Once the initial technical assistance period ends, WY MCH will attempt to sustain support through a contract, assuring that ongoing family

engagement consultation can inform all WY MCH family partnership activities.

Wyoming State Youth and Young Adult Council
In early 2020, WY MCH entered into a formal partnership to recruit for and launch a statewide youth council, to inform activities primarily in the Adolescent Domain. The Youth and Young Adult Council (YaYA) has met virtually on a regular basis throughout the COVID-19 pandemic, and has provided input and feedback to the YAYAHP and other Wyoming community organizations and state offices on how best to meet the health and wellness needs of the older adolescent population.

III.E.2.b.iii. MCH Data Capacity

III.E.2.b.iii.a. MCH Epidemiology Workforce

Staffing Structure and Composition Overview

The Wyoming MCH Epidemiology Program (MCH Epi) comprises four staff, which consists in total of 3.3 FTEs dedicated to the management and analysis of MCH data. The four positions are composed of one full-time MCH Epidemiology Program Manager (1 FTE), one full-time Pregnancy Risk Assessment Monitoring System (PRAMS) Coordinator/MCH Epidemiologist (1 FTE), one full-time CDC-assigned MCH Epidemiologist (0.8 FTE) and the Chronic Disease and MCH Epidemiology Unit Manager, with 50% of his time dedicated to MCH Epi (0.5 FTE).

The MCH Epi Unit is funded through multiple federal programs, which include the State Systems Development Initiative (SSDI) and PRAMS in addition to Title V funds, as well as Wyoming State General Funds.

Staff Experience, Roles and Funding Source

MCH Epidemiology Program Manager, 1.0 FTE

- *Education and training:* The current MCH Epidemiology Program manager, Moira Lewis, has a Masters in Public Health, Epidemiology and has held this role for two years. Ms. Lewis also holds three years of additional experience in clinic data management, as well as pharmaceutical research and management. Additionally, Ms. Lewis has over two years of training on community development, specifically focusing on public health, from her time serving as a Peace Corps volunteer in Mongolia.
- *Funding:* This position is funded with SSDI, PRAMS, and State General Funds.
- *Roles/Responsibilities:*
    - Manages the MCH Epidemiology Program, including direct supervision of the MCH Epi Program staff, management of grants and budgets for the program, and providing direction for surveillance and epidemiological duties of MCH Epi Program epidemiologists.
    - Oversees the collection and analysis of data for various surveillance systems that monitor and assess health status and its determinants for women of childbearing age, infants, children, adolescents, and families.
    - Manages data collection and analysis for WY MCH priorities and the Title V Block Grant, including national and state performance and outcome measures, and provides epidemiology assistance for MCH programs for grant applications, performance reports to funding agencies, Healthstat (the Wyoming Department of Health's performance management system) and other reports.
    - Provides epidemiologic leadership for the five-year MCH Needs Assessment process, including data collection, reporting, and monitoring to help identify priorities and performance measures, as well as collaborates with MCH programs to monitor and evaluate programmatic success.
    - Serves as the SSDI Principle Investigator (PI) and manages the SSDI grant and its budget, writes and submits the SSDI grant application, and implements the application plan.
    - Serves as the PRAMS Project Manager, supervising and providing overall management of PRAMS operations, including oversight of budget and fiscal operations, contracts, data downloads, protocol changes and Internal Review Board (IRB) approvals, data collection, and the dissemination of PRAMS data and results to MCH programs, stakeholders, and other WDH programs.

PRAMS Coordinator/MCH Epidemiologist, 1.0 FTE

- *Education and training:* The current PRAMS Coordinator/MCH Epidemiologist, Neva Ruso, has a Masters in Public Health, majoring in Epidemiology and minoring in Infectious Disease. Mrs. Ruso holds two years of additional experience with injury prevention research and one year of risk management.
- *Funding:* This position is funded with PRAMS and State General Funds.
- *Roles/Responsibilities:*
    - Serves as the PRAMS Project Coordinator, including managing and maintaining PRAMS mail and phone procedures, and entry of survey data into the PRAMS data system.
    - Serves as primary data analyst for PRAMS data, developing fact sheets, data briefs, and reports based on data analyses.
    - Assists with the collection and analysis of data for various surveillance systems, monitoring and assessing the health status and its determinant for MCH populations in Wyoming.

- Provides data translation and analysis of MCH data, and presents data for stakeholder use and epidemiological support to MCH program staff for the Title V Needs Assessment and Block Grant reporting. Evaluates program strategies implemented by WY MCH related to the selected priorities, under supervision of the MCH Epidemiology Program Manager.

Chronic Disease/MCH Epidemiology Unit Manager, 0.5 FTE

- *Education and training:* The current Unit Manager, Joe Grandpre, PhD, MPH, has over twenty years experience in public health and epidemiology. Dr. Grandpre also manages the Wyoming Behavioral Risk Factor Surveillance System (BRFSS) program and the Wyoming Violent Death Reporting System (WYVDRS).
- *Funding:* This position is funded with State General Funds.
- *Roles/Responsibilities:*
  - Supervises the MCH Epidemiology Program Manager, overseeing the activities of the MCH Epidemiology Unit and hiring and supervising MCH Epi staff.
  - Serves as the PRAMS PI, overseeing administrative aspects of PRAMS and monitoring PRAMS surveillance activities.

CDC-Assigned MCH Epidemiologist, 0.8 FTE

- *Education and training:* Dr. Ashley Busacker holds a PhD in Epidemiology. She has 13 years of experience in public health and epidemiology.
- *Funding:* This position is a direct assistance position from CDC funded through Title V.
- *Roles/Responsibilities:*
  - Provides scientific advice and support to Wyoming MCH Epi, including creating analysis plans, complex analyses, and data dissemination of Title V strategies and PRAMS activities.

Current Workforce Capacity

During the past year, the MCH Epi Unit has experienced organizational changes related to staff turn-over, organizational restructuring through the loss of an At-Will Employee Contract (AWEC) position, and changing demands due Wyoming's COVID-19 response. All members of the MCH Epi team shifted job duties to assist with the state's COVID-19 response, and the CDC-assigned MCH Epidemiologist in particular had to shift most of her focus to the pandemic, taking on lead on the contract tracing for Fremont County and the reservation.

Statewide budget cuts resulted in the elimination of an MCH Epi AWEC position that had supported both WY MCH and the Injury and Violence Prevention Program with their data and epidemiological needs. This position also supported programs run through WY MCH's Youth and Young Adult Health Program (YAYAHP); as a consequence, the MCH Epidemiology Program Manager has been working with the YAYAHP Program Manager to continue to support the program with its immediate data and epidemiological needs, while also discussing the long-term needs of WY MCH's programs and other potential options to help fulfill them.

Due to changes the loss of this position's impact on MCH Epi workforce capacity, MCH Epi has also been working with divisional management to discuss potential ways to restructure the roles of Epidemiology throughout the Public Health Division, with the goal MCH Epi being able to focus more strictly on the immediate needs of WY MCH, specifically with regard to building capacity around Title V reporting and strategies. This potential shift will also help MCH Epi to perform additional surveillance on Wyoming's MCH populations and improve workflow.

III.E.2.b.iii.b. State Systems Development Initiative (SSDI)

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 needs by developing new resources and tools to assist with surveillance, along with evaluation and quality improvement of programs.

Block Grant Reporting and Needs Assessment

The SSDI grant supports funding for MCH Epi 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 Epi 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). MCH Epi continues to work with WY MCH staff to ensure developed Title V strategies are measurable and to develop evaluation plans. MCH Epi will collect and monitor data surrounding the chosen priorities. Specifically, epidemiology will monitor and collect relevant data from PRAMS, BRFSS, Youth Risk Behavior Surveillance System (YRBSS), National Survey of Children's Health (NSCH), vital statistics, and others as part of the development of evaluation plans for the proposed strategies, and for block grant reporting purposes.

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 the timeliness and accuracy of its data. These efforts include:

- Creation and maintenance of data linkages between Wyoming birth and death certificates, as well as Wyoming death certificates for women of reproductive age to births and fetal deaths, to enhance MCH Epi's ability to monitor infant and maternal mortality.
- Creation and maintenance of real-time access to VSS reports, focused on newly developed linkages
- Creation of electronic maternal death reporting, enhancing quality and timeliness for MCH projects including the Maternal Mortality Review Committee (MMRC).
- Inclusion of maternal email and phone number on birth certificates, enhancing the ability of PRAMS to contact mothers for improved response rates.
- Development of linkage of birth file to Medicaid claims data to improve understanding of infant care and outcomes.
- 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 the data accuracy and decreasing burden and time for providers to complete certificates.
- Creation of geo-coding fields on birth certificates to better analyze the impact of the distance from the mother's residence to the birth facilities on birth procedures and outcomes.

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

- Continued participation in PRAMS, specifically the phone data collection protocol of PRAMS that is contracted to Market Decisions, LLC.
- Access to training and technical assistance on the data visualization software Tableau for MCH epidemiologists to enhance their ability to share data in a timely manner with internal and external partners.

MCH Surveillance

Ongoing surveillance has been developed for key MCH indicators. Epidemiologists utilized Tableau software for a dashboard that tracks injuries (including childhood injuries) and a dashboard to monitor Title V NOMs. MCH epidemiologists also work with the contractor Plante & Moran to develop an improved dashboard to monitor Title V NOMs and NPMs; this dashboard will both assist in the ongoing surveillance of outcomes and performance measures for both MCH Epi and WY MCH staff, in addition to aiding in completing evaluations of and reporting on chosen priorities and strategies.

Work with Plante & Moran, funded with SSDI funds, further resulted in the development of two additional Tableau dashboards. One visualizes Wyoming PRAMS data, allowing for easier access to state PRAMS data for internal staff, stakeholders, and other health professionals. The second dashboard visualizes Wyoming MCH VSS data and assists MCH Epi, WY MCH, and VSS staff, as well as outside stakeholders, in monitoring the status of the MCH populations in Wyoming

III.E.2.b.iii.c. Other MCH Data Capacity Efforts

MCH Epi relies on many sources of data, including those not funded by SSDI, to maintain and help grow the data capacity efforts of WY MCH. PRAMS funding allows MCH Epi to identify and monitor behaviors and experiences of women before, during, and after pregnancy. PRAMS data was utilized during the recent Five-Year Needs Assessment to help assist in choosing priority areas for the Women and Infant Health Program, including safe sleep and maternal smoking. Wyoming relies on PRAMS data for Title V NOMs and NPMs for annual block grant reporting purposes, as well as to monitor and evaluate proposed Title V strategies. Wyoming has also developed ESMs using PRAMS data to assist with annual reporting and evaluation. The Wyoming Behavioral Risk Factor Surveillance System (BRFSS) is another source of data MCH Epi utilizes for annual performance reporting on the block grant and for program evaluation.

MCH Epi has regular access to state hospital discharge and outpatient data, which allows for more in-depth monitoring and analysis on injury data, important to block grant reporting on child and adolescent injury hospitalization NPMs. Access to hospital discharge data also allows for routine monitoring of substance use during pregnancy, including neonatal abstinence syndrome. In addition, more insight can be gained regarding self-harming, especially among adolescents, through the analysis of hospitalization data. With adolescent suicide a stated priority of the Youth and Young Adult Health Program, examining suicide/self-harm attempts will provide the program with better insight on how to approach strategies to reduce self-harm and suicide rates in Wyoming. Wyoming is also currently participating in the NVDRS with funding from the CDC. Data submitted from reviews of statewide violent deaths will be available on the state level to Wyoming, as well.

The CDC-assigned MCH Epidemiologist is leading the epidemiology portions of the joint Utah-Wyoming MMRC for MCH Epi. The Utah Department of Health is a recipient of the CDC ERASE MM grant, and Wyoming is Utah's sub-recipient. The results of the MMRC review process will provide Wyoming with valuable information on maternal mortality in the state, as well as recommendations to assist with further efforts to prevent maternal mortality. In addition, MCH Epi will better be able to examine the accuracy of the check-box on the death certificate that indicates if the deceased was pregnant in the past year. MCH Epi's strong working relationship with Wyoming VSS means regular access to state birth and death records, in addition to the enhancements funded by SSDI already stated above. MCH Epi also now has access to Wyoming Medicaid data, which will allow for a more thorough case identification process for the MMRC via linkages with Medicaid data.

III.E.2.b.iv. MCH Emergency Planning and Preparedness

WDH-PHD has a written Emergency Operations Plan (EOP) that is updated by the WDH-PHD Public Health Preparedness and Response (PHPR) Unit as needed based on the needs of the community. While the current EOP does consider the broad needs of vulnerable populations, the EOP does not adequately cover the specific and unique needs of Wyoming's MCH populations, which include at-risk and medically vulnerable women, infants, and children. To date, WY MCH staff have not been consulted during planning and development of EOP updates, are not currently involved in the state's emergency preparedness and response planning efforts, and are not currently part of the state's Incident Management Structure (IMS).

Both WY MCH and PHPR Unit leadership are in the process of establishing opportunities for WY MCH members to become trained in the IMS so that they can be part of the Emergency Operations Center during an emergency. In addition, WY MCH have requested to review the state's current EOPs in order to make recommendations that ensure the unique needs of all MCH populations are planned for in emergencies. This collaborative work was prompted and supported by the state's participation in the Association of Maternal and Child Health Programs (AMCHP) Emergency Preparedness and Response Action Learning Collaborative (EPR ALC), a technical assistance project supported by the CDC Division of Reproductive Health to ensure that women of reproductive age, especially pregnant and postpartum women, and infants are planned for in the event of emergencies, including multiple emergencies with intersecting impacts.

During the most recently completed Title V Needs Assessment, WY MCH staff identified critical gaps in the unit's preparedness for emergencies that impact MCH populations and WY MCH operations (e.g. newborn screening operations) and identified MCH emergency preparedness and response as an emerging need. Recent emergencies impacting WY MCH operations included snow storms (including a historic storm in 2021, Storm Xylia) and an essential contractor's bankruptcy halting newborn screening specimen courier services for the entire state for a period of time before a stop gap measure could be implemented. During any emergency that leads to road closures, pick up of newborn screening specimens from birthing hospitals across Wyoming and delivery of these specimens to the contracted laboratory in Denver, Colorado are impacted, leading to delays that may be life-threatening.

In acknowledgement of the gaps and challenges noted above, WY MCH and PHPR Unit leadership jointly submitted a successful Public Health Associate Program (PHAP) application in 2020 to add an MCH Emergency Preparedness Liaison to the WY MCH team. The PHAP Assignee joined the WY MCH team in October 2020 and leads current efforts to review and update the Wyoming EOP to plan for and respond to short- and long-term impacts of disasters and emerging threats to all Wyoming MCH populations. The PHAP Assignee also co-leads the AMCHP EPR ALC team, a team comprised of members from WY MCH (including Women and Infant Health, Newborn Screening and Genetics, and CYSHCN Programs), PHPR, Public Health Nursing (including the Wyoming Hand in Hand home visiting program), MCH Epidemiology, and the University of Wyoming Institute for Disabilities (Wyoming's Family to Family Health Information Center). The Wyoming EPR ALC team selected the following strategies to focus on over the next year:

1. Integrate MCH considerations into state/territory EPR Plan. Activities include:

    a. During the next 12 months, the Title V Director and PHPR Unit leadership will meet at least one time to discuss EPR needs related to maternal and infant health.

    b. A WY MCH staff member will regularly review and provide suggestions to update sections of the state/territory EPR plan that pertain to MCH populations, with special focus on the health needs of women of reproductive age (including pregnant/postpartum/lactating women) and infants in emergencies.

2. Identify public health programs, interventions, and policies to protect/promote health and prevent disease and injury in emergencies among maternal and infant populations. Activities include:

    a. WY MCH will develop and review a contingency plan for newborn screening during and after emergencies

annually.

COVID-19 Response

In addition to broad collaborative efforts to better integrate MCH into Wyoming emergency preparedness and response efforts, WY MCH also supported the COVID-19 response. All MCH Epidemiology Program staff and some WY MCH staff volunteered or were reassigned to support activities such as staffing a 24-hour health care provider call line staffing, contact tracing, data visualization updating, and website maintenance. The WY MCH PHAP Assignee also participated in the COVID-19 communications workgroup. This workgroup is part of a front-facing effort to provide the greater Wyoming community with current information on the COVID-19 vaccines, and their availability and impact by responding to and addressing community member questions and concerns.

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

III.E.2.b.v.a. Public and Private Partnerships

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, WY MCH will continue to support statewide delivery of high-quality, evidence-based home visiting and care coordination services for families by PHN in all 23 Wyoming counties. Beyond providing support to PHN, each WY 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 high-quality 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 efforts to reduce maternal and infant mortality.

WY MCH strives to partner with all PHD programs with particular emphasis on fellow CHS units, including Immunizations, PHN, Prevention and Health Promotion (including Tobacco Prevention, Substance Abuse Prevention, Injury Prevention, Chronic Disease Prevention, and Cancer Prevention and Early Detection), and Women, Infants and Children (WIC). In addition, the WDH organizational structure and a current Title V-Title XIX interagency agreement encourage a close working relationship between WY MCH and Wyoming Medicaid, which is evident in program strategies.

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 by WY MCH and MCH Epidemiology staff in order to continually assess progress and alignment with state priority needs and emerging needs. The MCH Priority Action Teams, made up of State and private partners, will also meet at least annually to review progress on the State Action Plan and support implementation of its strategies.

In spring 2019, WY MCH partnered with the Utah Department of Health to apply for the Centers for Disease Control and Prevention Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM) Program. The multi-state application was funded and led to the development of a UT-WY maternal mortality review committee, a committee that significantly enhances WY MCH's ability to address maternal mortality. Although not funded, WY MCH also partnered with the Utah Department of Health to apply for the State Maternal Health Innovation Program. WY MCH has another long-standing cross-state partnership with the Colorado Department of Public Health and Environment, which provides laboratory services for Wyoming's Newborn Screening Program, a service that an in-state laboratory cannot adequately provide. Cross-state partnerships like this enhance WY MCH's capacity to improve systems of care for MCH populations that transcends state boundaries.

Other key WY MCH partners include Wyoming's Department of Workforce Services (Early Head Start); Department of Family Services (Child Care Licensing, Temporary Assistance for Needy Families, Preschool Development Grant); Department of Education; WDH Behavioral Health Division (Early Intervention, Behavioral Health Treatment, Early Hearing Detection Intervention Program); the University of Wyoming (Wyoming Institute for Disabilities, Wyoming Family to Family Health Information Center, School of Nursing, School of Social Work); Wyoming Health Council (Title X grantee); the federal Maternal, Infant, Early Childhood Home Visiting (MIECHV) grant, administered by an out-of-state, non-profit partner; and other statewide organizations and associations (Wyoming Medical Society, Uplift [Wyoming Family Voices Affiliate], Wyoming Primary Care Association, Wyoming American Academy of Pediatrics Chapter, Wyoming American College of Obstetricians and Gynecologists Chapter, Wyoming Kids First, Wyoming Afterschool Alliance, Wyoming 211, Wyoming Community Foundation). WY MCH representatives also sit on the following statewide councils:

- Wyoming Governor's Council on Developmental Disabilities
- Wyoming Governor's Early Childhood State Advisory Council

- Wyoming Early Intervention Council
- Wyoming Preschool Development Grant Executive Leadership Committee
- Wyoming Citizen Review Panel

III.E.2.b.v.b. Title V MCH – Title XIX Medicaid Inter-Agency Agreement (IAA)

In Wyoming, Title V and Medicaid are housed within one agency, the Wyoming Department of Health (WDH), allowing for frequent communication and partnership. The four WDH divisions are Aging, Behavioral Health, Health Care Financing (i.e. Medicaid), and Public Health (home of WY MCH).

Partnership is formalized by a 2013 intra-agency agreement and is strongly supported by WDH leadership. Specifically, senior administrators for PHD and Healthcare Financing 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. In past years, the Wyoming Medicaid Medical Director and Wyoming Title V Director met frequently due to the high number of ongoing collaborative projects. In early 2021, consistent bi-monthly meetings were set to provide programmatic updates, identify collaborative projects, and update the current WDH-Medicaid intra-agency agreement. The purpose of the current intra-agency agreement is to:

1. Enable WDH-PHD and Wyoming Medicaid to carry out the mandate of cooperation contained in related provisions of the federal statutes and regulations
2. Formalize and strengthen the relationship between WDH-PHD and Wyoming Medicaid in areas of mutual interest and concern
3. Avoid duplication of effort
4. Improve access to Title XIX (Medicaid), Title XXI (Kid Care CHIP), and Title V (MCH) for eligible Medicaid clients
5. Enhance the quality of Medicaid and MCH services
6. Enhance program coordination and information exchange to the extent possible

Program Outreach and Enrollment

WY MCH (including the CYSHCN Program) and partners (e.g. Public Health Nursing, including home visiting nurses) routinely promote outreach and enrollment in available Medicaid programs including children's programs (Medicaid Children's Program, Kid Care CHIP, and Children's Mental Health Waiver), assistance programs for pregnant women (presumptive eligibility, Medicaid Pregnant Women Program, and Pregnant by Choice), and other assistance programs (Parent and Caretaker Relative Program, Emergency Services Program [serving undocumented immigrants or ineligible immigrants]), Supplemental Security Income, Developmental Disabilities Waiver Program, and Community Choices Waiver Program).

WY MCH's CYSHCN Program, which offers care coordination and limited gap-filling financial assistance as the payer of last resort for enrolled clients (CYSHCN, high-risk pregnant women, and high-risk infants) who meet medical and financial eligibility criteria, requires that families first apply for Medicaid, Kid Care CHIP, and/or the Federal Marketplace before CYSHCN Program eligibility is determined. The program provides reimbursement to eligible providers (all CYSHCN-eligible providers must be Medicaid providers) for covered services provided to eligible clients. CYSHCN Program claims are processed through the Wyoming Medicaid billing system, increasing efficiency and reducing duplication of effort. If CYSHCN pays a claim for a Medicaid-covered service for a Medicaid-eligible client, CYSHCN will be reimbursed for that claim to assure Title V is the payer of last resort. In FFY20, CYSHCN actively served 540 clients, 93% of whom were on Medicaid during the reporting year.

Health Care Financing

Wyoming is one of two states whose Medicaid payments are based on fee for service. Overall, children make up 67% of Wyoming residents covered by Medicaid and KidCare Chip. Wyoming Medicaid and KidCare Chip serve a large portion of Wyoming's vulnerable populations, including 100% of children in foster care, 55% of children who live in or near poverty, 34% of children with disabilities or special health care needs, and 29% of infants, toddlers, and preschoolers (Georgetown University Health Policy Institute Wyoming Snapshot 2019).

Waivers

Wyoming Medicaid offers at least four waiver programs that support MCH populations, including CYSHCN and WIHP. The waivers include the Supports Waiver, the Comprehensive Waiver, the Children's Mental Health Waiver program, and the

Pregnant by Choice Waiver.

The Supports Waiver provides supportive services to eligible persons of all ages with an intellectual or developmental disability, so they can actively participate in the community with friends and family, be competitively employed, and live as safely and independently as possible according to their own choices and preferences. The Comprehensive Waiver provides a higher annual budget amount than the Supports Waiver based on the eligible individuals' level of need, if the eligible person provides documentation demonstrating the need for a higher level of services. At this time, children are not placed on this waiver unless an emergency request has been submitted and approved.
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The Children's Mental Health Waiver is a short-term home- and community-based program that uses an intensive care coordination model (high fidelity wraparound) designed to provide a community-based alternative for youth ages 4-20 with serious emotional disturbance who might otherwise be hospitalized and whose parents may be required to relinquish custody of their child for them to receive needed mental health treatment and services.

The Pregnant by Choice Waiver offers birth control and reproductive support services to women losing full Medicaid benefits under the Pregnant Women Program.

Joint Policy-Level Decision Making

Long-Acting Reversible Contraception
WY MCH and Wyoming Medicaid participated in a multidisciplinary long-acting reversible contraception (LARC) workgroup that led efforts to complete a cost analysis on LARC versus unintended pregnancy, changed Medicaid policies related to LARC reimbursement in federally qualified health centers (FQHCs) and rural health clinics (RHCs), and began development of an immediate postpartum LARC toolkit. While policy change to unbundle LARC insertion and device costs from the encounter bundle for FQHCs and RHCs was successful, the LARC workgroup decided to pause efforts to unbundle billing codes for immediate postpartum LARC insertion in hospital settings until Wyoming Medicaid completed diagnosis-related group implementation. This work will resume in 2021.

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Visits
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. Efforts to establish a statewide Bright Futures Implementation Task Force were delayed due to limited staff capacity and COVID-19; however, a WY MCH restructuring change in 2021 will fill a critical staffing gap to address this important collaborative work.

Childhood Lead Screening
WDH lost funding for a dedicated Environmental Health/Lead Prevention Program in 2014. Due to this absence and the increased interest the Department of Environmental Quality 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 to better coordinate messaging, education, screening, and prevention efforts related to childhood lead screening. Currently, Wyoming does not have a risk-based screening protocol for childhood lead. Lead screening is recommended at 12- and 24-month well-child visits in accordance with Bright Futures guidelines.

Maternal Depression Screening at Well-Child Visits
In 2020, Wyoming Medicaid opened codes to allow for maternal depression screening to occur and be billed during childhood well visits. WY MCH and Wyoming Medicaid will partner to promote this billable service as part of broader Bright Futures education for providers and consumers.

Maternal Mortality Review Committee (MMRC) and Wyoming Perinatal Quality Collaborative Membership

The Wyoming Medicaid Medical Director participates in the Utah-Wyoming MMRC and the Wyoming Perinatal Quality Collaborative (WYPQC). Although no joint policy-level decision making has resulted from this partnership yet, there is significant potential for future MMRC and WYPQC recommendations and projects to lead to policy change. For example, WY MCH and Wyoming Medicaid are currently discussing plans to justify extension of postpartum Medicaid coverage through twelve months in response to new incentives offered by the federal government under the American Rescue Plan Act of 2021.

Systems of Care for CYSHCN

The CYSHCN Program partners with organizations such as the Wyoming Institute for Disabilities, Uplift, Early Intervention and Education programs, and Wyoming Medicaid, among others, to assure CYSHCN 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 CYSHCN by using the National Standards of Care for CYSHCN and developing a CYSHCN advisory council.

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

State Action Plan Introduction

The Wyoming Maternal and Child Health Unit's (WY MCH) 2021-2025 strategic planning process was significantly impacted by the COVID-19 pandemic, and modifications to its strategic plan between FFY21 and FFY22 and beyond are anticipated.

After the March 2020 declaration of the global pandemic, many WY MCH staff had to realott work hours to assist with COVID-19 response. MCH epidemiologists and the CDC-assigned MCH epidemiologist were pulled for contact tracing, our CDC Public Health Associate Program (PHAP) colleague was assigned to work on COVID-19 communication, and the MCH Unit Manager, program managers, and other staff volunteered to help answer calls to the 24-hour provider hotline and complete contact tracing data entry. WY MCH managers and staff also juggled a trickle-down of new responsibilities normally handled by others in the Public Health Division who had to redistribute their duties to others in order to focus on COVID-19 response. Meanwhile, the key partners, community organizations, healthcare systems, and clients WY MCH planned to engage with around strategic planning were unavailable as they were also responding to the pandemic.

Fortunately, WY MCH was able to complete its Needs Assessment and State Action Plan before the September 15, 2020 submission deadline. However, the impact of the pandemic affected the degree of thoroughness WY MCH could devote to the development of its State Action Plan and planned Year 1 strategies, activities, and measures, as well as early implementation. WY MCH is working with the MCH Evidence Center to refine its plan and ESMs for Year 2, and we anticipate adjustments. WY MCH will apply lessons learned from Years 1-2 to the remaining three years of the cycle and continue requesting Maternal and Child Health Bureau support if needed.

Additionally, WY MCH recognized the need for external help to get back on track as the pandemic became more under control. In recognition of challenges due to the pandemic and interruptions to our strategic plan, we released a Request for Proposals for a consultant to help us reset in early 2021, and Lolina, Inc. was the selected entity. We expect changes to our plan as we begin to receive technical assistance from Lolina, Inc. over the next year.

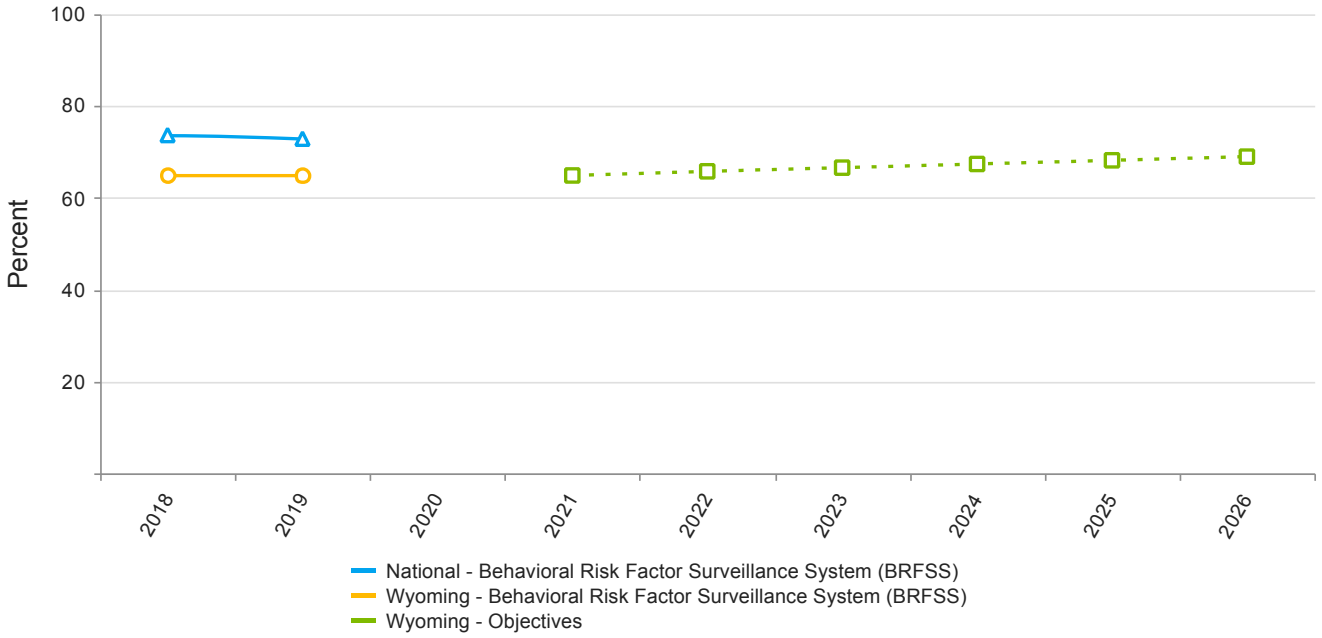
Women/Maternal Health

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-2018	52.4	NPM 1 NPM 14.1
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS-2015_2019	Data Not Available or Not Reportable	NPM 1 NPM 14.1
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2019	9.8 %	NPM 1 NPM 14.1
NOM 5 - Percent of preterm births (<37 weeks)	NVSS-2019	9.9 %	NPM 1 NPM 14.1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2019	28.7 %	NPM 1 NPM 14.1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2018	5.2	NPM 1 NPM 14.1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2018	5.3	NPM 1 NPM 14.1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2018	2.9	NPM 1 NPM 14.1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2018	2.4	NPM 1 NPM 14.1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2018	167.6	NPM 1 NPM 14.1
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2018	Data Not Available or Not Reportable	NPM 14.1
NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy	PRAMS-2019	7.2 %	NPM 1
NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations	SID-2018	2.3	NPM 1
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	92.0 %	NPM 14.1
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2019	19.4	NPM 1
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth	PRAMS-2019	15.3 %	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	**2020**
Annual Objective		
Annual Indicator	64.8	64.6
Numerator	61,481	61,360
Denominator	94,822	94,984
Data Source	BRFSS	BRFSS
Data Source Year	2018	2019

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	64.8	65.7	66.5	67.3	68.1	68.9

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

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	250.0	275.0	303.0	333.0	366.0	401.0

ESM 1.2 - Percent of women ages 18-44 interacting with developed messaging in regard to the well-woman visit and its importance on the My 307 Wellness App

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	20.0	25.0	30.0	35.0	40.0	45.0

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	
By September 30, 2022 develop messaging and content around the well women visit based on the results from the focus groups and develop a plan to promote the use of the My 307 Wellness App among women of reproductive age.	
Strategies	
Promote importance of well-woman visit and postpartum visit and identify and implement evidence-based strategies to address barriers to well-woman visit and postpartum visits.	
ESMs	Status
ESM 1.1 - Number of women ages 18-44 enrolled in the My 307 Wellness App	Active
ESM 1.2 - Percent of women ages 18-44 interacting with developed messaging in regard to the well-woman visit and its importance on the My 307 Wellness App	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 - Percent of women who drink alcohol in the last 3 months of pregnancy

NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations

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

Objectives

By September 30, 2022 implement plan developed with Medicaid to increase access to postpartum visits and postpartum contraception.

Strategies

Partner with Medicaid to increase access to postpartum visits and postpartum contraception.

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

Priority Need

Prevent Maternal Mortality

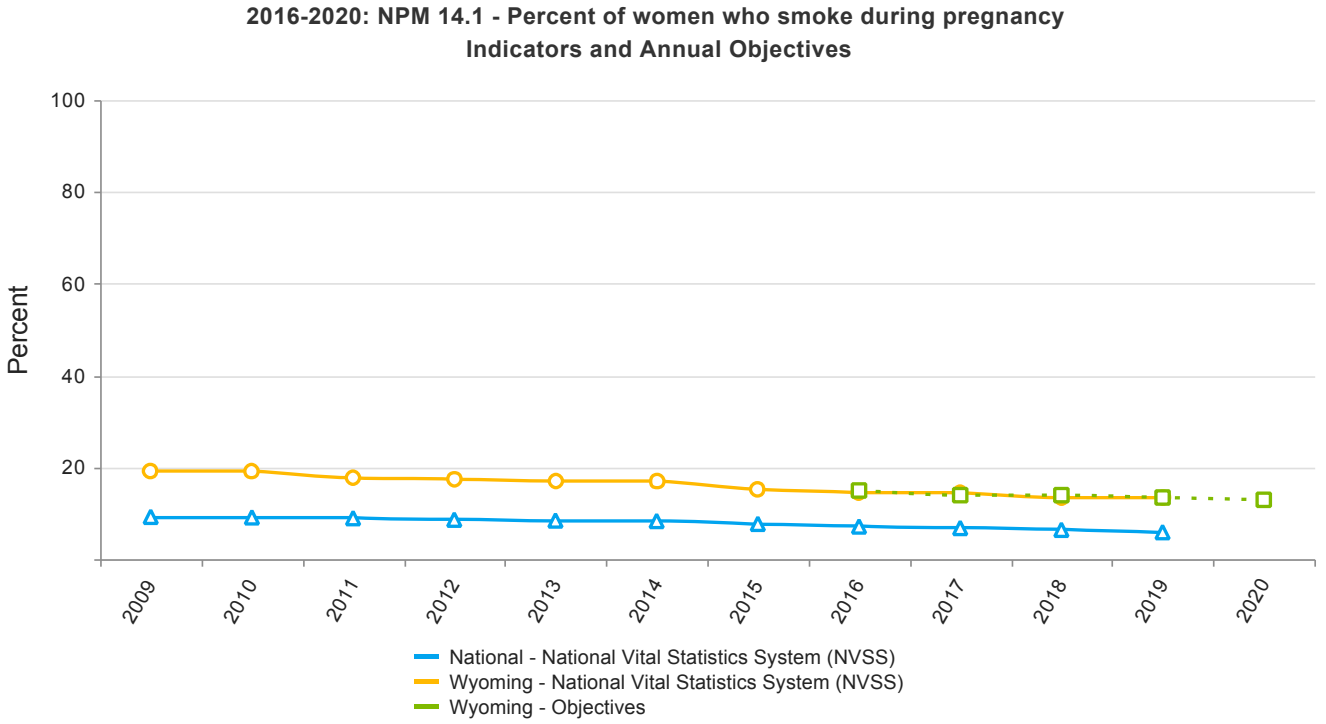
Objectives

By September 30, 2022 implement plans to address high priority recommendations.

Strategies

Implement evidence-based strategies to improve maternal health outcomes to include implementation of cross-state UT-WY maternal mortality review committee.

2016-2020: National Performance Measures



Federally Available Data					
Data Source: National Vital Statistics System (NVSS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	15	14	14	13.5	13
Annual Indicator	15.2	14.6	14.4	13.4	13.6
Numerator	1,148	1,043	968	859	855
Denominator	7,540	7,152	6,735	6,404	6,266
Data Source	NVSS	NVSS	NVSS	NVSS	NVSS
Data Source Year	2015	2016	2017	2018	2019

State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	15	14	14	13.5	13
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**	**2020**
Annual Objective			25	30
Annual Indicator			16	0
Numerator				
Denominator				
Data Source			WY Quitline	WY Quitline
Data Source Year			2019	2020
Provisional or Final ?			Provisional	Provisional

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

Measure Status:			**Active**	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			7	7
Annual Indicator			7	0
Numerator				
Denominator				
Data Source			Program Data	Program Data
Data Source Year			FFY19	FFY20
Provisional or Final ?			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**	**2020**
Annual Objective			66	68
Annual Indicator			66.4	69
Numerator			3,517	3,562
Denominator			5,296	5,160
Data Source			PRAMS	PRAMS
Data Source Year			2018	2019
Provisional or Final ?			Final	Final

In Wyoming, Title V and Medicaid are housed within one agency, the Wyoming Department of Health (WDH), allowing for frequent communication and partnership. The four WDH divisions are Aging, Behavioral Health, Health Care Financing (i.e. Wyoming Medicaid), and Public Health (home of WY MCH, Wyoming's Title V program).

Partnership is formalized by a 2013 intra-agency 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. In past years, the Wyoming Medicaid Medical Director and Wyoming Title V Director met frequently due to the high number of ongoing collaborative projects; however, no formal one-on-one meetings occurred. In early 2021, consistent bi-monthly meetings were set to provide programmatic updates, identify collaborative projects, and update the current WDH-Medicaid intra-agency agreement. The purpose of the current intra-agency agreement is to:

1. Enable WDH-PHD and Wyoming Medicaid to carry out the mandate of cooperation contained in related provisions of the federal statutes and regulations
2. Formalize and strengthen the relationship between WDH-PHD and Wyoming Medicaid in areas of mutual interest and concern
3. Avoid duplication of effort
4. Improve access to Title XIX (Medicaid), Title XXI (Kid Care CHIP), and Title V (MCH) for eligible Medicaid clients
5. Enhance the quality of Medicaid and MCH services
6. Enhance program coordination and information exchange to the extent possible

Program Outreach and Enrollment

WY MCH (including the Children and Youth with Special Health Care Needs [CYSHCN] Program) and partners (e.g. Public Health Nursing, including home visiting nurses) routinely promote outreach and enrollment in available Medicaid programs including children's programs (Medicaid Children's Program, Kid Care CHIP, and Children's Mental Health Waiver), assistance programs for pregnant women (presumptive eligibility, Medicaid Pregnant Women Program, and Pregnant by Choice), and other assistance programs (Parent and Caretaker Relative Program, Emergency Services Program [serving undocumented immigrants or ineligible immigrants]), Supplemental Security Income, Developmental Disabilities Waiver Program, and Community Choices Waiver Program).

WY MCH's CYSHCN Program, which offers care coordination and limited gap-filling financial assistance as the payer of last resort for enrolled clients (CYSHCN, high-risk pregnant women, and high-risk infants) who meet medical and financial eligibility criteria, requires that families first apply for Medicaid, Kid Care CHIP, and/or the Federal Marketplace before CYSHCN Program eligibility is determined. The program provides reimbursement to eligible providers (all CYSHCN-eligible providers must be Medicaid providers) for covered services provided to eligible clients. CYSHCN Program claims are processed through the Wyoming Medicaid billing system, increasing efficiency and reducing duplication of effort. If CYSHCN pays a claim for a Medicaid-covered service for a Medicaid-eligible client, CYSHCN will be reimbursed for that claim to assure Title V is the payer of last resort. In FFY20, CYSHCN actively served 540 clients. Of all enrolled clients, 449 were CYSHCN, 74 were high-risk infants, and 17 were high-risk pregnant women. Of clients served, 93% were on Medicaid during the reporting year.

Health Care Financing

Wyoming is one of two remaining states whose Medicaid payments are based on fee for service. Overall, children make up 67% of Wyoming residents covered by Medicaid and KidCare Chip. Wyoming Medicaid and KidCare Chip serve a large portion of Wyoming's vulnerable populations, including 100% of children in foster care, 55% of children who live in or near poverty, 34% of children with disabilities or special health care needs, and 29% of infants, toddlers, and preschoolers (Georgetown University Health Policy Institute Wyoming Snapshot 2019).

Waivers

Wyoming Medicaid offers three waiver programs that support MCH populations, including CYSHCN. The waivers include the

Supports Waiver, the Comprehensive Waiver, and the Children's Mental Health Waiver program.

The Supports Waiver provides supportive services to eligible persons of all ages with an intellectual or developmental disability, or an acquired brain injury, so they can actively participate in the community with friends and family, be competitively employed, and live as safely and independently as possible according to their own choices and preferences. All children start out on the Supports Waiver, with a capped annual budget of $18,457.00 per child. The annual budgeted amount has to last the entire plan year; if they over-utilize it, they will not get services paid for by the waiver until the next plan year.

The Comprehensive Waiver provides a higher annual budget amount based on the eligible individuals' level of need. Eligibility for the Comprehensive Waiver requires documentation demonstrating the need for a higher level of services. This waiver may provide individuals with 24-hour services (e.g. adults residing in a group home setting) if approved by a committee that reviews emergency requests. There are currently children and adults with varied levels of need on the Comprehensive Waiver who were grandfathered in during the transition from the Developmental Disabilities Waiver in 2014, but children are no longer placed on this waiver unless an emergency request has been submitted and approved. All new eligible applicants are placed on the Support Waiver waiting list and are funded by the Support Waiver as funding is available.

The Children's Mental Health Waiver is a short-term home- and community-based program that uses an intensive care coordination model (high fidelity wraparound) designed to provide a community-based alternative for youth with serious emotional disturbance who might otherwise be hospitalized and whose parents may be required to relinquish custody of their child for them to receive needed mental health treatment and services. The Children's Mental Health Waiver seeks to: (1) prevent custody relinquishment for youth to receive mental health treatment, (2) prevent or reduce the length of costly psychiatric hospital stays, and (3) provide a mechanism to offer mental health support services to youth with serious emotional disturbance and their families in identified service areas. The Children's Mental Health Waiver is not a long-term care waiver. To qualify for the waiver, a child must be age 4-20, meet the definition of serious emotional disturbance, meet at least one Medicaid criteria for inpatient psychiatric hospitalization, meet the diagnosis requirements, and be financially eligible for Medicaid based on their own resources.

Joint Policy-Level Decision Making

Long-Acting Reversible Contraception

WY MCH and Wyoming Medicaid participate in a multidisciplinary long-acting reversible contraception (LARC) workgroup that led efforts to complete a cost analysis on LARC versus unintended pregnancy, changed Medicaid policies related to LARC reimbursement in federally qualified health centers (FQHCs) and rural health clinics (RHCs), and began development of an immediate postpartum LARC toolkit. While policy change to unbundle LARC insertion and device costs from the encounter bundle for FQHCs and RHCs was successful, the LARC workgroup decided to pause efforts to unbundle billing codes for immediate postpartum LARC insertion in hospital settings until Wyoming Medicaid completed diagnosis-related group implementation. This work will resume in 2021.

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Visits

*T*he 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. Efforts to establish a statewide Bright Futures Implementation Task Force were delayed due to limited staff capacity and COVID-19; however, a WY MCH restructuring change in 2021 will fill a critical staffing gap to address this important collaborative work. Provider education on Wyoming Medicaid's adherence to the 4th Edition is a priority given that knowledge and implementation of the policy change may not be widespread.

Childhood Lead Screening

WDH lost funding for a dedicated Environmental Health/Lead Prevention Program in 2014. Due to this absence and the

increased interest the Department of Environmental Quality 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 to better coordinate messaging, education, screening, and prevention efforts related to childhood lead screening. Currently, Wyoming does not have a risk-based screening protocol for childhood lead. Lead screening is recommended at 12- and 24-month well-child visits in accordance with Bright Futures guidelines.

Maternal Depression Screening at Well-Child Visits

In 2020, Wyoming Medicaid opened codes to allow for maternal depression screening to occur and be billed during childhood well visits. WY MCH and Wyoming Medicaid will partner to promote this billable services as part of broader Bright Futures, 4th Edition education for providers and consumers.

Maternal Mortality Review Committee (MMRC) and Wyoming Perinatal Quality Collaborative Membership

The Wyoming Medicaid Medical Director participates in the Utah-Wyoming MMRC and the Wyoming Perinatal Quality Collaborative (WYPQC). Although no joint policy-level decision making has resulted from this partnership yet, there is significant potential for future MMRC and WYPQC recommendations and projects to lead to policy change. For example, WY MCH and Wyoming Medicaid are currently discussing plans to justify extension of postpartum Medicaid coverage through twelve months in response to new incentives offered by the federal government under the American Rescue Plan Act of 2021.

Systems of Care for CYSHCN

The CYSHCN Program partners with organizations such as the Wyoming Institute for Disabilities, Uplift, Early Intervention and Education programs, and Wyoming Medicaid, among others, to assure CYSHCN 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 CYSHCN by using the National Standards of Care for CYSHCN and developing a CYSHCN advisory council.

Women/Maternal Health - Application Year

Application Year Plan (FFY21): This section presents strategies/activities for 2021-2025 MCH priorities related to the Women/Maternal Domain. 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 ages 18-44 interacting with developed messaging in regard to the well-woman visit and its importance on the My 307 Wellness App**

The U.S. continues to see a rise in maternal mortality cases, especially among women of color. The COVID-19 pandemic and changed hospital protocols are driving maternal mortality and morbidity numbers even higher. In December 2020, U.S. Surgeon General Jerome Adams released a Call to Action to Improve Maternal Health, complementing the CDC Hear Her campaign. Both such actions by the federal government demonstrate that maternal mortality has hit crisis levels in our country.

Women in rural and frontier areas, such as Wyoming, face even more health care disparities while pregnant. Because Wyoming lacks tertiary care facilities, women who are deemed high-risk must deliver at hospitals in neighboring states, and if they experience an emergency before their planned delivery, they are often air-ambulanced out-of-state. Furthermore, Wyoming is a mental health provider desert, with primary care providers grossly under-equipped to provide wrap-around services to a woman who needs mental health care.

Of the May 2021 public input survey respondents who indicated that they have a woman aged 15-44 in their household, 96.55% indicated that they believe the Women and Infant Health Program's work to educate providers and the public on well woman visits to see their doctors each year and the focused efforts on maternal mental health fits well or very well with the needs of their family or community. One hundred percent indicated that they believe it is important or very important to increase the number of women seeing their doctor each year for a well woman visit to help women be as healthy as possible before pregnancy and to prevent new mothers from passing away in your community.

One public input respondent stated, "I don't think women in the community understand the importance of a well woman visit. They often brush it off and many health concerns fly under the radar until it is too late." Others echoed the importance of the WIHP's planned working, sharing: "women need additional care during their first year postpartum and are often lost in the crowds" and "having more mental health options would be great. Sometimes it's hard to know where to start to get the help you need."

In FFY22, WIHP will implement the following strategies to address the prevention of maternal mortality:

1. Promote the importance of the well-woman visit and postpartum visit and identify and implement evidence-based strategies to address barriers to well-woman visits and postpartum visits.
    a. WIHP identified support for well-woman and postpartum visits in the 2020 Title V Needs Assessment. However, barriers to these visits are not well understood. WIHP will conduct focus groups throughout the state in both English and Spanish to better understand women's knowledge of, and barriers to, attending a well woman visit. The focus group findings will guide the development of a culturally appropriate communication campaign, incorporating the My 307 Wellness app and WY MCH's Facebook page to communicate the importance of a well woman visit for all women of reproductive age.
2. Partner with Medicaid to increase access to postpartum visits and postpartum contraception.
3. Implement evidence-based strategies to improve maternal health outcomes, including implementation of cross-state UT-WY maternal mortality review committee.
    a. Stand up a joint state MMRC with the Utah Department of Health, create Wyoming-specific review protocols, and develop recommendations based on quarterly reviews. The recommendations will be shared with the WYPQC to turn into action for system change.

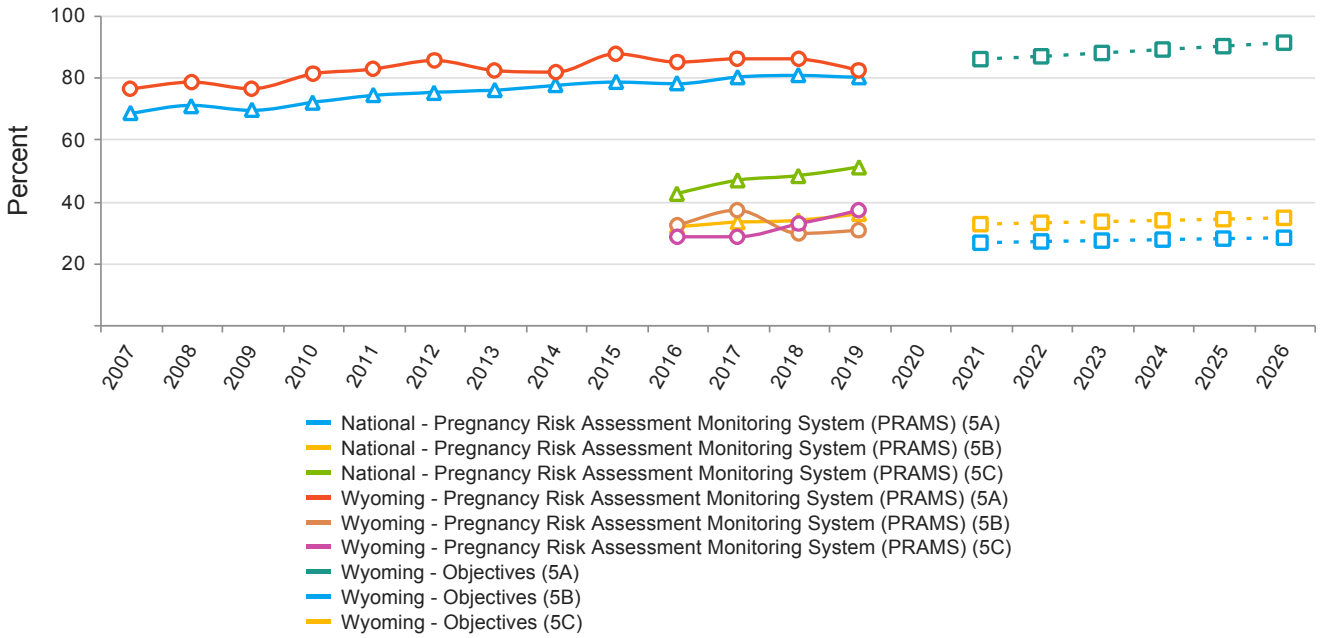
Perinatal/Infant Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2018	5.3	NPM 4 NPM 5
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2018	2.4	NPM 4 NPM 5
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2018	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	**2020**
Annual Objective		
Annual Indicator	85.7	82.3
Numerator	5,251	5,105
Denominator	6,130	6,201
Data Source	PRAMS	PRAMS
Data Source Year	2018	2019

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	85.7	86.6	87.7	88.8	89.9	91.0

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	**2020**
Annual Objective		
Annual Indicator	29.6	30.4
Numerator	1,775	1,800
Denominator	5,999	5,921
Data Source	PRAMS	PRAMS
Data Source Year	2018	2019

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	26.6	27.0	27.3	27.6	27.9	28.2

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	**2020**
Annual Objective		
Annual Indicator	32.6	37.1
Numerator	1,928	2,226
Denominator	5,918	6,001
Data Source	PRAMS	PRAMS
Data Source Year	2018	2019

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	32.6	33.0	33.4	33.8	34.2	34.6

Evidence-Based or –Informed Strategy Measures

ESM 5.1 - Percent of PRAMS moms who report having a home visit and report their baby sleeps on a separate approved sleep surface

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	32.6	33.0	36.0	38.0	40.0	42.0

ESM 5.2 - Percent of PRAMS moms who report having a home visit and report their baby sleeps without soft objects or loose bedding

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	31.0	31.0	33.0	35.0	37.0	39.0

State Performance Measures

SPM 1 - Percent of women who smoke during pregnancy

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	13.4	13.6
Numerator	859	855
Denominator	6,404	6,266
Data Source	NVSS	NVSS
Data Source Year	2018	2018
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	13.4	12.8	12.1	11.4	10.7	10.0

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	
By September 30, 2022, identify initial barriers to providing safe sleeping environment from focus groups to be addressed with interventions and start training for professionals, including Home visiting programs to recognize, identify and model safe sleep environments using the Health Equity lens.	
Strategies	
Promote importance of safe sleep practices and identify and implement evidence-based activities to address barriers to safe sleep practices.	
ESMs	**Status**
ESM 5.1 - Percent of PRAMS moms who report having a home visit and report their baby sleeps on a separate approved sleep surface	Active
ESM 5.2 - Percent of PRAMS moms who report having a home visit and report their baby sleeps without soft objects or loose bedding	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 - 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

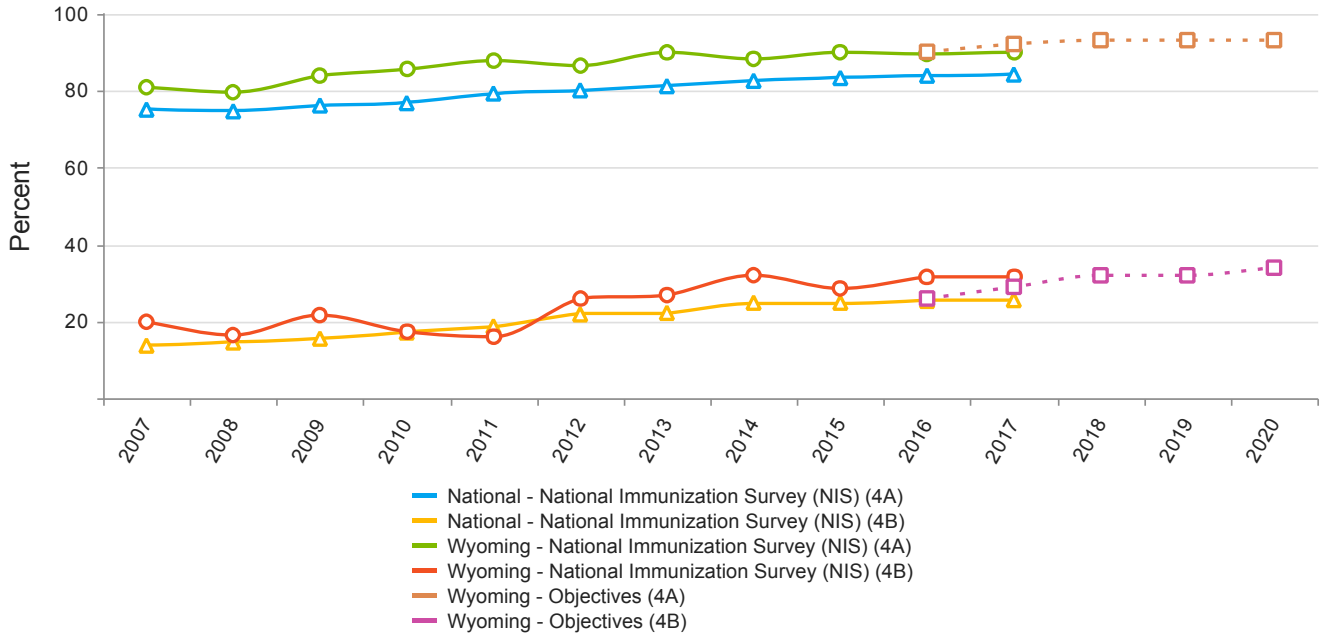
By September 30, 2022 increase the number of Quit Kits given to pregnant and postpartum women and increases the number of pregnant/postpartum women referred to the QuitLine by PHN.

Strategies

Promote importance of smoking cessation among women of reproductive age and pregnant women and implement evidence-based activities to address barriers to smoking cessation.

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**	**2020**
Annual Objective	90	92	93	93	93
Annual Indicator	89.7	88.3	90.0	89.6	90.0
Numerator	5,817	5,853	6,269	4,671	5,039
Denominator	6,486	6,628	6,963	5,216	5,599
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016	2017

State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	90	92	93	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**	**2020**
Annual Objective	26	29	32	32	34
Annual Indicator	27.0	32.0	28.8	31.4	31.8
Numerator	1,693	2,049	1,959	1,578	1,739
Denominator	6,263	6,412	6,790	5,027	5,472
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016	2017

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**	**2020**
Annual Objective	4	4	0	4
Annual Indicator	4	4	0	0
Numerator				
Denominator				
Data Source	Women and Infant Program	Women and Infant Health Program	Women and Infant Health Program	Women and Infant Health Program
Data Source Year	2017	2018	2019	2020
Provisional or Final ?	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**	**2020**
Annual Objective			100	100
Annual Indicator			100	0
Numerator			4	0
Denominator			4	4
Data Source			Program Data (self report from hospitals)	n/a
Data Source Year			CY 2018	n/a
Provisional or Final ?			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**	**2020**
Annual Objective			90	90
Annual Indicator			100	100
Numerator			23	23
Denominator			23	23
Data Source			Public Health Nursing Program Data	Public Health Nursing Program Data
Data Source Year			SFY 2020	SFY 2021
Provisional or Final ?			Provisional	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**	**2020**
Annual Objective		54	70	80	80
Annual Indicator	51.9	68	80.6	73.6	85.7
Numerator	42	68	50	53	72
Denominator	81	100	62	72	84
Data Source	Wyoming Vital Statistics Services	Wyoming Vital Statistics Services	Wyoming Vital Statistics Services	Wyoming Vital Statistics Services	Wyoming Vital Statistics Services
Data Source Year	2015	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Report Fiscal Year 2020: This section provides a summary of Federal Fiscal Year 2020 (FFY20) activities, accomplishments, and challenges related to National Performance Measures (NPMs) and State Performance Measures (SPMs) (2016-2020) for the Perinatal/Infant Domain.

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

The American Academy of Pediatrics 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 and ovarian cancer, diabetes, and heart disease.

Since 2015, when breastfeeding was declared as a priority in Wyoming, the prevalence of infants ever breastfeed in Wyoming, as well as though breastfeed exclusively through 6 months has remained higher than the U.S. prevalence. In 2019, 90.0% of Wyoming infants were ever breastfed compared to 84.1% in the U.S., and 31.8% of Wyoming infants were breastfeed exclusively through 6 months compared to 25.6% in the U.S.
Due to Wyoming's stellar performance in this priority, breastfeeding will no longer be seen as a top-level priority within the new Title V cycle; however, MCH Epidemiology will continue to monitor progress through interim needs assessment activities to identify reversing trends or emerging needs.

Strategy 1: Assure 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 assure that mothers and their infants served by public health nurses (PHNs) through home visitation have access

to breastfeeding support, the 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 FFY20, 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.

The WIHPM also assists the Wyoming Women, Infants and Children (WIC) Program with CLC certifications for their staff. Supporting breastfeeding programs in other public health programs is vital to maintaining Wyoming's high breastfeeding rate.

Additional Strategies:

Develop a WDH Breastfeeding at Work Policy in Collaboration with Wyoming WIC
Despite the Wyoming Department of Health Leadership not approving the Breastfeeding at Work Policy the WIHPM and WIC team continued to work with leadership staff to ensure that when the Department of Health moved into new buildings a designated lactation space was put on each floor of the buildings. New chairs, refrigerators, and other necessary supplies were put in each lactation space of the new floor.

Due to Covid-19 the new lactation rooms have not been used to their full potential, because the Wyoming Department of Health began a full time work from home policy. However, when lactating people begin to return to work these new lactation spaces will be at their disposal as well as a google calendar so that women can schedule each room as needed.

The MCH Unit and WIC team continue to work together on this initiative and are glad we have found a way to ensure women employed by the Wyoming Department of Health feel like they can continue to work while also feeding their infant the way they want.

A baby at work policy was briefly discussed, but there was no traction to continue such a discussion under current leadership.

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 and WY MCH Epidemiology piloted LOCATe in 2016 and provided facility reports in 2017, holding in-person meetings with some hospitals to review results. While a useful tool, no specific efforts related to LOCATe

were implemented in FFY20. WY MCH may consider repeating the tool in the future if a plan for using the results to inform efforts is developed. The WYPQC will be a key partner in any future implementation of LOCATe activities.

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)

Wyoming partners with Utah in order to bring AIM safety bundle activities to the birthing hospitals in the state. Utah invited Wyoming birthing hospitals to participate in the in-person close-out of the hypertension bundle and help kick off the opioid use disorder (OUD) safety bundle. The meeting was held in Salt Lake City, UT in March 2020. The WIHPM put out a notice to all 21 birthing hospitals in the state notifying them that WY MCH would provide travel assistance for up to two staff members to attend the in-person safety bundle meeting. Staff from six hospitals (Memorial Hospital of Sweetwater County; St. John's Health; Sheridan Memorial Hospital; Campbell County Health; Ivinson Memorial Hospital; Cheyenne Regional Medical Center) attended. These hospitals represent some of the largest birthing hospitals in each region of the state.

Shortly after the launch meeting, both states implemented travel restrictions due to Covid-19 and many of the participating Wyoming hospitals requested to put non Covid-19 work on hold. Utah honored this request and slowed down the pace of the work usually seen within the AIM safety bundles. Once the bundle began implementation again Wyoming birthing hospital staff requested that the AIM safety bundle focus on more than just OUD, because the rate of OUD in Wyoming is very low. Both Utah and Wyoming agreed to expand the safety bundle to discuss all substances, specifically methamphetamines and marijuana. Four of the six hospitals who attended the March 2020 launch meeting participated in at least one telehealth training session post-launch but sustained and active engagement was impeded by COVID-19.

Utah also partnered with the March of Dimes to host a virtual implicit bias training for Labor and Delivery staff from Wyoming and Utah. Utah bought enough licenses to allow Wyoming hospitals to participate in the implementation of this pilot training. Three Wyoming hospitals participated; Ivinson Memorial Hospital trained staff but did not hold a debrief session yet, Wyoming Medical Center trained and debriefed with over fourty participants, and Cheyenne Regional Medical Center trained staff and are scheduled to debrief in July 2021. Recruitment is ongoing for additional hospitals to participate.

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

The WYPQC is still in its infancy and is continuing to reach out to new members and work towards improving its structure and policies. Due to the Covid-19 pandemic this work drastically slowed, with most members being tasked with Covid-19 duties. The WIHPM and WYPQC Chair made the decision to not host meetings during this time and to slow down the pace of newsletters and email alerts as members were feeling overwhelmed.

The WIHP released a Request for Applications for coordination of the WYPQC in late 2018, and in April 2019, a contract was awarded to Brenda Burnett, RN, MSN, PCMH CCE, of Brenda Burnett Clinical Consulting, LLC. Brenda 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 assured ongoing engagement and recruitment of project partners and stakeholders. Brenda maintained her contract through December 2019; when she chose to retire. The WIHPM released an RFA in early 2020 to attempt to rehire a coordinator but a candidate was not selected. The WIHPM plans to release a RFP in late FFY 21 in order to rehire for the position.

Prior to the pandemic, the WYPQC established subcommittees, but only recently selected a chair for each subcommittee. One of the five topical areas is the Infant Health Subcommittee, which has begun to work with the Substance Use Disorder Subcommittee on a state-level policy for a Plan of Safe Care. The other three subcommittees are: Hospital Systems; Infant Health; Maternal Morbidity and Mortality; and Maternal Mental Health. In Summer 2021, the WYPQC leadership team will receive short-term strategic planning consultation to revisit the vision/mission and develop a 12-month strategic plan to reset efforts post-pandemic. WY MCH will also welcome a University of Washington MPH student to assist in logic model development and development of standard processes by which the WYPQC will review and act upon prioritized recommendations from the UT-WY maternal mortality review committee.

Strategy 4: Implement Fetal and Infant Mortality Review (FIMR) in pilot community
Preventing infant mortality remains a Title V priority for the WIHPM in the 2021-2025 grant cycle and establishing infrastructure to implement FIMR at the state or local level remains a possible strategy. Efforts to establish a maternal mortality review committee in partnership with the Utah Department of Health required significant staff time and effort during FFY20 and FFY21; therefore, efforts to implement FIMR have been put on hold until FFY22. Wyoming MCH will explore the idea of putting together a statewide FIMR instead of a community based review due to limited resources and capacity. This is also largely due to the low infant mortality rate we see in many counties and lessons learned from neighboring states like Montana, where some counties may not see a review for several years.

Training materials from the previous FIMR work led by WY MCH and community partners in Fremont County are still available to train potential future FIMR members and the National Center for Fatality Review and Prevention has offered technical assistance for this project. The CDC Epidemiology Assignee helped lead the pilot FIMR and is aware of and willing to assist in a reintroduction of a FIMR to Wyoming. 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.

Annual Report Fiscal Year 2020 Supplement: This section provides an interim update for Federal Fiscal Year 2021 (FFY21) activities currently in process for the WIHP.

After the summer 2020 needs assessment, the WIHP decided to continue the prevention of infant mortality Title V priority for the perinatal/infant domain. New strategies include conducting virtual focus groups throughout the state in both English and Spanish to better understand families' knowledge of, and barriers to, safe sleep practices.

A Request for Proposal for focus groups was released in January 2021 and the OMNI Institute will complete this work by late 2021 to inform ongoing efforts in FFY22. The program selected 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 to monitor progress over the five-year cycle.

Other Perinatal/Infant Activities:

Public Health Nursing Home Visiting
The Public Health Nursing Home Visiting Program officially began moving from the Bright Beginnings model to the Australian-based Maternal Early Childhood Sustained Home-Visiting (MECSH) model. This model is evidence-based, nurse-led, and can now be found in three states: Vermont, Minnesota, and Wyoming. The goal of the model is to enroll women and families while pregnant and follow the child, as needed, until the age of two. It focuses on the parent becoming self-sufficient sooner, building a positive relationship between the parent and child, and the parent

beginning to rely on the community and others as part of the family network. Wyoming PHNs have begun training to switch to this model.

Plan of Safe Care

Wyoming does not currently have a Plan of Safe Care in Place and needs to comply with this federal mandate issued under CAPTA/CARA. The WIHPM sits on a Plan of Safe Care working group (comprised of public health nursing staff, DFS staff, and a nurse champion) that has utilized partnerships with the ASTHO OMNI Learning Community and the Utah AIM OUD safety bundle to not only understand what other states have done to roll out this policy, but to educate providers and nursing staff about Wyoming mandatory reporting laws, CAPTA/CARA laws, and what Wyoming hope to achieve from this plan.

Through this work the Plan of Safe Care working group has sought federal in depth technical assistance with the National Center on Substance Abuse and Child Welfare. During the drafting of the federal application the working group lead and the possible federal lead presented to the WYPQC. The WIHPM facilitated the presentation and saw many great questions come through from WYPQC members. This presentation created further statewide buy in and interest in an alternative to ensure birthing people can receive the assistance they need and that the rate of infants placed in foster care decreases in Wyoming.

Newborn Screening

The Wyoming Newborn Screening (NBS) Program launched a de-identified, electronic Newborn Screening Report Card to improve quality assurance measures for the program and allow hospitals and consumers to easily obtain this data. By the fall of 2021, this information will be identifiable by hospital.

The NBS Program joined the Association of Maternal and Child Health Programs (AMCHP) Emergency Preparedness Learning Collaborative to create NBS emergency protocols. WY MCH identified this critical need after its then-NBS courier went bankrupt in December 2019, and after the southeast portion of Wyoming was shut down due to a spring blizzard. WY MCH'sCDC Public Health Associate Program (PHAP) assignee has taken on WY MCH's work within this learning community and successfully brought together partners that had not previously worked together. The NBS video found on the WyomingNBS Program website has been an excellent driver in helping new partners understand why this program is so vital.

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.

Priority	Performance Measure	ESM (if applicable)
Prevent Infant Mortality	**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** **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**	**ESM 5.1: % of PRAMS moms reporting their baby sleeps on a separate approved sleep surface, among moms who reported having a home visit** **ESM 5.2: % of PRAMS moms reporting their baby sleeps without soft objects or loose bedding, among moms who reported having a home visit**

Wyoming PRAMS data indicate that the majority of infants (84.7%) are put to sleep on their back only (2016-2019). During the same time period, 32.4% of infants in Wyoming were reported to always or usually be placed on a separate approved sleep surface, and 31.5% were usually placed to sleep with no soft bedding. The data also indicate that disparities in sleep environments (separate approved sleep surface and no soft bedding) exist by race/ethnicity and by income. Women living with higher incomes were more likely to always or usually place their infant on a separate approved sleep surface, as well as with *no* soft bedding (PRAMS, 2016-2018).

Of the May 2021 public input survey respondents who indicated that they have an infant age 0-1 in their household, 90% indicated that they believe it is important or very important to improve safe sleep for infants in Wyoming. One respondent stated, “Many parents are just unaware of safe sleep practices for infants.” Another pointed out the critical health equity component, suggesting “inexpensive alternatives to infant products that still align with safe sleeping practices [and] ideas on how to create a safe sleeping space when you're limited on space and money.”

Smoking cessation remains a priority for the WIHP and will be tracked as an SPM in the 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 SUID, as well as a higher risk of developing chronic diseases like asthma as they grow older.

In FFY22, the WIHP will implement the following strategies to address the prevention of infant mortality:

1. Promote importance of safe sleep practices and identify and implement evidence-based activities to address barriers to safe sleep practices.
    a. WIHP will conduct focus groups throughout the state in both English and Spanish to better understand

families' knowledge of, and barriers to, safe sleep practices. When disparities are identified, the WIHP 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.

2. Promote importance of smoking cessation among women of reproductive age and pregnant women and implement evidence-based activities to address barriers to smoking cessation.
    a. WIHP will partner with Public Health Nurses to monitor QuitKit use by MESCH home-visiting families to drive an increase in pregnancy/postpartum use of the Wyoming Quitline. WIHP and partners will also 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 WIHP will research and promote other available evidence-based smoking cessation programs.

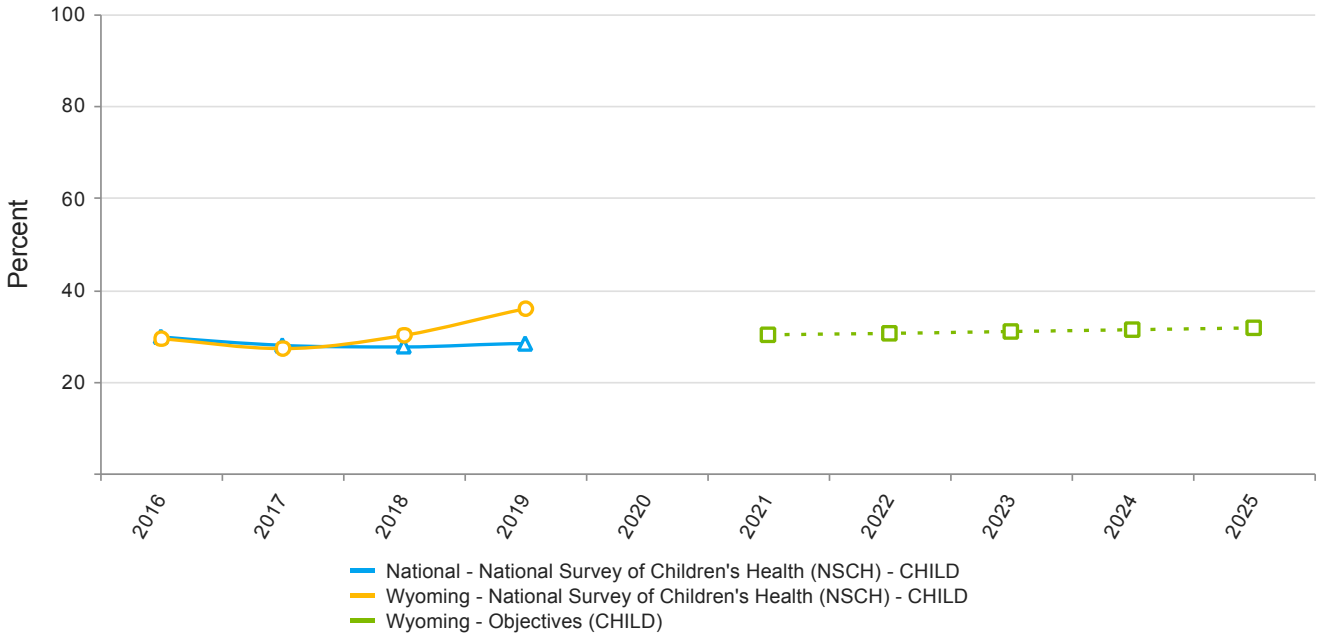
Child Health

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-2018_2019	92.0 %	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-2018_2019	13.7 %	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-2018	10.6 %	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)	YRBSS-2015	11.0 %	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**	**2020**
Annual Objective			
Annual Indicator		30.2	35.8
Numerator		14,688	17,398
Denominator		48,676	48,566
Data Source		NSCH-CHILD	NSCH-CHILD
Data Source Year		2017_2018	2018_2019

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**	**2026**
Annual Objective	30.2	30.5	30.9	31.3	31.7	32.1

Evidence-Based or –Informed Strategy Measures

ESM 8.1.1 - Number of childcare providers receiving training and technical assistance on Wyoming Healthy Policies Toolkit

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	15.0	20.0	25.0	30.0	35.0	40.0

State Performance Measures

SPM 3 - Percent of children (ages 1-9 years old) who should receive at least one visit based on the "periodicity schedule", receiving at least 1 EPSDT visit as noted within CMS 416 report

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	64.2	64.6
Numerator	10,333	9,775
Denominator	16,100	15,130
Data Source	CMS-416 Report	CMS-416 Report
Data Source Year	2018	2019
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	64.2	65.8	67.4	69.0	70.6	72.2

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	
By September 30, 2022 increase the # Childcare Providers receiving orientation training and TA on Wy Health Policies by 25%.	
Strategies	
Continue to promote the Healthy Policies Toolkit and expand outreach for TA to additional licensed childcare facilities.	
ESMs	**Status**
ESM 8.1.1 - Number of childcare providers receiving training and technical assistance on Wyoming 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

SPM

SPM 3 - Percent of children (ages 1-9 years old) who should receive at least one visit based on the "periodicity schedule", receiving at least 1 EPSDT visit as noted within CMS 416 report

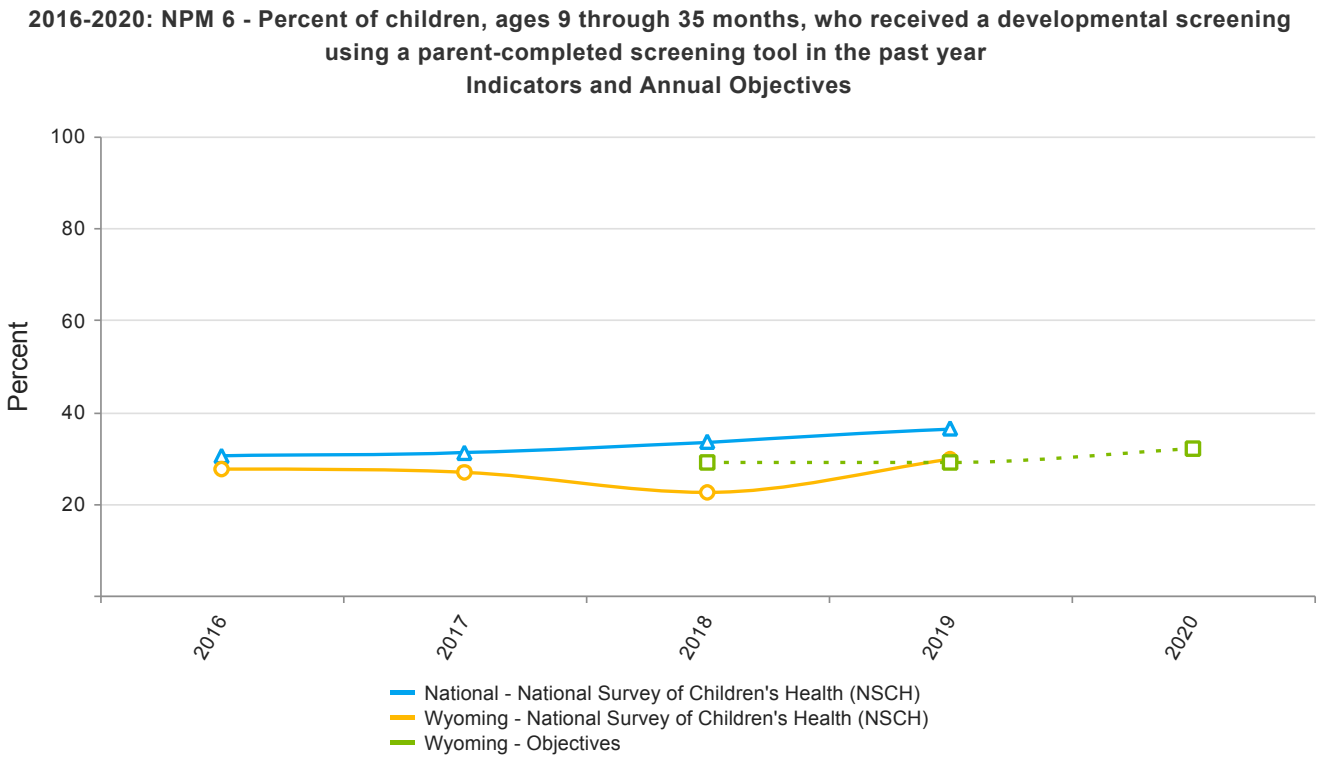
Objectives

By September 30, 2022 implement promotion plan of childhood specific topics developed with the Bright Futures Task force.

Strategies

Promote Bright Futures (4th Ed.) Guidelines for 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. to health care providers and community partners and ensuring providers and community partners are aware that Bright Futures is Wyoming's EPSDT periodicity schedule.

2016-2020: National Performance Measures



Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			29	29	32
Annual Indicator		27.6	27.0	22.5	29.8
Numerator		4,900	4,651	3,759	4,784
Denominator		17,751	17,226	16,730	16,069
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

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**	**2020**
Annual Objective	30	45	60	0
Annual Indicator	39	49	14	0
Numerator				
Denominator				
Data Source	HMG Reports	HMG Reports	HMG Reports	n/a
Data Source Year	2017	2018	2019	n/a
Provisional or Final ?	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**	**2020**
Annual Objective			50	0
Annual Indicator			41	0
Numerator				
Denominator				
Data Source			HMG Reports	n/a
Data Source Year			2019	n/a
Provisional or Final ?			Final	Final

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

Measure Status:			**Active**
State Provided Data			
	2018	**2019**	**2020**
Annual Objective			10
Annual Indicator			12
Numerator			
Denominator			
Data Source			Internal program report
Data Source Year			2020
Provisional or Final ?			Final

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**	**2020**
Annual Objective		20	30	30	29
Annual Indicator	25.3	32.2	13	14.5	28.2
Numerator	22	28	11	12	23
Denominator	86,903	86,855	84,348	83,015	81,466
Data Source	Wyoming Hospital Discharge Data	Wyoming Hospital Discharge Data	Wyoming Hospital Discharge Data	Wyoming Hospital Discharge Data	Wyoming Hospital Discharge Data
Data Source Year	FY 2015	CY 2016	CY17	CY18	CY19
Provisional or Final ?	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**	**2020**
Annual Objective			32	34
Annual Indicator			30.2	35.8
Numerator			14,688	17,398
Denominator			48,676	48,566
Data Source			NSCH	NSCH
Data Source Year			2017-2018	2018-2019
Provisional or Final ?			Final	Final

Annual Report Fiscal Year 2020: This section provides a summary of Federal Fiscal Year 2020 (FFY20) activities, accomplishments, and challenges related to National Performance Measures (NPMs) and State Performance Measures (SPMs) (2016-2020) for the Child Health domain.

Priority	Performance Measure	ESM (if applicable)
Promote Preventive and Quality Care for Children	**NPM 6: Percent of children (10-71 months) receiving developmental screen using a parent-completed tool (National Survey of Children's Health (NSCH))**	**N/A**

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-month, 18-month, 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 the 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.

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 as needed.

PHN launched a new data system in October 2018, increasing the capacity to track ASQ screening implementation as part of the Healthy Baby Home Visitation Program. In FFY20, 2,215 ASQ screenings were completed in partnership between parents/caregivers and PHN staff. This is a large reduction from the previous year, which reported 1,798 ASQ screenings. In addition, in December 2019, WY MCH distributed 17 ASQ kits to five county PHN offices and one medical clinic. The CHP reached out to all county PHN offices to offer additional ASQ kits as needed.

In FFY20, WY MCH continued to focus on the importance of developmental surveillance, screening, and observations through participation as steering committee members for the Wyoming Preschool Development capacity-building grant. WY MCH staff provided subject matter expertise and connection to knowledge leaders. In addition, WY MCH staff participated in weekly needs assessment and strategic planning meetings representing WY MCH. WY MCH leveraged this opportunity to promote AAP Bright Futures recommendations and guidelines as a standard of care for Wyoming families, as well as other related Title V priorities.

WY MCH also maintained active representation on the Governor's Early Childhood State Advisory Council, providing guidance and recommendations to members of the Wyoming early childhood system. This membership provided opportunities to expand partner knowledge of Title V priorities and alignment with other efforts within the early childhood system.

Strategy 2: Promote lead screening

WDH lost funding for a dedicated Environmental Health/Lead Prevention Program in 2014. Due to this absence and the increased interest related to lead exposure, detection, and prevention, 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 to better coordinate messaging, education, screening, and prevention efforts related to lead screening. As one respondent to the 2021 public input survey stated, “Regular lead testing is a must.” Through this work, a draft letter was created to be endorsed by the State Health Officer for publication in the Wyoming Medical Society magazine addressing the need for child lead screening. In early 2020, the work group also began drafting an application to the Centers for Disease Control and Prevention (CDC) Childhood Lead Poisoning Prevention and Surveillance of Blood Lead Levels in Children grant funding opportunity. Unfortunately, due to COVID-19, the letter has not yet been submitted to the magazine and the CDC temporarily suspended the grant opportunity. However, in April 2021, WDH-PHD submitted an application for the CDC Childhood Lead Poisoning Prevention and Surveillance of Blood Lead Levels in Children grant and is waiting for notification of award status. Within the grant application, WDH was authorized to budget for an at-will state position that will focus on statewide lead surveillance and prevention efforts. In addition, the grant application includes a role for WY MCH staff to support provider education and improve linkages of lead-exposed children to recommended services. WY MCH staff coordinated the effort to draft and submit the CDC application.

Strategy 3: Train providers on Bright Futures recommendations

The CHP continued to convene the Bright Futures Implementation Task Force (BFITF) in FFY20 but meetings ended at the start of COVID-19. The BFITF is composed of stakeholders including, but not limited to, Wyoming Medicaid, the Wyoming Medical Society, the Wyoming Primary Care Association, the Wyoming Chapter of the American Academy of Pediatrics, practicing primary care providers, and multiple WDH-PHD programs (e.g. Public Health Nursing, Immunizations). The BFITF adopted the following vision and mission statements:

- Vision: The BFITF envisions a future where all children and their families are provided the information, tools, and resources for optimal growth and development.
- Mission: The BFITF seeks to increase the quality, affordability, and availability of preventive health services for children and families. We strongly value community engagement and collaboration in accomplishing this.

The BFITF identified four primary target areas to focus efforts and potential to establish workgroups over time. These four target areas are:

- Provider Education
- Family / Consumer Education
- Medical Coding
- Access to Care

WY MCH coordinated with AAP to offer a short-term demonstration trial of the AAP Bright Futures virtual toolkit to BFITF members in 2020. After assessing the functionality of the toolkit, WY MCH purchased the licensing rights to distribute virtual toolkit access to any Wyoming provider. Distribution of toolkit licenses was delayed due to COVID-19 but will resume in late 2021. Additionally, WY MCH purchased AAP Bright Futures pocket guides for distribution

to Wyoming providers; WY MCH distributed copies of the pocket guide to all PHN offices as an initial step in evaluating the functionality and usefulness of the tool prior to establishing a larger distribution plan.

To promote consumer awareness about the importance of well-child visits, WY MCH, Wyoming Medicaid, and Wyoming Vital Statistics Services partnered to draft and distribute a letter to all new mothers based on birth certificate data. The letter encourages parents and caregivers to schedule and attend their first well-baby visit and postpartum visit for mother and to continue to follow the recommended well baby and well child visits throughout childhood. In addition, parents and caregivers are introduced to resources that support family knowledge building. The letter referred parents and caregivers to the My 307 Wellness phone application as an important health information resource.

In late 2020, the CHPM and Women and Infant Health Program Manager partnered to draft a Request for Proposal to implement focus groups on four key MCH topic areas including consumer knowledge and understanding of well visit recommendations and Bright Futures, 4th. Edition guidelines. The OMNI Institute was selected to lead this focus group project and will begin work in summer 2021. Results of these focus groups will inform FFY21 and FFY22 Bright Futures consumer education strategies.

Of the May 2021 public input survey respondents who indicated that they have a child age 2-11 in their household, 77.36% indicated that they believe the Child Health Program's focus on sharing more information on Bright Futures with healthcare providers and the public, getting more childcare centers to use the Healthy Policies Toolkit, and childhood blood testing for lead levels fits well or very well with the needs of their family or community.

Priority	Performance Measure	ESM (if applicable)
Prevent Childhood Obesity	**SPM 5: Percent of children ages 6-11 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 to implement evidence-based childhood obesity prevention strategies in early childhood facilities and schools.

WY MCH continued to connect with state-level partners to support the increase in childhood physical activity (SPM5) through the following activities.

WY MCH continued to promote and actively support the Healthy Policies Toolkit and provided TA and training to the University of Wyoming, Cent$ible Nutrition Program. The Cent$ible 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 TA and training reaching 838 children. All CNEs utilize the policy toolkit as a standardized framework to support settings in increasing physical activity and reducing obesity.

Each year, Cent$ible Nutrition conducts a statewide conference for CNEs. The CHPM developed a presentation on the importance of the Healthy Policies Toolkit and implementation considerations. The CHPM was able to present

this information to every Cent$ible Nutrition CNE in FFY20. The CHPM placed primary emphasis on encouraging and supporting Wyoming early childhood education providers to adopt physical activity priorities from the toolkit.

The CHPM also actively participated in a state-level nutrition collaborative, the Wyoming State Nutrition Action Coalition. This group consists of representatives from the University of Wyoming, Wyoming Hunger Initiative, Wyoming Department of Health, Wyoming Department of Workforce Services, Wyoming Department of Education, Wyoming Department of Family Services, and Wyoming chapter of the American Academy of Pediatrics, as well as other applicable invitees depending upon the meeting topic. The CHPM applies a Title V lens to the collective areas of work on hunger, obesity, food sustainability, access, and the promotion of physical activity within the state collaborative.

Of the May 2021 public input survey respondents who indicated that they have a child age 2-11 in their household, 92.45% indicated that they believe it is important or very important to address child obesity in their community.

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

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

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

Based on ongoing and continuous data gathering and needs assessment, WY MCH identified that the burden of childhood injury-related hospitalization and death was on the adolescent population. WY MCH adjusted its focus on the “Prevent Childhood Injury” priority in 2018 to address the emerging topics of adolescent motor vehicle safety and adolescent suicide prevention. As a result of this adjustment, the Youth and Young Adult Health Program (YAYAHP) took on primary leadership of this priority. The CHPM continued to serve as an active member of the Child Safety Network Childhood Injury Learning Collaborative (CSLC).

In spring 2020, the Wyoming CSLC team elected to continue participating in the second cohort of the CSLC. The YAYAHP will utilize membership in the CSLC to support both the Promote Adolescent Motor Vehicle Safety and the Prevent Adolescent Suicide priorities.

Other Programmatic Activities

My 307 Wellness Phone Application

WY MCH staff supported the application developers by serving as subject matter experts and also provided content reviews for their respective population domains. In addition, WY MCH staff served in several leadership and administrative roles in support of expanding public use of this free health resource which provides valuable health information to adolescents, parents, caregivers, and the general public. The My 307 Wellness application also connects Wyoming residents to identify resources within the state.

COVID-19 Response

COVID-19 impacted the CHP's ability to interact with critical partners in support of child-related priorities. For example, statewide closures of early childhood care and education centers impacted partnership with University of Wyoming Cent$ible Nutrition Program and the ability to provide ongoing education and support on the Healthy Policies Toolkit. In addition, the CHPM was one of several WDH-PHD staff partially reassigned to COVID-19 related support and response efforts as a primary call taker for the WDH COVID-19 provider hotline. This shift in staff responsibility impacted the CHP's ability to focus on the Title V identified priorities.

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

Priority	Performance Measure	ESM (if applicable)
Promote Healthy and Safe Children	**NPM 8.1: Percent of children, ages 6 through 11, who are physically active at least 60 minutes** **SPM 3: % of children (ages 1-9 years old) who should receive at least one visit based on the "periodicity schedule", receiving at least 1 EPSDT visit as noted within CM 416 report**	**ESM 8.1.1: # of childcare providers receiving training and technical assistance on Wyoming Healthy Policies Tool Kit.**

Childhood obesity remains 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.

Respondents to the 2021 public input survey echoed the need for a comprehensive approach to healthy children. Their qualitative responses highlighted access to healthy food, safe indoor and outdoor play areas for physical activity, access to pediatric mental health care, and parent education, including around vaccines, nutrition, and screen time, as needs in their communities.

WY MCH will promote healthy and safe children through the following proposed strategies:

1. Continue to promote the Healthy Policies Toolkit and expand outreach to additional licensed childcare facilities through a proposed subaward to the University of Wyoming, Cent$ible Nutrition Program; this subaward will establish a mini-grant program to incentivize 25 or more licensed childcare centers to adopt at least one policy from the Healthy Policies Toolkit. Additionally, WY MCH and Cent$ible Nutrition will work to expand the number of policies adopted at childcare settings that have already integrated some policies.

2. Support state-level expansion of early childhood mental health services through the contribution of funding supporting the statewide Early Childhood Mental Health Consultation Project. This funding will be blended with funding from the Health Resources and Services Administration (HRSA) Preschool Development Birth to Five Grant to expand early childhood mental health service.

3. Continue involvement in statewide childhood blood lead surveillance and prevention efforts. WY MCH

contributed support to the CDC Childhood Lead Poisoning Prevention and Surveillance of Blood Lead Levels in Children 2021 grant award application. The CHP will continue to find areas to educate families on the impacts of childhood lead exposure and the importance of implementation of the American Academy of Pediatrics (AAP) Bright Futures guidelines. The CHP will also conduct consumer education on the comprehensive well child visit and promote Bright Futures resources to Wyoming families.

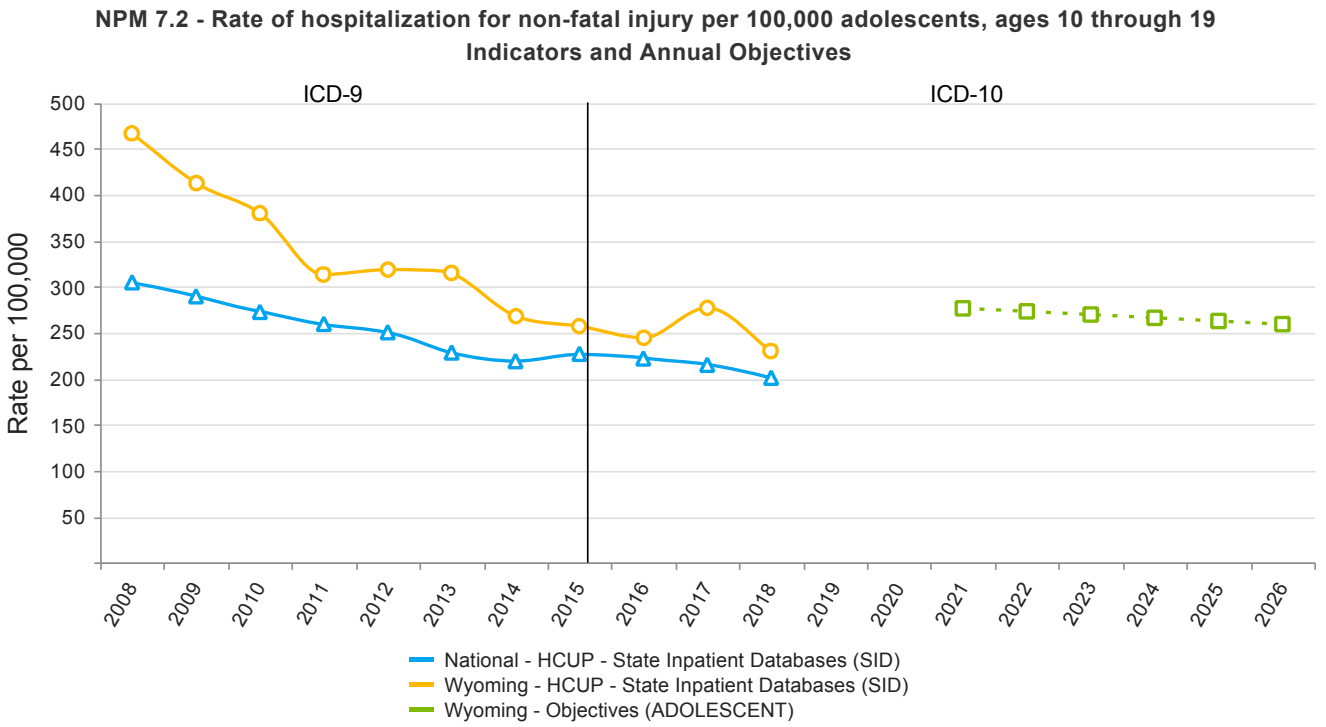
Adolescent Health

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-2019	16.8	NPM 7.2
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS-2019	52.7	NPM 7.2 NPM 10
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS-2017_2019	22.0	NPM 7.2 NPM 10
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2017_2019	32.1	NPM 7.2 NPM 10
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-2018_2019	8.6 %	NPM 10
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2018_2019	54.4 %	NPM 10
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	92.0 %	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-2018_2019	13.7 %	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-2018	10.6 %	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	YRBSS-2015	11.0 %	NPM 10
NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza	NIS-2019_2020	59.0 %	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NIS-2019	59.1 %	NPM 10
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS-2019	90.7 %	NPM 10

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine	NIS-2019	73.9 %	NPM 10
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2019	19.4	NPM 10

National Performance Measures



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	**2020**
Annual Objective		
Annual Indicator	276.4	230.7
Numerator	207	174
Denominator	74,890	75,417
Data Source	SID-ADOLESCENT	SID-ADOLESCENT
Data Source Year	2017	2018

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	276.4	273.1	269.6	266.1	262.6	259.1

Evidence-Based or –Informed Strategy Measures

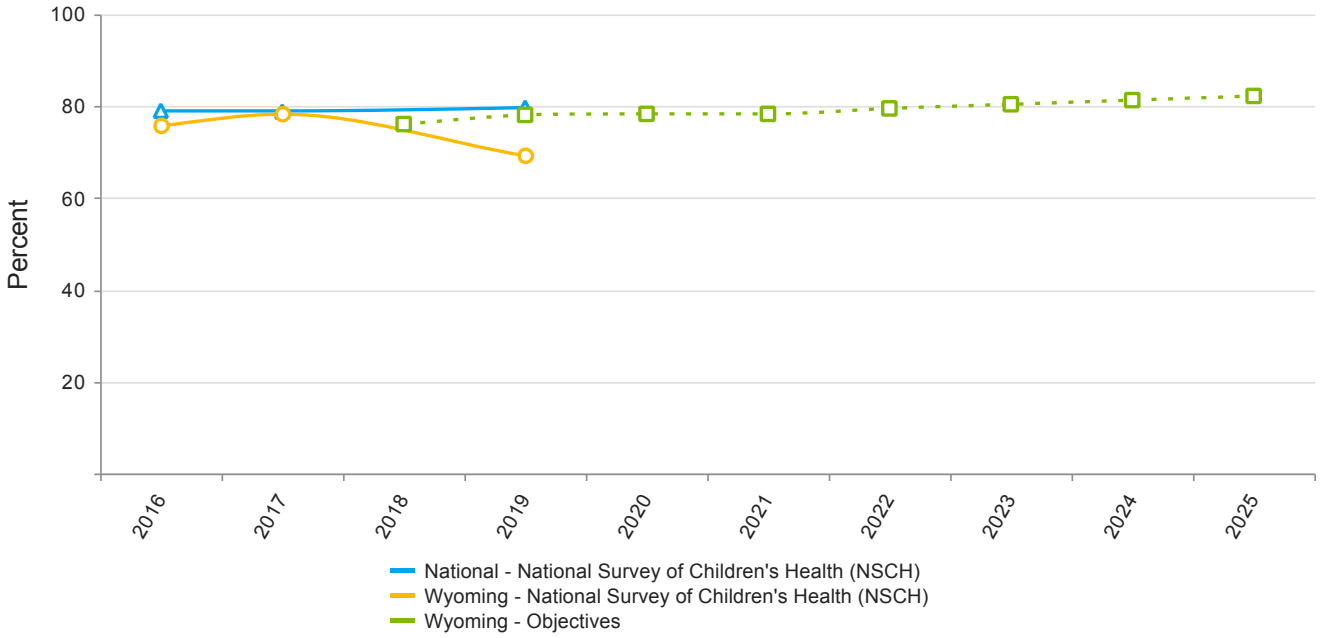
ESM 7.2.1 - Percent of high schools providing Teens in the Driver's Seat

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	3.0	6.0	12.0	18.0	27.0	31.0

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**	**2020**
Annual Objective			76	78	78.2
Annual Indicator		75.7	78.2	78.2	69.1
Numerator		34,569	35,814	35,814	28,695
Denominator		45,669	45,789	45,789	41,524
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2016_2017	2019

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**	**2026**
Annual Objective	78.2	79.4	80.3	81.2	82.1	83.0

Evidence-Based or –Informed Strategy Measures

ESM 10.1 - Percent of Medicaid pediatric providers sending text reminders for annual well visits for 10-19-year-olds linking patients to web-based well visit information

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	15.0	25.0	35.0	40.0	45.0

ESM 10.2 - Wyoming EPSDT rate for 10-20 year olds

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	36.0	40.0	45.0	50.0	55.0

State Performance Measures

SPM 3 - Percent of children (ages 1-9 years old) who should receive at least one visit based on the "periodicity schedule", receiving at least 1 EPSDT visit as noted within CMS 416 report

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	64.2	64.6
Numerator	10,333	9,775
Denominator	16,100	15,130
Data Source	CMS-416 Report	CMS-416 Report
Data Source Year	2018	2019
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	64.2	65.8	67.4	69.0	70.6	72.2

SPM 4 - Percent of Wyoming youth reporting increased youth/adult connectedness

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	84	83
Numerator	20,244	9,047
Denominator	24,099	10,905
Data Source	WY PNA	WY PNA
Data Source Year	2018	2020
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	84.0	86.1	86.1	88.2	88.2	90.3

State Action Plan Table

State Action Plan Table (Wyoming) - Adolescent Health - Entry 1	
Priority Need	
Promote Adolescent Motor Vehicle Safety	
NPM	
NPM 7.2 - Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19	
Objectives	
By September 30, 2022 100% of pilot schools will be implementing Teens in the Driver Seat and a plan with partners will be developed to fund additional schools to implement Teens in the Driver Seat.	
Strategies	
Implement and expand Teens in the Driver Seat in high schools through collaboration with statewide partners.	
Develop MVTS guidelines and materials to promote teen driver safety in adolescent well visits.	
ESMs	**Status**
ESM 7.2.1 - Percent of high schools providing Teens in the Driver's Seat	Active
NOMs	
NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000	
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	

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

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

By September 30, 2022 implemented developed plan new Reminder protocols and develop a plan to implement recommendations based on youth council assessment.

Strategies

Promote the Adolescent well-visit to youth (ages 10-20) through partnership with Medicaid, providers, and the Youth Council.

ESMs	Status
ESM 10.1 - Percent of Medicaid pediatric providers sending text reminders for annual well visits for 10-19-year-olds linking patients to web-based well visit information	Active
ESM 10.2 - Wyoming EPSDT rate for 10-20 year olds	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

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

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

Priority Need

Prevent Adolescent Suicide

SPM

SPM 4 - Percent of Wyoming youth reporting increased youth/adult connectedness

Objectives

By September 30, 2022 Source of Strength is implemented in all school identified as pilot schools.

Strategies

Implement and expand Sources of Strength in Wyoming junior high and high schools.

State Action Plan Table (Wyoming) - Adolescent Health - Entry 4

Priority Need

Prevent Adolescent Suicide

Objectives

By September 30, 2022 100% of clinics participating in the University of Michigan Adolescent Health Initiative to implement Adolescent-Centered Environment-Assessment Process (ACE-AP) focus efforts on Behavioral Health Clinical Practices.

Strategies

Improve the ability and capacity of Wyoming clinics to provide mental health screening and care to adolescents in continued partnership with the University of Michigan Health Initiative to implement Adolescent-Centered Environment-Assessment Process (ACE-AP).

Annual Report Fiscal Year 2020: This section provides a summary of Federal Fiscal Year 2020 (FFY20) activities, accomplishments, and challenges related to National Performance Measures (NPMs) and State Performance Measures (SPMs) (2016-2020) for the Youth and Young Adult Health Program (YAYAHP).

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 to 21, as this may help adolescents adopt and 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.

Over the last five years, the YAYAHP has made progress on improving the adolescent well-visit experience and providing information on healthy and safe relationships to adolescents in Wyoming. After participation in the Adolescent and Young Adult Health Collaborative Improvement and Innovation Network (AYAH COIIN), the YAYAHP and partners identified the Adolescent Centered Environment Assessment Process (ACE-AP) as a strategy to increase and improve adolescent well-visits. As of FFY20, six clinics have participated in the ACE-AP, and the YAYAHP plans to continue the program and offer the opportunity for participation to another round of adolescent-serving clinics. Based on the ACE-AP self assessment, the first cohort of clinics each saw improvement in at least six of the twelve indicator categories, and two of those clinics saw 50% improvement in several indicator categories. The number of sites (e.g. public middle and high schools and youth-serving community organizations) regularly implementing YAYAHP-supported sexual health curricula to adolescents doubled, from five sites in FFY16 to ten sites in FFY20. The YAYAHP experienced turnover during the last five years, and the current program manager onboarded in December 2020.

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 ACE-AP within six pilot clinics between 2018 and 2020. The ACE-AP is a facilitated, comprehensive self-assessment and guided improvement process that includes customized resources, recommendations, technical assistance, and implementation plans using Plan, Do, Study, Act improvement cycles. The ACE-AP addresses 12 indicator categories of adolescent-centered care, listed below along with the number of clinics that chose to work in each category:

- Access to Care (5 of 6 clinics)
- Adolescent Appropriate Environment (6 of 6 clinics)
- Confidentiality (6 of 6 clinics)
- Best Practices and Standards of Care (6 of 6 clinics)
- Reproductive and Sexual Health (6 of 6 clinics)
- Behavioral Health (5 of 6 clinics)

- Nutritional Health (5 of 6 clinics)
- Cultural Responsiveness (4 of 6 clinics)
- Respectful Treatment (4 of 6 clinics)
- Adolescent Involvement and Empowerment (4 of 6 clinics)
- Parent Engagement (4 of 6 clinics)
- Community Engagement and Outreach (1 of 6 clinics)

In 2020 (late spring for clinic 1 and late fall for clinic 2), the second cohort of two clinics completed a baseline self-assessment of their organizations' environment, policies, and practices related to youth-friendly services to identify opportunities for improvement. Then, they met with the University of Michigan to identify and implement quality improvement initiatives. Clinics are eligible to receive up to $2,000 to implement changes 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 assure ongoing quality improvement and evaluation, each clinic collected staff and provider surveys assessing the extent to which the clinic provides a youth-friendly environment and adolescent-centered care. All four clinics reported up to 50% improvement in "[Using] positive body language and an approachable, warm tone in communicating with adolescents" and "[Using] sensitivity and maintain[ing] neutral language and body language with adolescents, [and] withholding judgment related to sensitive subjects, such as sexual health, substance use, interpersonal violence, gender and personal expression, and mental health."

The first cohort of four clinics completed mid-year and end-of-year self-assessments in 2019. The ACE-AP offers a certification at three levels - bronze, silver and gold - if a clinic scores "Fully Implemented" in 10 (bronze), 11 (silver), or 12 (gold) pre-identified clinic measures. Clinics that do not achieve certification do so either because they are unable to achieve a "Fully Implemented" score in the necessary pre-identified measures, or because the clinic chose not to focus on implementing those pre-identified measures as part of their ACE-AP. Of the four first-cohort clinics, three achieved the following certifications:

- Bronze-Level certification: 2 clinics
- Silver-Level certification: 1 clinic
- Gold-Level certification: 0 clinics

All four first cohort clinics saw improvement in at least six areas, and three of the clinics improved in at least ten areas.

One common need identified across all six participating ACE-AP 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.

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.

The COVID-19 pandemic significantly impacted the second cohort's ability to focus on environmental improvements. The YAYAHP extended the timeline for the second cohort's participation in the ACE-AP to accommodate clinics' need to focus on safety modifications to continue to offer medical care in the midst of the pandemic.

The YAYAHP anticipates releasing a mini-grant Request for Application (RFA) to recruit the third cohort of clinics to implement the ACE-AP model, with a focus on improving adolescent mental health screening and care. This new focus will support one of the new priorities identified for the 2021-2025 grant cycle identified and discussed further below.

Strategy 2: Develop statewide Youth Council to assure 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. One council member shared, "I joined [the Wyoming Youth Council] because I believe this council could have an impact on the lives of youth and young adults in Wyoming. I

want [the Youth Council] to develop strong community partners and to hear from other youth and young adults in Wyoming to get a grasp on the concerns they have. From there, the possibilities are endless."

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 assure ongoing collaboration and information sharing on best practices and emerging issues related to youth and young adults ages 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, after which membership recruitment activities took place. The Youth Council had its first meeting in July 2020 with 14 adolescent members aged 18-24, representing a range of educational attainment; racial, ethnic, and gender identities; and socio-economic standing. The council meets virtually every other week to discuss current projects and hear from organizations and agencies across Wyoming that are currently engaging in activities to promote youth wellness, and recently launched a website to engage young adults across the state.

Priority	Performance Measure	ESM (if applicable)
Promote Healthy and Safe Relationships for Adolescents	**SPM: % of high schoolers reporting zero 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.

WY MCH has used the Collective Impact Model to frame activities for this priority. 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 following strategies related to this priority were funded with Title V Block Grant, Rape Prevention and Education (RPE) Program grant, Preventive Health and Health Services (PHHS) Block Grant, and the State Personal Responsibility Education Program (PREP) grant.

Strategy 1: Complete Request for Proposal 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 for Wyoming. WY MCH contracts with the Wyoming Coalition against Domestic Violence and Sexual Assault (WCADVSA) to support RPE-funded activities in Wyoming communities. The target audience for this work is adolescents ages 12-24. From February 2019 through December 2020, two communities were funded through this grant to conduct primary prevention in their local communities with a shared risk and protective factors approach. One of these communities implemented Coaching Boys into Men and Athletes as Leaders for at least 50 student athletes. These programs teach adolescent athletes about healthy masculinity and how to be leaders in creating cultures of safety and respect. The other funded community includes the Wind River Reservation, and has focused on supporting culturally-specific youth engagement activities.

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.

The pilot community program will continue with RPE funds, but will no longer be a primary focus of Title V funding during the FFY21-25 cycle.

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

The YAYAHPM serves as a Steering Committee member 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 workgroups continue to develop strategic goals and work towards statewide shared Collective Impact efforts for sexual violence prevention. In July 2020, the WSVPC met virtually with 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) and focused on supporting members in adapting to COVID-19, including ways to continue to engage in prevention work online and in socially-distanced environments.

The WSVPC will continue with RPE funds, but will no longer be a primary focus of Title V funding during the FFY21-25 cycle.

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. 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 FFY20: seven school districts; two community-based, youth-serving organizations; and the Wyoming Institute for Disabilities. Starting in the 2017-2018 school year to present (2017/2018, 2018/2019, 2019/2020, and fall semester 2020), WyPREP reached over 2,250 Wyoming youth.

COVID-19 significantly impacted the provision of sexual health curricula for most of the 2020 calendar year. Many sites paused curriculum delivery entirely during the first half of 2020 while they adjusted to hybrid or remote learning schedules (for schools) or to public health orders prohibiting or severely limiting in-person gatherings (community

organizations). Several sites were able to adapt their curricula to remote delivery, and other sites returned to in-person delivery late in 2020 as health mitigation measures allowed schools to return to in-person learning and community organizations to again host in-person gatherings.

Strategy 4: Develop and maintain statewide Youth Council to assure youth voices are included in program development, implementation, and evaluation

See the Promote Preventive and Quality Care for Adolescents priority, Strategy 2 above.

Annual Report Fiscal Year 2020 Supplement: *This section provides an interim update for Federal Fiscal Year 2021 (FFY21) activities currently in process for the YAYAHP.*

After the summer 2020 needs assessment, the YAYAHP identified new priorities for the adolescent domain:

- **Promote Adolescent Motor Vehicle Safety**
    - Measures include NPM 7.2: Rate of hospitalization for non-fatal injury per 100,000 adolescents ages 10-19.
    - New strategies include collaborating on evidence-based strategies for adolescent motor vehicle safety promotion; implementing Teens in the Driver's Seat, a peer-to-peer traffic safety education program; and developing motor vehicle safety guidelines to provide to patients and parents at adolescent well-visits.
- **Prevent Adolescent Suicide**
    - Measures include NPM 10: % of adolescents ages 12-17 with a preventive medical visit in the past year.
    - New strategies include improving adolescent mental health screening and care in clinical settings and implementing Sources of Strength, a social-emotional learning program, in Wyoming middle and high schools.

Work on these new priorities combine new strategies and continuing strategies with an updated focus. Continuing strategies include:

- Implement adolescent-centered environment assessment process (ACE-AP) in Wyoming clinics to improve adolescent-friendly environment
    - The ACE-AP, coupled with new strategies to increase adolescent well visits, will support the **Prevent Adolescent Suicide** priority. Two clinics currently mid-process will complete the program, and the YAYAHPM will release a new RFA to solicit new clinics to complete the ACE-AP as well as engage in additional activities to increase adolescent well visits and mental health screening.
- Develop statewide Youth Council to assure youth voices are included in decisions related to program development, implementation, and evaluation
    - The Youth Council convened for the first time in the summer of 2020, and is currently meeting biweekly to learn about and discuss a range of issues impacting adolescent health and wellness. The Youth Council will support both the **Promote Adolescent Motor Vehicle Safety** and the **Prevent Adolescent Suicide** priorities, and the YAYAHP will also support the expansion of the Youth Council to engage adolescents between the ages of 12 and 17. Youth council members have connected to statewide initiatives on priorities identified by the Youth Council, to provide the youth voice to those initiatives and council members and the facilitator have participated in professional development opportunities as attendees and presenters.
- Participate in the Child Safety Learning Collaborative
    - In spring 2020, the Wyoming team decided to participate in the second cohort of the Child Safety Learning Collaborative (CSLC), a program of the Child Safety Network. The CSLC provides support

to Title V programs to 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. The YAYAHP will utilize membership in the CSLC to support both the **Promote Adolescent Motor Vehicle Safety** and the **Prevent Adolescent Suicide** priorities.

In addition to the new priorities, the YAYAHP will continue activities from the FY19 priority **Promote Healthy and Safe Relationships for Adolescents** under the Personal Responsibility Education Program (PREP) and the Rape Prevention Education Program (RPE).

Other YAYAHP Activities:

New Program Manager

WY MCH hired and onboarded a new Program Manager for the Adolescent domain in December 2020.

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
- Students Against Destructive Decisions (SADD)
- Wyoming Children's Trust Fund
- Wyoming Department of Education
- Wyoming Highway Patrol
- Wyoming Department of Transportation
- Wyoming Medicaid
- UPLIFT
- Wyoming County Prevention Specialists
- Office of Health Equity of WDH
- Injury and Violence Prevention Program of WDH
- Communicable Disease Unit of WDH
- Immunization Unit of WDH
- Wyoming Division of Victim Services

Campus Consortium

The Campus Consortium (comprised of the University of Wyoming and Wyoming's eight community colleges), YAYAHP, WSVPC, and WCADVSA have worked to assure primary sexual violence prevention information is shared and technical assistance is provided. 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.

MCH Community Mini-Grant Program

In FFY20, the YAYAHP closed out two community mini-grants focused on adolescent injury prevention. In collaboration with the Child Health Program, YAYAHP funded seven community mini-grants with a focus on childhood injury prevention in summer 2019; two of these mini-grants specifically focused on adolescent needs.

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 offers training in adverse childhood experiences (ACEs) to

their own 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 Campbell County. Sessions were provided to over ten agencies/organizations, including local schools and prevention councils.

Campbell County School District (CCSD) implemented school HOPE Squads as an adolescent suicide prevention strategy. 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. CCSD conducted branding, marketing, and other events/activities in the community and within schools to promote the HOPE Squads and create a safe and non-threatening environment for all students.

WYOMING CAN Mini-Grant

With funding from the CDC to help advance the RPE goal of preventing sexual violence perpetration and victimization, the YAYAHP developed and released an RFA for Wyoming organizations to support the implementation of community/societal-level primary sexual violence prevention strategies.

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. The tool, which was developed because Wyoming no longer participates in the YRBSS, is informed by the CDC's "Connecting the Dots" strategic vision 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 tool 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 Sexual Attitudes survey
4. Rape myth acceptance
5. Intimate partner violence/relationship control myths - dating and social norms items validated
6. Connectedness - school/teacher/families connectedness scales
7. Sexual assault and intimate partner violence perpetration - YRBSS victimization and perpetration items
8. Bystander intent and behavior - Coaching Boys Into Men items

In April 2020, two applicants were selected to receive funding; they used 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. One applicant funded an evidence-based bystander intervention program targeted at college students and was able to offer that program online as a COVID-19 adaptation. The other applicant expanded access to an evidence-based parent-teen communication and support program.

YAYAHPM Memberships

The YAYAHPM has remained an active member of AMCHP. As a member of PHD'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. The YAYAHPM is an active participant in the National Network of State Adolescent Health Coordinators (NNSAHC).

COVID-19 Response

The YAYAHP launched a social media campaign during summer (June-August) 2021 to inform adolescents of available intervention and support resources for adolescents who are experiencing suicidal ideation or suffering from other mental health concerns, including depression and anxiety.

Adolescent Health - Application Year

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

Priority	Performance Measure	ESM (if applicable)
Promote Adolescent Motor Vehicle Safety	**NPM 7.2: Rate of hospitalization for non-fatal injury per 100,000 adolescents ages 10-19**	**ESM 7.2.1: % of high schools providing Teens in the Driver's Seat**

The Wyoming 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 2017-2019 adolescent MVT mortality rate for 15-19-year-olds is 22.0/100,000, almost double the U.S. 2017-2019 rate of 11.2/100,000.

Work during FFY21 so far has allowed the YAYAHP to refine strategies for this priority based on conversations with key partners and stakeholders, and additional review of continuing strategies.

Of the May 2021 public input survey respondents who indicated that they have a teen or young adult age 12-24 in their household, 96.15% indicated that they believe the Youth and Young Adult Health Program's recent and planned work, including around motor vehicle traffic safety, fits well or very well with the needs of their family or community.

In FFY21, the YAYAHP will implement the following strategies to address NPM 7.2 within the Adolescent Motor Vehicle Mortality Prevention priority:

1. Facilitate collaborative efforts to strengthen partnerships across entities with a focus on implementing evidence-based strategies to reduce adolescent MVT mortality.

    1. The YAYAHP is joining transportation and safety professionals who have been working for several years on reducing adolescent motor vehicle crashes and related injuries and fatalities. One-on-one conversations with these professionals have identified opportunities to bring additional evidence-based interventions to work already occurring statewide to address this priority, and YAYAHP intends to provide information and support to our transportation and safety partners to incorporate these additional evidence-based practices into existing efforts. Additionally, the YAYAHP will identify ways to support current evidence-based practices in Wyoming, including broadening parent and new driver knowledge of Graduated Driver's License requirements and restrictions.

2. Implement Teens in the Driver's Seat (TDS) in a high school setting.

    1. The YAYAHP will pilot the TDS peer learning program in up to five high schools in Wyoming, with a focus on increasing correct seat belt usage. The most recent crash report (2019) from the Wyoming Department of Transportation (WYDOT) showed that for all crashes in Wyoming, 5% of the occupants involved (driver or passenger of all ages) either misused or did not use seatbelts, 46% of fatalities

among occupants in fatal crashes were not wearing seatbelts or were wearing them incorrectly, and 39% of the occupants who sustained serious injuries were not using seatbelts or were using them incorrectly. If the pilot demonstrates a positive impact, the YAYAHP will collaborate with partners to expand the TDS program to include additional high schools across the state.

3. Develop motor vehicle traffic safety (MVTS) guidelines and materials to promote teen driver safety in adolescent well visits.

    a. The YAYAHP will work with transportation and safety professionals and the state Youth Council to develop materials educating new adolescent drivers and their parents and guardians on important safety considerations. These materials will be distributed to pediatric and family practice clinics to provide to adolescents and their parents at well visits that coincide with the adolescent beginning driver's education or receiving a driver's license.

Priority	Performance Measure	ESM (if applicable)
Prevent Adolescent Suicide	**NPM 10: % of adolescents ages 12-17 with a preventive medical visit in the past year** **SPM TBD: % of Wyoming youth reporting increased youth-adult connectedness**	**ESM 10.1: % of Medicaid pediatric providers sending text reminders for annual well visits for 10-19-year-olds linking patients to web-based well visit information** **ESM 10.2: Wyoming EPSDT rate**

The Wyoming adolescent suicide rate is significantly higher than the U.S. rate and has been since 2007. Both the U.S. and Wyoming adolescent suicide rates have increased; however, the Wyoming rate is increasing at a faster 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, prevent disease, and identify emerging health concerns.

Of the May 2021 public input survey respondents who indicated that they have a youth or young adult aged 12-24 in their household, 96.30% indicated that they believe it is very important or important to address how comfortable youth feel talking to adults about difficult issues in Wyoming, with one respondent sharing that "the need for connection and belonging should continue to be addressed." Another survey respondent expressed that, "We are seeing a big increase of suicidal ideation and attempts in our community. I feel Wyoming in general handles adolescent mental health issues poorly because it seems like there [aren't] enough discussion, education, or resources for them."

May 2021 public input survey respondents also shared that for many, access to mental health care services for

adolescents is an ongoing challenge. One respondent expressed, “We desperately need more mental health services. Our local agency has a three month waiting list right now. There is an agency from out of town and they are scheduled two months in advance.” Of the May 2021 public input survey respondents who indicated that they have a teen or young adult age 12-24 in their household, 96.15% indicated that they believe the Youth and Young Adult Health Program’s recent and planned work, including around teen mental health and suicide prevention, fits well or very well with the needs of their family or community. In their qualitative responses, multiple survey respondents specifically called out the need for more focus to be put on LGBTQ+ adolescents in order to help them feel included and protected.

In FY21, the YAYAHP will review possible strategies to identify barriers to mental health care and support access to care, and may include an additional strategy related to mental health care access for FY22.

Work to date has allowed the YAYAHP to refine strategies for this priority based on conversations with key partners and stakeholders, and additional review of continuing strategies.

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

1. Improve the ability and capacity of Wyoming clinics to provide mental health screening and care to adolescents.
    a. The YAYAHP will continue to offer the ACE-AP to pediatric and family practice clinics, but will prioritize improvement in the behavioral health measures. Additionally, the YAYAHP will solicit adolescent-serving behavioral health clinics to participate in the ACE-AP to improve services for adolescents receiving mental health care. YAYAHP will also encourage the adoption of Bright Futures adolescent guidelines, including identifying and providing access to at least one evidence-based mental health screening tool.

2. Support providers in retaining and encouraging adolescent well visits.
    a. The YAYAHP will identify evidence-based strategies to improve adolescent well-visit rates overall, with the goal to increase mental health screening and referrals to mental health care for adolescents. The YAYAHP will work with the newly established state Youth Council to identify possible barriers to attending visits, effective messaging to encourage visits, and appropriate outlets to reach adolescents with information about the importance of well visits. The YAYAHP will work with Medicaid and providers to explore evidence-informed approaches to increasing well visits, including updated office scheduling practices and targeted outreach to adolescents.

3. Implement and expand Sources of Strength (SoS) in Wyoming junior high and high schools.
    a. The YAYAHP will support the implementation with fidelity of SoS, an evidence-based social-emotional learning program evaluated for middle and high school students to reduce suicidal ideation, suicide attempts, and deaths by suicide. SoS is currently in place in at least one school each in ten counties in Wyoming, and the YAYAHP will both support the expansion of the program to additional schools and counties, and support existing school programs in delivering the program with fidelity. The YAYAHP will partner with the WDH Injury and Violence Prevention Program and local Community Prevention Specialists in extending the impact of SoS in Wyoming.

Other Programmatic Activities

Sexual Violence Prevention

The YAYAHPM is also the RPE Director for Wyoming. The YAYAHP uses RPE and Preventive Health and Health Services Block Grant funds to support health relationship and sexual violence prevention programs in Wyoming. These programs use approaches that specifically address healthy relationships and violence prevention, and support shared risk and protective factors (such as adult-youth connectedness) that also support Title V priorities, including adolescent suicide prevention and adolescent motor vehicle safety promotion.

WyPREP

The YAYAHPM is also the Wyoming PREP (WyPREP) Manager for Wyoming. The YAYAHP uses WyPREP funds to support the provision of evidence-based reproductive health curricula to adolescents in school and community settings across Wyoming. WyPREP also supports addressing shared risk and protective factors (such as parent-child connectedness) that also support Title V priorities, including adolescent suicide prevention and adolescent motor vehicle safety promotion.

Children with Special Health Care Needs

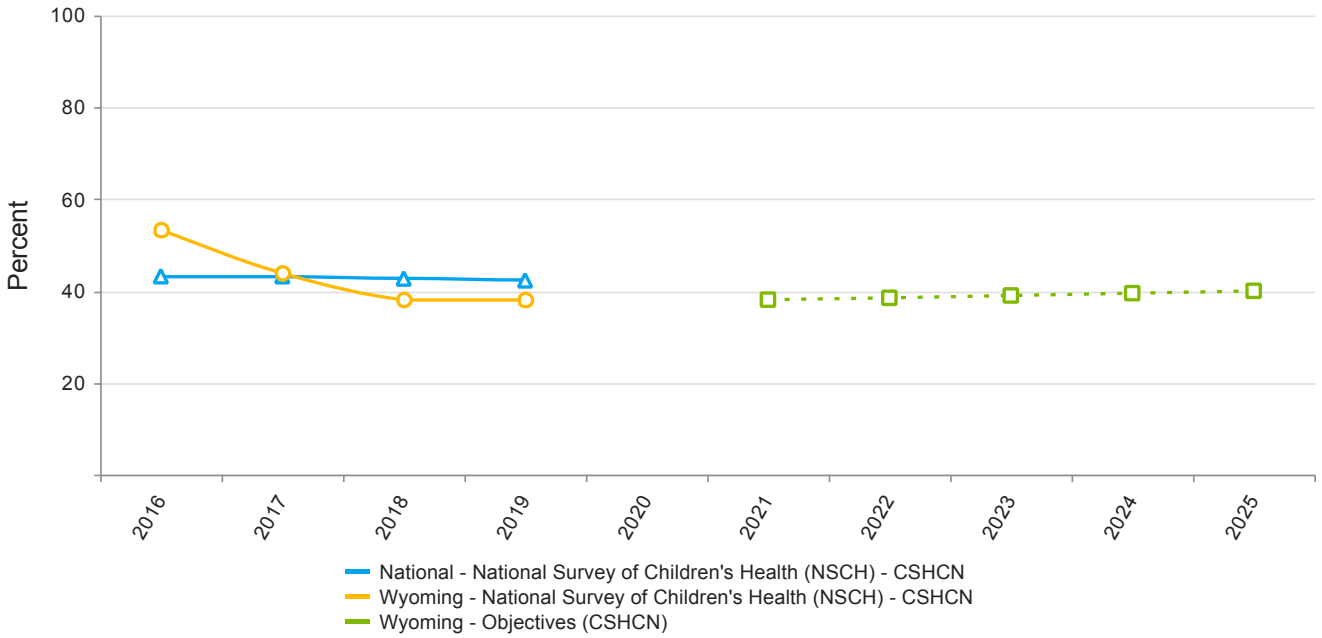
Linked National Outcome Measures

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-2018_2019	8.6 %	NPM 11 NPM 12
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2018_2019	54.4 %	NPM 11
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	92.0 %	NPM 11
NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year	NSCH-2018_2019	4.5 %	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**	**2020**
Annual Objective			
Annual Indicator		38.1	37.9
Numerator		10,270	9,240
Denominator		26,977	24,351
Data Source		NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2017_2018	2018_2019

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	2026
Annual Objective	38.1	38.5	39.0	39.5	40.0	40.5

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	50.0	50.0	50.0	50.0	50.0	50.0

ESM 11.2 - Complete assessment of National Standards for Systems of Care for CYSHCN

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

ESM 11.3 - Develop an Action Plan based on results of National Standards Assessment

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

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	
By September 30, 2022 implement plan to address gaps identified by the National Standards for Systems of Care Assessment.	
Strategies	
Improve upon the Wyoming CSH program to reach more families to provide gap-filling financial assistance, and better meet the National Standards for Systems of Care of CYSHCN.	
ESMs	**Status**
ESM 11.1 - Percent of CSH Advisory Council members with lived experience	Active
ESM 11.2 - Complete assessment of National Standards for Systems of Care for CYSHCN	Active
ESM 11.3 - Develop an Action Plan based on results of National Standards Assessment	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 unable to obtain needed health care in the past 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

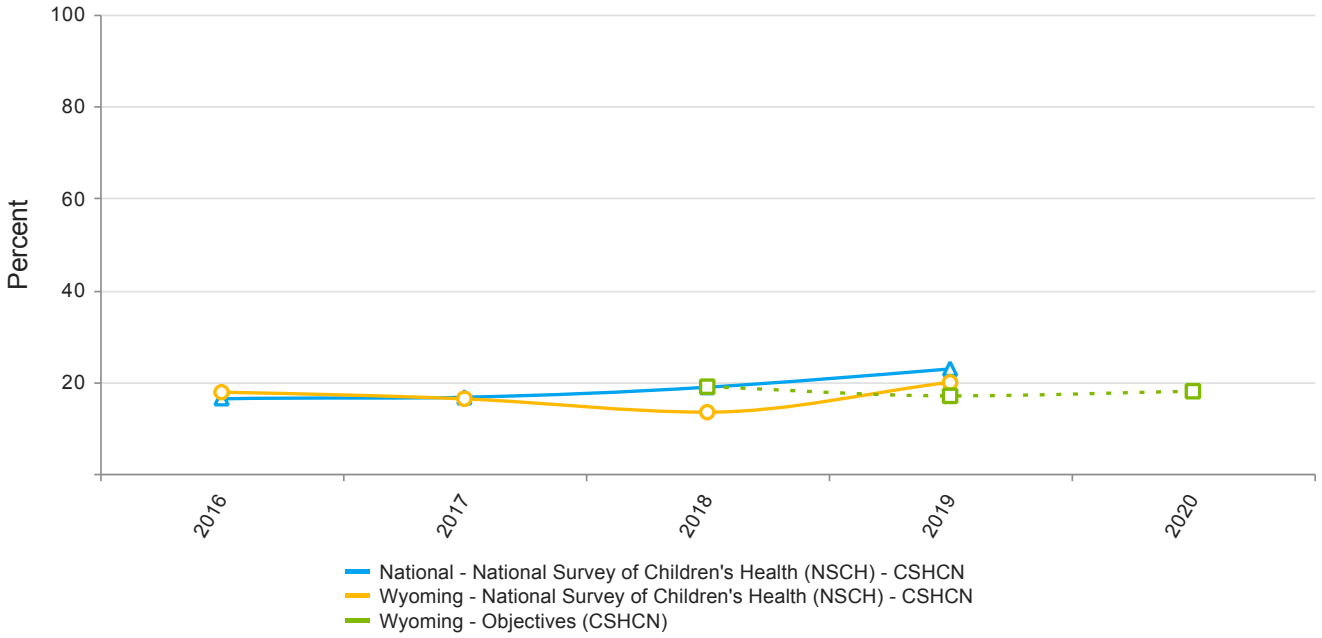
By September 30, 2022 have at least 50% of the CSH Advisory Council members with lived experience.

Strategies

Convene a CSH Advisory Council with the goal of including members with lived experience to support statewide collaboration, parent education, and provider education around patient/ family centered medical home and other CYSHCN related topics.

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 to prepare for the transition 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**	**2020**
Annual Objective			19	17	18
Annual Indicator		17.9	16.5	13.4	19.8
Numerator		2,073	2,119	1,872	2,365
Denominator		11,609	12,855	13,940	11,948
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018	2018_2019

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**	**2020**
Annual Objective			45	47
Annual Indicator			49	25
Numerator				
Denominator				
Data Source			CSH Program Data	CSH Program Data
Data Source Year			FFY19	FFY20
Provisional or Final ?			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**
State Provided Data			
	2018	**2019**	**2020**
Annual Objective			45
Annual Indicator		46.6	47.6
Numerator		64,636	64,074
Denominator		138,743	134,702
Data Source		NSCH	NSCH
Data Source Year		2017-2018	2018-2019
Provisional or Final ?		Final	Final

Annual Report Fiscal Year 2020: This section provides a summary of Federal Fiscal Year 2020 (FFY20) activities, accomplishments, and challenges related to National Performance Measures (NPMs) and State Performance Measures (SPMs) (2016-2020) for the Children and Youth with Special Health Care Needs (CYSHCN) domain.

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

The percentage of Wyoming children with special health care needs able to identify a medical home was 37.9% during 2018-2019, similar to the U.S. percent of 49.7% (NSCH, 2018-2019). 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. The Children's Special Health (CSH) Program continued to focus efforts on increasing the number of children and families receiving care in a medical home but made important programmatic shifts in FFY20 in response to the 2020 needs assessment.

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

The Wyoming Parent Partner Project (PPP) The Wyoming Parent Partner Project (PPP), funded by WY MCH through a contract with the Hali Project,helped medical clinics identify and hire a parent who has a child with special health care needs, called Parent Partners, within their practice. The Parent Partners worked as peer mentors to support families and provide many of the elements of a patient-centered medical home. Parent Partners received $15 per hour.

Through the 2020 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.

Strategy 2: Provide Care Coordination Services to Eligible Clients

Care coordination remained a central priority of the CSH program in FFY20 as state-level Benefit and Eligibility Specialists and local-level public health nurses continued to provide care coordination services to children and youth with special health care needs. As the payer of last resort, the CSH Program also continued to provide gap-filling financial assistance to Wyoming families in three sub-programs: the Children's Special Health Program (CSH), Maternal High-Risk Program (MHR), and Newborn Intensive Care Program (NBIC).

CSH provides services to children and youth (ages 0-18) with special health care needs who have, or are at increased risk for, a chronic physical, developmental, behavioral, or emotional condition, and who require health and related services of a type or amount beyond that required by children generally. Currently, CSH clients must meet both medical and financial eligibility to receive gap-filling financial assistance; however, the program encourages public health nurses to serve families of CYSHCN in need of care coordination services only, even if they narrowly miss eligibility requirements for gap-filling financial assistance. In FFY20, CSH provided services to 449 eligible

CSH clients, compared to 530 eligible CSH clients in FFY19. The decrease is likely due to COVID-19.

MHR serves Wyoming women experiencing high-risk pregnancies that receive Level III obstetric and maternity care services and/or deliver in a Level III facility. In FFY20, WY MCH provided services to 17 eligible MHR clients, compared to 24 eligible MHR clients in FFY19.

NBIC services are available to high-risk infants who are delivered at, or transferred to, an out-of-state Level III nursery, such as in Fort Collins, CO; Denver, CO; Salt Lake City, UT; and Billings, MT. In FFY20, CSH provided services to 74 eligible NBIC clients, compared to 83 eligible NBIC clients in FFY19.

CSH also provides up-front emergency travel assistance to Wyoming families enrolled in Medicaid, as well as to non-Medicaid families enrolled in one of the three CSH sub-programs. In FFY20, CSH processed ten emergency travel or lodging requests. Some of these requests arose as a result of COVID-19 and its impact on the pre-existing support network in place (i.e. Ronald McDonnald House closures).

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

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 decreased 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 AAP, optimal health and access to health care are key barriers impacting successful transition to adult care. In 2018-2019, 19.8% of CSHCN ages 12-17 in Wyoming were reported to have received the services necessary to transition to adulthood, compared to 23.0% of non-CSHSCN ages 12-17 in Wyoming (NSCH).

Strategy 1: Train CSH nurses on how to conduct a transition readiness assessment

The CSH Program and the YAYAHP continued to focus on the use of the WY MCH transition readiness assessment and toolkit. A transition readiness assessment was sent to all enrolled CSH clients ages 14-19 and their caregivers, along with transition readiness letters as part of the programmatic annual update process. The distribution and completion of transition readiness assessments was impacted by the program's need to adjust as a result of the COVID-19 pandemic. CSH and PHN elected to suspend the requirement that all people enrolled in the CSH Program complete an annual client eligibility review. Unfortunately as a result of the suspension of this requirement, it was not possible to distribute transition tools; however, WY MCH deemed CSH clients' uninterrupted coverage during the pandemic to be a higher priority. The CSH Program received 70 completed transition readiness assessments in FFY20 and suspended distribution and processing of these assessments after July 2020 in response to COVID-19. It should be noted that CSH only received 49 completed transition assessments in FFY19, so although COVID-19 impacted this strategy, it did not reduce overall numbers.

All new PHNs continue to receive training on the transition toolkit upon hire.

Annual Report Fiscal Year 2020 Supplement: *This section provides an interim update for Federal Fiscal Year 2021 (FFY21) activities currently in process for the CYSHCN Program.*

After the summer 2020 needs assessment, the CSH Program identified a new priority for the CYSHCN domain, Improve Systems of Care for CYSHCN. The selected NPM is NPM11, percent of children with and without special health care needs, ages 0 through 17, who have a medical home. New strategies include completing the National Standards to Improve Systems of Care for CYSHCN Comprehensive Assessment Tool, followed by the development of a CSH Program action plan informed by assessment findings. All early work connected to the National Standards to Improve Systems of Care for CYSHCN has been supported through MCHB-provided TA from a national leader in CYSHCN systems improvement work. Meredith Pylebegan supporting CSH staff and WY MCH in late 2020 to build internal workforce capacity around the National Standards to Improve Systems of Care for CYSHCN. Ms. Pyle also supported unit staff in completing the National Standards to Improve Systems of Care for CYSHCN Single Organization assessment tool. Additionally, she trained WY MCH how to administer this tool to current and future partners.

Other Programmatic Activities

High-Risk Pregnant Women and Infants

The CSH Program continues to also serve high-risk pregnant women and newborns receiving care from an out-of-state provider trained to care for high-risk clients. Structurally, the CSH Program contains 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 teams to connect families to needed resources. In some cases, CSH also provides financial and travel assistance to families.

In FFY20, the CSH Program overall actively served 540 clients, which is a decline of 100 clients from FFY19. Of these clients, 449 were CYSHCN covered by the CSH sub-program, 74 were high-risk infants served by the NBIC sub-program, and 17 were high-risk pregnant women served by the MHR sub-program.

Genetic Clinics

The Wyoming Genetic Program, in partnership with the University of Utah, held both in-person and telehealth clinics in Cheyenne, Casper, and Riverton. In FFY20, this program served 37 clients in-person and 12 clients through telehealth. Telehealth appointments were reserved primarily for follow-up appointments, while in-person appointment times were for new patients.

The Genetic Program released an RFP for genetic clinic services in late 2020. It was awarded to the University of Colorado/Colorado Children's Hospital. This contract is to continue genetic services in Cheyenne, Casper, and Riverton via in-person clinics and telehealth for Wyoming clients.

Wyoming Family to Family Health Information Center Partnership

WY MCH and the Wyoming institute for Disabilities (WIND), which serve as Wyoming's Family to Family Health information Center, began a convincing monthly meeting. These meetings served to coordinate needs assessment activities and better understand ongoing activities supporting Wyoming CYSHCN and their families. As a result of this more frequent communication with WIND, CSH was able to co-draft a Wyoming Provider Survey evaluating providers perceived ability to manage care for CYSHCN based on several factors to include unique conditions.

Quality Improvement

The CHSPM continued to work with the Wyoming Department of Health, Quality Improvement and Performance Management Council to establish ongoing program performance measures. This partnership also became a component of ongoing MCHB technical assistance, which allowed for CSH Program staff to work with a national CYSHCN expert on program transition to systems-level improvements and documentation of program performance.

The CSH Program operationalizes the WY MCH data-driven core value by prioritizing continuous quality improvement in an effort to improve care coordination services for children with special health care needs and their families. Quality improvement involves internal chart audits through the Program Manager randomly selecting charts from each CSH Benefits and Eligibility Specialist (BES) and assigning the charts to a second BES, who completes a chart audit scoring rubric and returns the results to the CSHPM for corrective action. CSH conducted a limited number of chart audits due to remote work constraints related to COVID-19. The CSH Program has also established a quality improvement project connected to the establishment and continued measurement of quality and performance standards within the program and plans to establish these measures in the coming year..

Health Equity

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

Additionally, a CSH staff member attended training on the impacts of poverty and strategies to build system-level efforts to reduce poverty, then reported back to the CSH team on the connections between course content and the population CSH serves. The CSH Program also continued its collaboration with Wyoming Medicaid to offer emergency travel assistance to families in an effort to alleviate barriers to receiving care with out-of-state specialists.

Reorganization and Succession Planning

In FY2020, the CSH Program caseload was redistributed to two BES to adjust to the retirement of a key staff member and the movement of that position out of the CSH Program due to WY MCH reorganization. The CSH Program reorganization adjustment installed a full-time, permanent program manager to support dedicated day-to day-leadership of the program. The addition of a permanent program manager also allowed for the foundation for a targeted strategic plan for the CSHCN domain.

In late 2017, CSH Program staff began developing a comprehensive, program-wide desk manual to promote uniform adherence to procedures and for succession planning by creating standards for how cases and caseloads are worked. The CSH Program completed the desk manual and put it into operation in fall 2019; CSH program staff have updated the desk manual every four months through FFY20.

Leadership Education in Neurodevelopmental and Related Disabilities

WY MCH increased its support for Wyoming’s participation in the Utah Regional Leadership Education in Neurodevelopmental and Related Disabilities (URLEND) by providing a letter of support to the Wyoming Institute for Disabilities as well as meeting multiple times with 2020-2021 Wyoming URLEND trainees. Trainee projects included

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COVID-19 Response

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Based on the impact of COVID-19 on CSH clients, the CSH team suspended the requirement that families complete

an in-person check-in with their assigned CSN PHN. CSH also suspended the requirement that clients update their eligibility information, preventing any CSH family from losing coverage without the direct approval of the program manager. The temporary suspension of annual updates was also necessary to support PHNs who shifted activities due to COVID-19 response. Additionally, CSH reduced the amount of physical mail being sent to the PHN offices and instead started to provide scanned copies of materials electronically, reducing the burden on CSH staff and PHNs.

CSH identified barriers impacting Wyoming residents' ability to access care due to the COVID-19 pandemic. The W CSH team provided travel support and assistance to support families' ability to access and receive appropriate care in out-of-state hospitals.

Children with Special Health Care Needs - Application Year

Application Year Plan (FFY21): This section presents strategies/activities for 2021-2025 MCH priorities related to the Children and Youth with Special Health Care Needs (CYSHCN) domain. See Five-Year State Action Plan Table for more information.

Priority	Performance Measure	ESM (if applicable)
Improve Systems of Care for Children and Youth with Special Health Care Needs	**NPM 11: Percent of children with and without special healthcare needs, ages 0-17, who have a medical home**	**ESM 11.1: Percent of CSH Advisory Council members with lived experience** **ESM 11.2: Complete assessment of National Standards for Systems of Care for CYSHCN** **ESM 11.3: Develop an Action Plan based on results of National Standards Assessment**

The National Survey of Children's Health (NSCH, 2018-19) estimates there are 24,352 children with special health care needs (CSHCN) ages 0-17 in Wyoming. In Wyoming, only 8.6% of CSHCN receive care in a well-functioning health care system compared to 14.1% nationally (NSCH, 2018-19).

Of the May 2021 public input survey respondents, 86.05% of those who indicated that they have a child age 2-11 in their household and 88.46% who indicated they have a teen or young adult age 12-24 in their household indicated that they believe the Children's Special Health Program's focus on medical homes and their family advisory council fits well or very well with the needs of their family or community. Also among respondents indicating that they have a child age 2-11 in their household, 95.92% indicated that they believe it is important or very important to improve the healthcare system for children with special health care needs in Wyoming, and 96.43% of those who indicated that they have a teen or young adult age 12-24 in their household also indicated this.

Responses to the 2021 public input survey and comments made at the 2021 virtual family engagement forum reflected the impact that systems-level improvements and working to meet national standards will have in the lives of CYSHCN families. One family engagement forum participant shared the need for a list of available mental health providers that includes what they specialize in, so that families do not have to continue wasting time looking into services that do not prove beneficial. Another cited the lack of affordable mental healthcare and having "to jump through so many hoops to qualify for services" and financial assistance. Underscoring the need for CYSHCN families to have care coordination and a medical home, one respondent shared: "I felt like we've definitely fallen through the cracks before [...] there are so many specialists and things you have to find out on your own [...] It's going to be so much more helpful and less stress on the family [… having a medical home] at one place versus the families trying to find all these specialists and do all the leg work themselves."

WY MCH will leverage and expand existing relationships with family-serving organizations, to understand and improve systems of care for CSHCN. In FY22, the CSH Program will identify and contract with a family engagement consultant to embed family engagement principles across all domains and action plans, with particular emphasis on the CSHCN domain. The consultant will also support creation of a CSH Advisory Council. The CSH Program will

continue to implement the following strategies to improve systems of care for CSHCN and address NPM 11:

1. Complete a comprehensive gap analysis of Wyoming's CSH Program and services to understand where gaps exist internally for meeting the National Standards for Systems of Care for CYSHCN.

2. Utilize internal staff knowledge of National Standards for Systems of Care for CYSHCN to address internally prioritized national standards.

3. Develop and convene a family-centered CSH Advisory Council to include caregivers with lived experience. The CSH Program will work with the CSH Advisory Council to engage statewide CYSHCN stakeholders to support the adoption of a shared definition for CYSHCN.

4. Continue to increase collaboration and coordination between State agencies, community-based organizations, families, service providers, and the University of Wyoming, supporting the creation of a comprehensive CSH resource guide.

5. Incorporate focus group aggregate data and comprehensive summary report into ongoing Title V needs assessment and program planning efforts.

6. Identify and implement internal CSH program changes that support implementation of the National Standards for Systems of Care for CYSHCN.

7. Focus on medical home as both a Wyoming Title V NPM and an identified CYSHCN National Standard for Systems of Care. CSH continues to support Wyoming Primary Care Providers in serving as the coordinator and primary resource for families in Wyoming, linking them to identified services and confirming that their needs are being met. Wyoming MCH will continue to build on this internal definition of medical home over the next year.

8. Partner with PHN to establish one shared performance measure targeting improvement of systems of care for CYSHCN based upon National Standards for Systems of Care for CYSHCN alignment.

Other Programmatic Activities

Genetics

WY MCH continues to offer telehealth and in-person genetics clinics in partnership with the University of Colorado and PHN. In FFY22, 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 - Percent of new WY MCH staff completing MCH orientation (including MCH Navigator self-assessment) within first 6 months

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	100.0	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 - Percent of new WY MCH staff completing MCH orientation (including MCH Navigator self-assessment) within first 6 months
Objectives
By September 30, 2022, develop a MCH orientation.
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 Builiding - Annual Report

Annual Report Fiscal Year 2020: This section provides a summary of Federal Fiscal Year 2020 (FFY20) activities, accomplishments, and challenges related to State Performance Measures (SPMs) (2016-2020) for the Cross-Cutting/Systems Building Domain.

During the 2020 needs assessment, WY MCH established a new Title V Priority under the Cross-Cutting/Systems Building Domain: Strengthen MCH Workforce Capacity to Operationalize MCH Core Values. Since this priority is new for the 2021-2025 cycle, there are no activities to report on for FFY20.

Annual Report Fiscal Year 2021 Supplement: This section provides an interim update for Federal Fiscal Year 2021 (FFY21) activities currently in-progress for the Cross-Cutting/Systems Building Domain.

In late 2020, WY MCH began holding weekly 30-30 meetings to check in on state action plan progress, successes, and challenges experienced over the past 30 days and planned commitments for the upcoming 30 days. This effort was designed to improve individual and team accountability for implementation of strategies in the state action plan and to hold space for team dialogue about challenges, barriers, and technical assistance needs. The monthly 30-30 schedule rotates by domain to ensure each MCH population domain (including the sixth domain, cross-cutting/systems building) is highlighted regularly. Every fourth week, the 6th domain is scheduled and a discussion is led by the MCH Unit Manager/Title V Director about unit-wide activities related to MCH core values. Each staff member also contributes ways in which they individually or in smaller teams have operationalized core values in their work. While the meetings are designed to cover all core values, health equity and engagement are more heavily emphasized.

In summer 2020, WY MCH released a statement to its listserv expressing feelings staff experienced (anger, sadness, shame) following the murder of George Floyd and a collective commitment to prioritize health equity, advocate for equity, educate ourselves and our partners on health equity, and speak out against racism and inequities we hear, see, or perpetuate. The statement was released after holding a number of internal WY MCH staff meetings in which staff acknowledged the need to do more to truly embody the WY MCH vision for a Wyoming where all families and communities are healthy and thriving, to include confronting inequities and raising the bar in how we demonstrate health equity in our actions, words, and relationships.

Since then, the WY MCH Unit Manager has worked closely with the WDH-PHD Performance Improvement and Health Equity Manager to research available experts on health equity and selected an organization, Human Impact Partners, that will provide the HEW and MCH Unit with training and technical assistance throughout 2021. In addition, the Title V Block Grant Coordinator and Women and Infant Health Program Manager created a virtual space for critical reflection and dialogue around articles, podcasts, and other media that highlight a WY MCH core value, with emphasis on health equity and engagement. This virtual “book/article club” began in April and will continue monthly for as long as participation is active. Lastly, the WY MCH Unit Manager released a Request for Proposal in January 2021 for strategic planning, strategic implementation, workforce development, and leadership consultation services. Seven proposals were received and Lolina, Inc. was selected for an initial two-year contract with options for renewals throughout the 2021-2025 Title V cycle, as needed. Lolina, Inc. will assist WY MCH leadership and staff to better operationalize WY MCH core values throughout state action plans and related activities.

Cross-Cutting/Systems Building - Application Year

Application Year Plan (FFY22): 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)
Strengthen MCH Workforce Capacity to Operationalize MCH Core Values	**SPM 2: % of new WY MCH staff completing MCH orientation (including MCH Navigator self-assessment) within first six months**	**N/A**

In 2015, the Maternal and Child Health Unit (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. As a result, WY MCH established a new 2021-2025 Title V Priority under the Cross-Cutting/Systems Building Domain: Strengthen MCH Workforce Capacity to Operationalize MCH Core Values.

Participants in the May 2021 family engagement forum and 2021 public input survey respondents both identified Wyoming's lack of affordable mental health care, having "to jump through so many hoops to qualify for services," and limited access to mental health care in the rural parts of the state as a significant health equity need. Access to care in general; lack of childcare available in the evenings; having services, resources, and materials available in Spanish; and the need for undocumented immigrants to feel comfortable seeking health care were also common themes for survey respondents.

In FFY22, WY MCH will implement the following strategies to address SPM 2:

1. Develop and improve professional development opportunities to increase competencies related to MCH core values. Proposed activities include:
    a. Conduct MCH workforce assessment (i.e. MCH Navigator self-assessment) to identify baseline knowledge and training needs for existing and new WY MCH staff and volunteers within six months of hire. WY MCH leadership will work with the MCH Workforce Development Center to review MCH Navigator baseline data for Wyoming and determine a plan for repeating the assessment to show improvement in knowledge after implementation of a new WY MCH orientation.
    b. Develop and implement an MCH orientation for internal MCH staff and volunteers, including content related to each core value. MCH orientation shall be completed within six months of hire for all new staff and volunteers. Within the five-year cycle, WY MCH will offer all or part of the orientation to WYMCH contractors and/or external MCH stakeholders, as appropriate.
    c. Have WY MCH staff participate alongside WDH-PHD Health Equity Workgroup (HEW) members in health equity trainings and technical assistance opportunities offered by Human Impact Partners.

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 the degree to which strategies address core values).
    b. WY MCH staff will participate in monthly meetings (30-30s) to discuss priority area progress, challenges, and commitments to action. We will attempt to elevate our core values in these discussions - holding all staff accountable to considering these values in decision making.
    c. WY MCH staff (including MCH Epi and PHN partners) will participate in ongoing strategic implementation TA and leadership development activities offered by Lolina, Inc.
    d. Identify and complete available core value assessment tools (e.g. engagement tool, health equity tool).
    e. Develop a mechanism to measure core value implementation (e.g. develop performance metric to track number/percent of strategies related to a core value).

3. Develop an understanding of individual and team strengths within WY MCH. Proposed activities include:
    a. All MCH staff and volunteers will complete the CliftonStrengths assessment upon hire/start.
    b. All staff will continue to participate in CliftonStrengths team activities.

III.F. Public Input

Engagement with the public and stakeholders is one of the core values of the Maternal and Child Health Unit (WY MCH), and is of particular focus given WY MCH's 6th domain priority of operationalizing its core values. In 2021, WY MCH continued to build on its 2020 progress in having accessible communication and genuine engagement drive public input efforts.

The central component of WY MCH's public input plan was once again 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 in 2020 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/educational status. Providing an excerpt 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 embed 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 questions for each domain. In 2020, this model worked extremely well, increasing the number of public input responses from two in 2019 to 107 in 2020.

Given the success of the new public input process piloted in 2020, WY MCH chose to employ the same public input model in 2021, with additional tweaks in an attempt at further improvement. WY MCH reduced the number of questions per domain from 6-8 to 3-5 to lessen the time commitment required by survey respondents. WY MCH also used its new Facebook page to market the survey to the general public. Following suggestions from last year's Title V grant reviewers, WY MCH opened its survey for three weeks (April 19-May 9, 2021) instead of two weeks. These efforts seem to have had a positive impact, as detailed later in this document.

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 and a recent WDH (non-MCH) data breach. WY MCH instead used the following channels to market its public input survey:

- Wyoming's Family Voices Affiliate Uplift's social media and connections
- A public webinar held April 26, 2021
    - Seventeen people attended the webinar
- WY MCH's quarterly email newsletter
    - The newsletter was sent to 66 stakeholders, who were asked to spread the word about the survey. The newsletter had a 64% open rate and 36% click rate.
- Wyoming's local MCH PHNs
    - All MCH PHNs were provided with flyers advertising the survey and containing a QR code linking the survey, as well as sample social media text. These PHNs were asked to hang the flyers in their public health offices and share mention of the survey on their county health department social media.
- WY MCH's website
- Word-of-mouth through other Wyoming Department of Health (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 and the WDH Performance Improvement Manager's professional contacts

In 2020, WY MCH also recognized the importance of offering an incentive in order to communicate the value of

survey respondents' time, and did so again for the 2021 survey. 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, wanted a gift card, 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). As several general public respondents who were eligible for a gift card incentive declined to receive the gift card, 45 respondents were provided with one.

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 101 responses to its survey, comparable to the 107 responses received in 2020 (which was 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). One success noted in 2021 was that a higher percentage of respondents (60%) were members of the general public, whereas 2020 saw a majority of respondents be public employees with only 35% of respondents being members of the general public; WY MCH believes this may be due to marketing the survey through more directly engaging means, such as the new WY MCH Facebook page. The 2021 survey responses were also more geographically diverse than in 2020; although the number of counties represented dropped to 18 instead of 21 of Wyoming's 23 counties, the responses were less heavily weighted toward Laramie County than in 2020, with a high proportion of responses from Laramie, Teton, Albany, Natrona, and Johnson counties. Of all 101 respondents, 68.32% reported having a woman aged 15-44 in their household, 20.79% reported having an infant in their household, 52.48% reported having a child aged 2-11 and under in their household, and 31.68% 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 fits the needs of their community, and to rank how important addressing certain MCH topics (e.g. child obesity, teen pregnancy) are in their community. Qualitatively, respondents were posed with open-ended questions around unmet needs, health equity, potential partners in their communities, and any other thoughts they wanted to express. Findings from the survey are included in the domain reports and applications and in the needs assessment update.

The most significant change in WY MCH's public input process this year was a close partnership with Uplift to pilot a virtual family feedback forum on the CYSHCN domain, in which Uplift staff solicited verbal feedback on the same types of content and questions included in the survey. The family feedback forum was held May 5, 2021 and four parents of CYSHCN attended. Uplift intends to expand the virtual family feedback forum in future years to obtain public input on all MCH domains and anticipates a higher rate of participation after COVID-19.

WY MCH utilized the feedback from both the public input survey and the family engagement forums 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 June 18, 2021[1]. 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.

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 expanding its social media communication to better reach the public, acting on direct feedback from the Youth Council on MCH work, and initiating a CSHCN Advisory Council whose members have lived experience.

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[1]Note to confirm this date is when it happens

III.G. Technical Assistance

MCH Emergency Preparedness Planning

The Maternal and Child Health Unit (WY MCH) welcomed a CDC Public Health Associate (PHAP) in October 2020. The PHAP is working to implement efforts to improve WY MCH parent and family partnership activities and develop a statewide MCH Emergency Preparedness Plan for newborn screening. Additional state plans are being reviewed for inclusivity of Wyoming's MCH parents and families. WY MCH applied and was approved for the Action Learning Collaborative to support WY MCH in building emergency preparedness and response capacity for MCH populations. The Action Learning Collaborative was a success, but Wyoming is still in need of additional technical assistance as we try to integrate Emergency Preparedness into our MCH domain priorities.

Increasing Well Visits

The Adolescent and Women/Maternal domains have both identified increased well visits as a strategy to meet priorities identified in the most recent needs assessment. A review of evidence-informed approaches to increasing adolescent and well woman preventive care visits in other states demonstrates that effective approaches are still in development, and likely are informed by needs and barriers specific to a community or demographic population. WY MCH may request technical assistance to adapt promising practices to the Wyoming context, and to enable WY MCH to understand and support provider needs and tools to increase preventive care visits.

Public Health Communication

WY MCH is increasing the intentional use of public communication as strategies across domains. These strategies include the use of a health app intended for mobile devices, the launch of a social media account on Facebook, and planning for several marketing campaigns. WY MCH may request technical assistance on best practices in public health communication through these platforms and strategies to improve reach and efficacy of these communication campaigns.

Provider Associations Engagement

Unlike other states, Wyoming does not have active professional associations such as the American Academy of Pediatrics or the American College of Obstetricians and Gynecologists. 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 technical assistance on engaging providers and provider groups in rural/frontier states.

MCH Workforce Development

WY MCH established a new Title V priority dedicated to strengthening MCH workforce development for the 2021-2025 grant cycle. WY MCH has also onboarded two new program managers, one new program coordinator, a CDC PHAP, and a new grant coordinator in the last year. 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. Technical assistance may also be requested to inform and support the development of a WY MCH orientation that includes content related to each identified WY MCH core value.

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

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

Supporting Document #01 - signed 424 form.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - PHD Org Chart_June-July 2020 .pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Wyoming

	FY 22 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	$ 323,424	(30%)
B. Children with Special Health Care Needs	$ 323,424	(30%)
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)	$ 706,848	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 1,850,000	
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)	$ 525,591	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 2,375,591	
A. Your State's FY 1989 Maintenance of Effort Amount $ 2,375,591		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 3,453,671	
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)	$ 653,000	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 4,106,671	

OTHER FEDERAL FUNDS	FY 22 Application Budgeted
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) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 80,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 230,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 93,000

	FY 20 Annual Report Budgeted		FY 20 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 1,100,000		$ 1,078,080	
A. Preventive and Primary Care for Children	$ 400,000	(36.4%)	$ 350,415	(32.5%)
B. Children with Special Health Care Needs	$ 385,000	(35%)	$ 377,269	(34.9%)
C. Title V Administrative Costs	$ 45,000	(4.1%)	$ 103,890	(9.7%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 830,000		$ 831,574	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 1,825,591		$ 1,825,591	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0		$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 550,000		$ 550,000	
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		$ 3,453,671	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$ 1,877,176		$ 1,877,176	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 5,352,767		$ 5,330,847	

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

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:	**2022**
	Column Name:	**Application Budgeted**
	Field Note: Expenditures to MCHVEN (WY budget program for primary care and preventive services). Includes youth council support, Univ of Mich contract, payroll for child health, My307wellness, and MCH emergency preparedness grants.	
2.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs**
	Fiscal Year:	**2022**
	Column Name:	**Application Budgeted**
	Field Note: Expenditures to MCHCSH (WY budget program for CSHCN services). Includes payroll for CSH, Wyoming genetics program expenses, CYSHCN systems of care improvement connected to bright futures implementation, family-centered medical home support and expansion, CSH family engagement/partnership improvement.	
3.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs**
	Fiscal Year:	**2022**
	Column Name:	**Application Budgeted**
	Field Note: Expenditures to MCHADM (WY budget program for admin costs). Includes indirects, general MCH supplies/payroll, consultation services.	
4.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children:**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: Expenditures to MCHVEN (WY budget program for primary care and preventive services). Includes youth council support, Univ of Mich contract, payroll for child health, My307wellness, and MCH emergency preparedness grants.	
5.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs:**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**

	Field Note: Expenditures to MCHCSH (WY budget program for CSHCN services). Includes payroll for CSH, Wyoming genetics program expenses, CYSHCN systems of care improvement connected to bright futures implementation, family-centered medical home support and expansion, csh family engagement/partnership improvement.	
6.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: Expenditures to MCHADM (WY budget program for admin costs). Includes indirects, general MCH supplies/payroll, consultation services.	

Data Alerts: None

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

State: Wyoming

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Pregnant Women	$ 201,171	$ 90,079
2. Infants < 1 year	$ 170,061	$ 92,079
3. Children 1 through 21 Years	$ 323,424	$ 350,414
4. CSHCN	$ 323,424	$ 377,269
5. All Others	$ 0	$ 64,349
Federal Total of Individuals Served	$ 1,018,080	$ 974,190

IB. Non-Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Pregnant Women	$ 201,171	$ 201,171
2. Infants < 1 year	$ 1,768,718	$ 1,768,718
3. Children 1 through 21 Years	$ 190,609	$ 190,609
4. CSHCN	$ 215,094	$ 215,094
5. All Others	$ 0	$ 0
Non-Federal Total of Individuals Served	$ 2,375,592	$ 2,375,592
Federal State MCH Block Grant Partnership Total	$ 3,393,672	$ 3,349,782

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:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: This is from Wyoming MCH FAMZ budget line and includes 200 series expenditures for WIH program (breastfeeding education, AMCHP registration, HV outreach materials, pregnancy Quitline outreach materials) Smoking Quit Kits, CLC training grant, UW technical assistance - survey development. WIH Payroll, infant motor vehicle safety training, and equipment, Breastfeeding training, and equipment i.e. breast pumps for low-income or under resources parents.	
2.	**Field Name:**	**IA. Federal MCH Block Grant, 2. Infant < 1 Year**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: This is from Wyoming MCH FAMZ budget line and includes 200 series expenditures for WIH program (breastfeeding education, AMCHP registration, HV outreach materials, pregnancy Quitline outreach materials) Smoking Quit Kits, CLC training grant, UW technical assistance - survey development. WIH Payroll, infant motor vehicle safety training, and equipment, Breastfeeding training, and equipment i.e. breast pumps for low-income or under resources parents.	
3.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1 through 21 years**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: This is from Wyoming MCH MCHVENZ Payroll for Youth and Young Adult Program, Expeses for youth council, emergency prepairedness grant program, AMCHP registration, University of Michigan ACE work.	
4.	**Field Name:**	**IA. Federal MCH Block Grant, 4. CSHCN**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: Wyoming MCH derives CSHCN federal expenditures from Wyoming MCH budget program MCHCSHZ which includes CSH program payroll. MIE Contract (MCH contribution on WebChart contract - to support CSH form development and data capacity) Uplift (WY FV) support of public input initiative.	
5.	**Field Name:**	**IA. Federal MCH Block Grant, 5. All Others**

	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: This represents are unexpended funds as of8/31/2021	
6.	**Field Name:**	**IA. Federal MCH Block Grant, Federal Total of Individuals Served**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: As of 8/31/21 $25,320 remained unexpended.	

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.

Form 3b
Budget and Expenditure Details by Types of Services

State: Wyoming

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Direct Services	$ 0	$ 0
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 0	$ 0
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 0	$ 0
2. Enabling Services	$ 178,080	$ 306,815
3. Public Health Services and Systems	$ 900,000	$ 771,265
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Direct Services Line 4 Expended Total		$ 0
Federal Total	$ 1,078,080	$ 1,078,080

IIB. Non-Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Direct Services	$ 0	$ 35,047
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 0	$ 0
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 0	$ 35,047
2. Enabling Services	$ 443,629	$ 2,050,721
3. Public Health Services and Systems	$ 1,461,144	$ 297,680
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		$ 5,362
Physician/Office Services		$ 3,888
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 2,069
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 2,005
Laboratory Services		$ 0
Other		
All other direct services connected to CYSHCN		$ 21,723
Direct Services Line 4 Expended Total		$ 35,047
Non-Federal Total	$ 1,904,773	$ 2,383,448

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

1.	**Field Name:**	**IIA. Federal MCH Block Grant, 1. Direct Services**
	Fiscal Year:	**2022**
	Column Name:	**Application Budgeted**
	Field Note: All Federal funds are applied to Enabling and Public Health Services and Systems. Non-Federal MOE funds are applied to Direct Services.	
2.	**Field Name:**	**IIB. Non-Federal MCH Block Grant, 1. C. Services for CSHCN**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: direct gap-filling services to CSHCN population.	
3.	**Field Name:**	**IIB. Non-Federal MCH Block Grant, 2. Enabling Services**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: MCH PHN County Contract to support MCH and CSH services to include home visiting, Children's Special Health, Maternal High risk, and newborn intensive care.	
4.	**Field Name:**	**IIB. - Other - All other direct services connected to CYSHCN**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**
	Field Note: This included emergency travel support to include emergency lodging near level three or higher birthing hospital or level three or higher NICU.	

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

State: Wyoming

Total Births by Occurrence: 5,622 **Data Source Year: 2020**

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Valid Screen	(B) Aggregate Total Number of Out-of-Range Results	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	5,552 (98.8%)	6	6	6 (100.0%)

Program Name(s)		
Classic Phenylketonuria	Cystic Fibrosis	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 did not perform long-term follow-up in the past. However, in early 2021 the state of Colorado was awarded a HRSA supplemental grant to support long-term follow-up. The State of Colorado coordinated with Wyoming MCH and included Wyoming in the grant application creating a regional approach to long-term follow-up. This funding opportunity started on August 1st, 2021.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

1.	**Field Name:**	**Total Births by Occurrence**
	Fiscal Year:	**2020**
	Column Name:	**Total Births by Occurrence Notes**
	Field Note: Source: WY VSS	
2.	**Field Name:**	**Core RUSP Conditions - Total Number Receiving At Least One Screen**
	Fiscal Year:	**2020**
	Column Name:	**Core RUSP Conditions**
	Field Note: Source: 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 2020

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

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	1,148	67.0	0.0	31.5	0.0	1.5
2. Infants < 1 Year of Age	1,913	55.1	0.0	41.0	0.0	3.9
3. Children 1 through 21 Years of Age	771	25.2	0.0	16.0	1.9	56.9
3a. Children with Special Health Care Needs 0 through 21 years of age^	449	0.0	0.0	0.0	2.3	97.7
4. Others	1,876	55.9	0.0	44.1	0.0	0.0
Total	5,708					

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	6,565	No	6,134	100.0	6,134	1,148
2. Infants < 1 Year of Age	5,921	No	6,572	100.0	6,572	1,913
3. Children 1 through 21 Years of Age	156,931	Yes	156,931	8.4	13,182	771
3a. Children with Special Health Care Needs 0 through 21 years of age^	29,594	Yes	29,594	9.9	2,930	449
4. Others	413,403	Yes	413,403	0.5	2,067	1,876

^Represents a subset of all infants and children.

Form Notes for Form 5:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2020**
	Field Note: Wyoming Title V serves pregnant women through the maternal high-risk program (17) and through home visiting services (1131). Insurance coverage for women in the maternal high-risk program is based on programmatic information. Coverage for women receiving prenatal home visiting services is based on the reference data for Wyoming coverage of pregnant women. Home Visiting data from PHNI system from October 1, 2019 - September 30, 2020.	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2020**
	Field Note: Wyoming Title V serves infants through the Newborn Intensive Care Program (74) and postpartum home visitation (1839). Insurance coverage for NBIC is based on programmatic information. Coverage for infants in home visiting services is based on the reference data for Wyoming infants. Home Visiting data from PHNI system from October 1, 2019 - September 30, 2020.	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2020**
	Field Note: Wyoming Title V serves children through genetic clinics (55) and family home visitation services (267). Coverage information for genetics forms from programmatic data, Estimates for primary coverage type for home visitation services are based on Wyoming coverage for children. This also includes services for eligible-CSH program clients (449). Home Visiting data from PHNI system from October 1, 2019 - September 30, 2020.	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2020**
	Field Note: Wyoming Title V serves Children with Special Health Care Needs through the Children's Special Health Program (449). Insurance coverage for CSHCN comes from programmatic data. Estimates for primary coverage type for the Parent Partner Program are based on Wyoming insurance coverage for children.	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2020**
	Field Note: Wyoming Title V serves parents through home visiting services both when their children are between 0-1 (1876) and when their children are 1-older (303). Estimation for coverage type for home services are based on the Wyoming reference data for adults aged 22 and older. Home Visiting data from PHNI system from October 1, 2019 - September 30, 2020.	

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women**
	Fiscal Year:	**2020**
	Field Note: Home Visitation, MHR, Maternal Mortality, PQC (all pregnant women), CLC training for breastfeeding (21), opioid mini-grants	
2.	**Field Name:**	**InfantsLess Than One Year**
	Fiscal Year:	**2020**
	Field Note: Home Visitation, NBIC, PQC (all), CLC training (21), NBS	
3.	**Field Name:**	**Children 1 Through 21 Years of Age**
	Fiscal Year:	**2020**
	Field Note: Family Home Visitation, Genetics, PREP, ASQ Screenings, Adolescent Centered Environment clinics	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2020**
	Field Note: CSH, Transition Education, Genetics	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2020**
	Field Note: For this reporting year, 'other' numbers were only reported form PHNI family visits.	

Data Alerts:

1.	Others, Form 5a Count is greater than or equal to 90% of the Form 5b Count (calculated). Please check that population based services have been included in the 5b Count and not in the 5a Count.

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

State: Wyoming

Annual Report Year 2020

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	6,134	4,816	56	820	182	42	24	139	55
Title V Served	1,148	1,148	0	0	0	0	0	0	0
Eligible for Title XIX	1,832	1,238	16	365	133	10	6	45	19
2. Total Infants in State	6,572	5,122	166	992	209	83	0	0	0
Title V Served	1,913	1,913	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. Total Deliveries in State**
	Fiscal Year:	**2020**
	Column Name:	**Total**
	Field Note: Source: WY VSS 2020	
2.	**Field Name:**	**1. Title V Served**
	Fiscal Year:	**2020**
	Column Name:	**Total**
	Field Note: This field represents the number of women that were served through Healthy Baby home Visitation and the Maternal and High Risk program. Data on race and ethnicity are not reliably collected.	
3.	**Field Name:**	**1. Eligible for Title XIX**
	Fiscal Year:	**2020**
	Column Name:	**Total**
	Field Note: Source: WY VSS 2020	
4.	**Field Name:**	**2. Total Infants in State**
	Fiscal Year:	**2020**
	Column Name:	**Total**
	Field Note: Infants in State for Form 6 is more than 5% different than occurrent births in Form 4. Source: CDC Wonder 2019	
5.	**Field Name:**	**2. Title V Served**
	Fiscal Year:	**2020**
	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.	
6.	**Field Name:**	**2. Eligible for Title XIX**
	Fiscal Year:	**2020**

Column Name:	**Total**

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

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

State: Wyoming

A. State MCH Toll-Free Telephone Lines	2022 Application Year	2020 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"		200

B. Other Appropriate Methods	2022 Application Year	2020 Annual Report Year
1. Other Toll-Free "Hotline" Names	N/A	N/A
2. Number of Calls on Other Toll-Free "Hotlines"		0
3. State Title V Program Website Address	https://health.wyo.gov/publichealth/mch/	https://health.wyo.gov/publichealth/mch/
4. Number of Hits to the State Title V Program Website		3,722
5. State Title V Social Media Websites	https://www.facebook.com/Maternal-and-Child-Health-Unit-Wyoming-Department-of-Health-102428631919483	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	MCH Unit Manager/Title V Director
Address 1	122 West 25th Street
Address 2	3rd Floor West
City/State/Zip	Cheyenne / WY / 82002
Telephone	3077776326
Extension	
Email	danielle.marks@wyo.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Jamin Johnson
Title	CYSHCN Program Manager/Title V CSHCN Director
Address 1	122 West 25th Street
Address 2	3rd Floor West
City/State/Zip	Cheyenne / WY / 82002
Telephone	(307) 777-3733
Extension	
Email	jamin.johnson1@wyo.gov

3. State Family or Youth Leader (Optional)	
Name	Michelle Heinen
Title	Executive Director, Uplift (Wyoming Family Voices)
Address 1	109 E 17th Street, Suite 211
Address 2	
City/State/Zip	Cheyenne / WY / 82001
Telephone	(307) 432-4055
Extension	
Email	mheinen@upliftwy.org

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: Wyoming

Application Year 2022

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 9 State Priorities – Needs Assessment Year – 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
2019	79.2 %	0.5 %	5,089	6,428
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
2018	52.4	9.6	30	5,725
2017	47.9	8.9	29	6,051
2016	70.0	10.5	45	6,431
2015	44.0	9.4	22	5,004
2014	78.5	10.5	56	7,134
2013	73.4	10.1	53	7,220
2012	63.9	9.5	46	7,197
2011	72.5	10.1	52	7,177
2010	52.3	8.5	38	7,259
2009	53.6	8.4	41	7,644
2008	42.6	7.6	32	7,503

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
2015_2019	NR	NR	NR	NR
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
2019	9.8 %	0.4 %	643	6,564
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
2019	9.9 %	0.4 %	648	6,564
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**
2019	28.7 %	0.6 %	1,882	6,564
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
2019/Q1-2019/Q4	2.0 %			
2018/Q4-2019/Q3	2.0 %			
2018/Q3-2019/Q2	2.0 %			
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
2018	5.2	0.9	34	6,579
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
2018	5.3	0.9	35	6,562
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
2018	2.9	0.7	19	6,562
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
2018	2.4	0.6	16	6,562
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
2018	167.6	50.6	11	6,562
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 - 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
2018	NR	NR	NR	NR
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 - Percent of women who drink alcohol 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**
2019	7.2 %	1.4 %	460	6,407
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 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	2.3	0.6	13	5,642
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
2018_2019	13.5 %	1.4 %	17,196	127,723
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
2019	16.8	5.1	11	65,655
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
2019	52.7	8.3	40	75,945
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
2017_2019	22.0	4.5	24	108,936
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
2017_2019	32.1	5.4	35	108,936
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
2018_2019	18.1 %	1.4 %	24,351	134,843
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
2018_2019	8.6 %	2.0 %	2,103	24,351
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
2018_2019	2.8 %	0.6 %	3,144	111,450
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
2018_2019	7.2 %	1.1 %	8,023	110,815
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
2018_2019	54.4 %	5.0 %	9,713	17,871
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
2018_2019	92.0 %	1.1 %	123,930	134,680
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
2018	10.6 %	0.5 %	342	3,231
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	11.0 %	0.8 %	2,767	25,167
2013	10.7 %	0.7 %	2,545	23,783
2011	11.1 %	0.7 %	2,766	25,025
2009	9.7 %	0.6 %	2,446	25,250
2007	9.2 %	0.7 %	2,395	26,024
2005	8.3 %	0.6 %	2,194	26,439

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
2018_2019	13.7 %	2.0 %	7,872	57,302
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
2019	10.1 %	1.5 %	13,648	134,788
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 who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	72.3 %	3.5 %	5,000	7,000
2015	63.1 %	3.6 %	4,000	7,000
2014	64.9 %	3.6 %	5,000	7,000
2013	71.8 %	4.0 %	5,000	7,000
2012	68.1 %	4.7 %	5,000	7,000
2011	64.6 %	4.4 %	5,000	7,000

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
2019_2020	59.0 %	2.4 %	75,031	127,171
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
2019	59.1 %	3.3 %	21,921	37,093
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
2019	90.7 %	2.0 %	33,660	37,093
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
2019	73.9 %	2.9 %	27,424	37,093
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
2019	19.4	1.1	338	17,449
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
2019	15.3 %	2.0 %	976	6,365
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 unable to obtain needed health care in the past year

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	4.5 %	0.9 %	6,105	134,597
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	**2020**
Annual Objective		
Annual Indicator	64.8	64.6
Numerator	61,481	61,360
Denominator	94,822	94,984
Data Source	BRFSS	BRFSS
Data Source Year	2018	2019

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	64.8	65.7	66.5	67.3	68.1	68.9

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	**2020**
Annual Objective		
Annual Indicator	85.7	82.3
Numerator	5,251	5,105
Denominator	6,130	6,201
Data Source	PRAMS	PRAMS
Data Source Year	2018	2019

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	85.7	86.6	87.7	88.8	89.9	91.0

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	**2020**
Annual Objective		
Annual Indicator	29.6	30.4
Numerator	1,775	1,800
Denominator	5,999	5,921
Data Source	PRAMS	PRAMS
Data Source Year	2018	2019

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	26.6	27.0	27.3	27.6	27.9	28.2

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	**2020**
Annual Objective		
Annual Indicator	32.6	37.1
Numerator	1,928	2,226
Denominator	5,918	6,001
Data Source	PRAMS	PRAMS
Data Source Year	2018	2019

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	32.6	33.0	33.4	33.8	34.2	34.6

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	**2020**
Annual Objective		
Annual Indicator	276.4	230.7
Numerator	207	174
Denominator	74,890	75,417
Data Source	SID-ADOLESCENT	SID-ADOLESCENT
Data Source Year	2017	2018

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	276.4	273.1	269.6	266.1	262.6	259.1

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**	**2020**
Annual Objective			
Annual Indicator		30.2	35.8
Numerator		14,688	17,398
Denominator		48,676	48,566
Data Source		NSCH-CHILD	NSCH-CHILD
Data Source Year		2017_2018	2018_2019

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**	**2026**
Annual Objective	30.2	30.5	30.9	31.3	31.7	32.1

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**	**2020**
Annual Objective			76	78	78.2
Annual Indicator		75.7	78.2	78.2	69.1
Numerator		34,569	35,814	35,814	28,695
Denominator		45,669	45,789	45,789	41,524
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2016_2017	2019

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**	**2026**
Annual Objective	78.2	79.4	80.3	81.2	82.1	83.0

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**	**2020**
Annual Objective			
Annual Indicator		38.1	37.9
Numerator		10,270	9,240
Denominator		26,977	24,351
Data Source		NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2017_2018	2018_2019

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**	**2026**
Annual Objective	38.1	38.5	39.0	39.5	40.0	40.5

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**	**2020**
Annual Objective	90	92	93	93	93
Annual Indicator	89.7	88.3	90.0	89.6	90.0
Numerator	5,817	5,853	6,269	4,671	5,039
Denominator	6,486	6,628	6,963	5,216	5,599
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016	2017

State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	90	92	93	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**	**2020**
Annual Objective	26	29	32	32	34
Annual Indicator	27.0	32.0	28.8	31.4	31.8
Numerator	1,693	2,049	1,959	1,578	1,739
Denominator	6,263	6,412	6,790	5,027	5,472
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016	2017

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**	**2020**
Annual Objective			29	29	32
Annual Indicator		27.6	27.0	22.5	29.8
Numerator		4,900	4,651	3,759	4,784
Denominator		17,751	17,226	16,730	16,069
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

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 to prepare for the transition 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**	**2020**
Annual Objective			19	17	18
Annual Indicator		17.9	16.5	13.4	19.8
Numerator		2,073	2,119	1,872	2,365
Denominator		11,609	12,855	13,940	11,948
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018	2018_2019

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**	**2020**
Annual Objective	15	14	14	13.5	13
Annual Indicator	15.2	14.6	14.4	13.4	13.6
Numerator	1,148	1,043	968	859	855
Denominator	7,540	7,152	6,735	6,404	6,266
Data Source	NVSS	NVSS	NVSS	NVSS	NVSS
Data Source Year	2015	2016	2017	2018	2019

State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	15	14	14	13.5	13
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

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	13.4	13.6
Numerator	859	855
Denominator	6,404	6,266
Data Source	NVSS	NVSS
Data Source Year	2018	2018
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	13.4	12.8	12.1	11.4	10.7	10.0

Field Level Notes for Form 10 SPMs:

None

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

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	100.0	100.0	100.0	100.0	100.0	100.0

Field Level Notes for Form 10 SPMs:

None

SPM 3 - Percent of children (ages 1-9 years old) who should receive at least one visit based on the "periodicity schedule", receiving at least 1 EPSDT visit as noted within CMS 416 report

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	64.2	64.6
Numerator	10,333	9,775
Denominator	16,100	15,130
Data Source	CMS-416 Report	CMS-416 Report
Data Source Year	2018	2019
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	64.2	65.8	67.4	69.0	70.6	72.2

Field Level Notes for Form 10 SPMs:

None

SPM 4 - Percent of Wyoming youth reporting increased youth/adult connectedness

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	84	83
Numerator	20,244	9,047
Denominator	24,099	10,905
Data Source	WY PNA	WY PNA
Data Source Year	2018	2020
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	84.0	86.1	86.1	88.2	88.2	90.3

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: The March 2020 school closures for COVID-19 mitigation efforts interrupted data collection, resulting in lower response rates and less participation than typical survey years. The 2020 survey results are unweighted. Users should be cautious when making comparisons between 2020 and previous survey years.	
2.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**
	Field Note: The PNA is only administered on even years so odd year estimates are the same as the previous year.	
3.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**
	Field Note: The PNA is only administered on even years so odd year estimates are the same as the previous year.	

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**	**2020**
Annual Objective		54	70	80	80
Annual Indicator	51.9	68	80.6	73.6	85.7
Numerator	42	68	50	53	72
Denominator	81	100	62	72	84
Data Source	Wyoming Vital Statistics Services	Wyoming Vital Statistics Services	Wyoming Vital Statistics Services	Wyoming Vital Statistics Services	Wyoming Vital Statistics Services
Data Source Year	2015	2016	2017	2018	2019
Provisional or Final ?	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.	
5.	**Field Name:**	**2020**
	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**	**2020**
Annual Objective		20	30	30	29
Annual Indicator	25.3	32.2	13	14.5	28.2
Numerator	22	28	11	12	23
Denominator	86,903	86,855	84,348	83,015	81,466
Data Source	Wyoming Hospital Discharge Data	Wyoming Hospital Discharge Data	Wyoming Hospital Discharge Data	Wyoming Hospital Discharge Data	Wyoming Hospital Discharge Data
Data Source Year	FY 2015	CY 2016	CY17	CY18	CY19
Provisional or Final ?	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 calculated the overall injury hospitalization rate, it does impact the state's ability to further investigate the causes of injury. Due to the change from ICD-9 to ICD-10 coding the two numbers are not comparable.	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: We changed to reporting calendar year so that all codes would be in ICD-10 for the reporting year. Since the transition to ICD-10, Wyoming has seen a significant decrease in the use of external cause codes. Though it does not affect our ability to calculated the overall injury hospitalization rate, it does impact the state's ability to further investigate the causes of injury. Due to the change from ICD-9 to ICD-10 coding the two numbers are not comparable.	

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**	**2020**
Annual Objective		70	70	70	72
Annual Indicator	68.4	68.4	66.3	66.3	72.2
Numerator					
Denominator					
Data Source	Prevention Needs Assessment	Prevention Needs Assessment	Prevention Needs Assessment	Prevention Needs Assessment	Prevention Needs Assessment
Data Source Year	2016	2016	2018	2018	2020
Provisional or Final ?	Final	Final	Final	Final	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	
4.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Restricted to 10th and 12th grades, ‘zero occasions’ From the 2018 Prevention Needs Assessment. The Prevention Needs Assessment is completed only in even years.	
5.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Restricted to 10th and 12th grades, ‘zero occasions’ From the 2020. Prevention Needs Assessment. The March 2020 school closures for COVID-19 mitigation efforts interrupted data collection, resulting in lower response rates and less participation than typical survey years. The 2020 survey results are unweighted. Users should be cautious when making comparisons between 2020 and previous survey years.	

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**	**2020**
Annual Objective			32	34
Annual Indicator			30.2	35.8
Numerator			14,688	17,398
Denominator			48,676	48,566
Data Source			NSCH	NSCH
Data Source Year			2017-2018	2018-2019
Provisional or Final ?			Final	Final

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**	**2020**
Annual Objective			66	68
Annual Indicator			66.4	69
Numerator			3,517	3,562
Denominator			5,296	5,160
Data Source			PRAMS	PRAMS
Data Source Year			2018	2019
Provisional or Final ?			Final	Final

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	
State Provided Data			
	2018	**2019**	**2020**
Annual Objective			45
Annual Indicator		46.6	47.6
Numerator		64,636	64,074
Denominator		138,743	134,702
Data Source		NSCH	NSCH
Data Source Year		2017-2018	2018-2019
Provisional or Final ?		Final	Final

Field Level Notes for Form 10 SPMs:

None

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

State: Wyoming

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

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	250.0	275.0	303.0	333.0	366.0	401.0

Field Level Notes for Form 10 ESMs:

None

ESM 1.2 - Percent of women ages 18-44 interacting with developed messaging in regard to the well-woman visit and its importance on the My 307 Wellness App

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	20.0	25.0	30.0	35.0	40.0	45.0

Field Level Notes for Form 10 ESMs:

None

ESM 5.1 - Percent of PRAMS moms who report having a home visit and report their baby sleeps on a separate approved sleep surface

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	32.6	33.0	36.0	38.0	40.0	42.0

Field Level Notes for Form 10 ESMs:

None

ESM 5.2 - Percent of PRAMS moms who report having a home visit and report their baby sleeps without soft objects or loose bedding

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	31.0	31.0	33.0	35.0	37.0	39.0

Field Level Notes for Form 10 ESMs:

None

ESM 7.2.1 - Percent of high schools providing Teens in the Driver's Seat

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	3.0	6.0	12.0	18.0	27.0	31.0

Field Level Notes for Form 10 ESMs:

None

ESM 8.1.1 - Number of childcare providers receiving training and technical assistance on Wyoming Healthy Policies Toolkit

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	15.0	20.0	25.0	30.0	35.0	40.0

Field Level Notes for Form 10 ESMs:

None

ESM 10.1 - Percent of Medicaid pediatric providers sending text reminders for annual well visits for 10-19-year-olds linking patients to web-based well visit information

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	15.0	25.0	35.0	40.0	45.0

Field Level Notes for Form 10 ESMs:

None

ESM 10.2 - Wyoming EPSDT rate for 10-20 year olds

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2022	2023	2024	2025	2026
Annual Objective	36.0	40.0	45.0	50.0	55.0

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	50.0	50.0	50.0	50.0	50.0	50.0

Field Level Notes for Form 10 ESMs:

None

ESM 11.2 - Complete assessment of National Standards for Systems of Care for CYSHCN

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10 ESMs:

None

ESM 11.3 - Develop an Action Plan based on results of National Standards Assessment

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

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**	**2020**
Annual Objective	4	4	0	4
Annual Indicator	4	4	0	0
Numerator				
Denominator				
Data Source	Women and Infant Program	Women and Infant Health Program	Women and Infant Health Program	Women and Infant Health Program
Data Source Year	2017	2018	2019	2020
Provisional or Final ?	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.	
4.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: The program ended before the start of FFY19. Therefore, no new data is available in FFY20.	

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**	**2020**
Annual Objective			100	100
Annual Indicator			100	0
Numerator			4	0
Denominator			4	4
Data Source			Program Data (self report from hospitals)	n/a
Data Source Year			CY 2018	n/a
Provisional or Final ?			Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: This program has not continued.	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	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**	**2020**
Annual Objective			90	90
Annual Indicator			100	100
Numerator			23	23
Denominator			23	23
Data Source			Public Health Nursing Program Data	Public Health Nursing Program Data
Data Source Year			SFY 2020	SFY 2021
Provisional or Final ?			Provisional	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**	**2020**
Annual Objective	30	45	60	0
Annual Indicator	39	49	14	0
Numerator				
Denominator				
Data Source	HMG Reports	HMG Reports	HMG Reports	n/a
Data Source Year	2017	2018	2019	n/a
Provisional or Final ?	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)	
3.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Contact with Wyoming 211 to implement Help Me Grow ended on June 30, 2019. Therefore, no data is reportable in FFY20.	

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**	**2020**
Annual Objective			50	0
Annual Indicator			41	0
Numerator				
Denominator				
Data Source			HMG Reports	n/a
Data Source Year			2019	n/a
Provisional or Final ?			Final	Final

Field Level Notes for Form 10 ESMs:

1.	**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)	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Contact with Wyoming 211 to implement Help Me Grow ended on June 30, 2019. Therefore, no data is reportable in FFY20.	

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

Measure Status:			Active
State Provided Data			
	2018	**2019**	**2020**
Annual Objective			10
Annual Indicator			12
Numerator			
Denominator			
Data Source			Internal program report
Data Source Year			2020
Provisional or Final ?			Final

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**	**2020**
Annual Objective			4	6
Annual Indicator			4	4
Numerator				
Denominator				
Data Source			Program Data	Program Data
Data Source Year			2019	2020
Provisional or Final ?			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	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Cycles for 2 clinics in cohort two extended due to COVID impacts; QI cycle will be complete late 2021/early 2022.	

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**	**2020**
Annual Objective			45	47
Annual Indicator			49	25
Numerator				
Denominator				
Data Source			CSH Program Data	CSH Program Data
Data Source Year			FFY19	FFY20
Provisional or Final ?			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**	**2020**
Annual Objective			25	30
Annual Indicator			16	0
Numerator				
Denominator				
Data Source			WY Quitline	WY Quitline
Data Source Year			2019	2020
Provisional or Final ?			Provisional	Provisional

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
Due to staffing changes this data is not available to provide.

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

Measure Status:			**Active**	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			7	7
Annual Indicator			7	0
Numerator				
Denominator				
Data Source			Program Data	Program Data
Data Source Year			FFY19	FFY20
Provisional or Final ?			Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
Women and Infant Health Program changed direction and this data is not available to provide.

Form 10
State Performance Measure (SPM) Detail Sheets

State: Wyoming

SPM 1 - Percent of women who smoke during pregnancy
Population Domain(s) – Perinatal/Infant Health

Measure Status:	Active
Goal:	Decrease the percent of women who smoke during pregnancy
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of women who report smoking during pregnancy **Denominator:** Number of live births
Data Sources and Data Issues:	National Vital Statistics System (NVSS)
Significance:	Women who smoke during pregnancy are more likely to experience a fetal death or deliver a low birth weight baby. Adverse effects of parental smoking on children have been a clinical and public health concern for decades. Children have an increased frequency of ear infections; acute respiratory illnesses and related hospital admissions during infancy; severe asthma and asthma-related problems; lower respiratory tract infections; and SIDS.

SPM 2 - Percent 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:	**Unit Type:** Percentage **Unit Number:** 100 **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
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 - Percent of children (ages 1-9 years old) who should receive at least one visit based on the "periodicity schedule", receiving at least 1 EPSDT visit as noted within CMS 416 report
Population Domain(s) – Child Health, Adolescent Health

Measure Status:	Active
Goal:	Increase the % of children receiving at least one EPSDT of those who should be receiving at least one visit base on the "periodicity schedule"
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Total Eligibles (ages 1-9) Receiving at least One Initial or Periodic Screen **Denominator:** Total Eligibles (ages 1-9) who Should Receive at Least One Initial or Periodic Screen
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 4 - Percent of Wyoming youth reporting increased youth/adult connectedness
Population Domain(s) – Adolescent Health

Measure Status:	Active
Goal:	Increase the percent of students reporting having an adult with whom they can talk with about their problems
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of Wyoming students answering "Yes" to the question on the WY PNA: "Is there an adult in your community who you can talk to about your problems?' **Denominator:** Total number of Wyoming students answering (either "Yes" or "No") the question on the WY PNA "Is there an adult in your community who you can talk to about your problems?'
Data Sources and Data Issues:	Wyoming Prevention Needs Assessment. WY does not currently administer the YRBS questionnaire.
Significance:	"Strong, positive relationships with parents and other caring adults protect adolescents from a range of poor health-related outcomes and promote positive development" (Sieving, et al., AJPM, 2017)

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:	**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
Healthy People 2020 Objective:	MICH-33: 83.7%
Data Sources and Data Issues:	Numerator: Vital Records-number of VLBW infants delivered; delivery hospital Denominator: Vital Records- number of VLBW infants delivered Limitation: LOCATe has not been completed in all states where Wyoming babies are delivered.
Significance:	Neonatal intensive care has improved the outcomes of high risk infants who were born too early or with serious medical conditions. The American Academy of Pediatrics defines levels of neonatal care to allow for regionalization of efforts to ensure that babies born preterm or with serious medical conditions receive the neonatal services they need to address the often severe morbidity they endure. Most infant deaths occur in the United States among very preterm infants in the first days of life. This measure captures the ability for these babies to access necessary services through a regionalized system. (Levels of Neonatal Care: Policy Statement, Pediatrics, 130(3), September 2012)

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:	**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
Data Sources and Data Issues:	Numerator: Hospital Discharge Data (HDD) Denominator: Census population estimates Limitation: HDD is only available for Wyoming hospitals. It is possible that individuals with more severe injuries may be taken immediately out of state for treatment as there are no Level I trauma centers in Wyoming.
Significance:	Injury is the number one cause of death and hospitalization among children 1-11 in Wyoming and nationally. Wyoming's rates of injury are consistently higher than the national rates.

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:	**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
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:	**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)
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:	**Unit Type:** Percentage **Unit Number:** 100 **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)
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

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the percent of children with and without special health care needs having a medical home</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<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>
</table>
</td></tr>
<tr><td>Healthy People 2020 Objective:</td><td>Identical to Maternal, Infant, and Child Health (MICH) Objectives 30.1: Increase the proportion of children who have access to a medical home, (Baseline: 57.5%, Target: 63.3%) and 30.2: Increase the proportion of children with special health care needs who have access to a medical home. (Baseline: 49.8%, Target: 54.8%)

Related to Objective Maternal, Infant, and Child Health (MICH) Objective 31: Increase the proportion of children with special health care needs who receive their care in family-centered, comprehensive, coordinated systems. (Baseline: 20.4% for children aged 0-11, Target: 22.4%; Baseline: 13.8% for children aged 12 through 17, Target 15.2%)</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>National Survey of Children's Health (NSCH)</td></tr>
<tr><td>Significance:</td><td>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</td></tr>
</table>

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 accessing the My 307 Wellness App
Definition:	**Unit Type:** Count **Unit Number:** 10,000 **Numerator:** # of women who enroll during reporting year **Denominator:**
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 - Percent of women ages 18-44 interacting with developed messaging in regard to the well-woman visit and its importance on 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 enrolled women who access well woman visit information
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** # of women who interact with developed messaging on well woman visit **Denominator:** # of women who enroll during reporting year
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 - Percent of PRAMS moms who report having a home visit and 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:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** # of women reporting their infant is put to sleep on a separate approved sleep surface **Denominator:** # of women reporting having a home visit since their baby was born.
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 - Percent of PRAMS moms who report having a home visit and 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 % of moms, who report a home visit, who put infant to sleep without soft objects or loose bedding.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** # of women responding their infant is put to sleep without soft objects or loose bedding **Denominator:** # of women reporting having a home visit since their baby was born.
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 7.2.1 - Percent of high schools providing Teens in the Driver's Seat
NPM 7.2 – Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19

Measure Status:	Active
Goal:	Increase the # of high schools providing Teen in the Driver Seat
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** # of high schools providing Teen in the Driver Seat **Denominator:** # of High Schools in Wyoming
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 providers receiving training and technical assistance on Wyoming Healthy Policies Toolkit
NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase # of childcare providers receiving training and TA on Wyoming Healthy Policies Toolkit</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>500</td></tr>
<tr><td>Numerator:</td><td>Total number of licensed Child Care providers through DFS who received training and TA on Wyoming Health Policies Toolkit</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>DFS Data, Program Data, WFS Data</td></tr>
<tr><td>Significance:</td><td>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.</td></tr>
</table>

ESM 10.1 - Percent of Medicaid pediatric providers sending text reminders for annual well visits for 10-19-year-olds linking patients to web-based well visit information
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Measure Status:	Active
Goal:	Increase percent of Medicaid pediatric providers sending text reminders for annual well visits for 10-19 year olds linking patients to web-based well visit information
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** # of Medicaid Providers sending text reminders for annual well visits for 10-19 year olds linking patients to web-based well visit information **Denominator:** # of Medicaid Providers in Wyoming
Data Sources and Data Issues:	Medicaid; providers
Evidence-based/informed strategy:	N/A
Significance:	It is important for providers to engage directly with adolescent patients to encourage preventive care through well-visits, and to educate adolescent patients about the value of annual well-visits.

ESM 10.2 - Wyoming EPSDT rate for 10-20 year olds
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Measure Status:	Active
Goal:	Increase Wyoming EPSDT rate among 10-20 year olds
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** # of eligible 10-20 years olds receiving at least One Initial or Periodic Screen **Denominator:** # of eligible 10-20 year olds who Should Receive at Least One Initial or Periodic Screen
Data Sources and Data Issues:	Medicaid 416-CMS Report
Evidence-based/informed strategy:	N/A
Significance:	Primary care providers have an important role in proactive screening for mental health concerns that may lead to suicidality. Since most pediatric providers in Wyoming accept Medicaid, the EPSDT rate for adolescents is a good indicator of overall pediatric well visits and adolescent exposure to proactive mental health screening.

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
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:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of advisory council members with lived experience **Denominator:** Total number of advisory council members
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 - Complete assessment of 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
Goal:	Complete assessment of National Standards for Systems of Care for CYSHCN with specific emphasis on improving access to and quality of medical homes
Definition:	**Unit Type:** Text **Unit Number:** Yes/No **Numerator:** Yes or No **Denominator:**
Data Sources and Data Issues:	CSHCN 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.

ESM 11.3 - Develop an Action Plan based on results of National Standards Assessment
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	Complete action plan based on standards assessment results to help drive improvement
Definition:	**Unit Type:** Text **Unit Number:** Yes/No **Numerator:** Yes or No **Denominator:**
Data Sources and Data Issues:	Program Data
Significance:	After completing the assessment, the program, Advisory Council, and partners will identify and target gaps within the system of care to focus improvement efforts.

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:	**Unit Type:** Count **Unit Number:** 26 **Numerator:** N/A **Denominator:**
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:	**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
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:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** # of counties with at least one CLC **Denominator:** # of counties
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:	**Unit Type:** Count **Unit Number:** 100 **Numerator:** Number of referrals from 211 to HMG **Denominator:**
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

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the number of connections made between local services and families by HMG.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>500</td></tr>
<tr><td>Numerator:</td><td>Number of referrals from HMG that result in a connection to services</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>211 System</td></tr>
<tr><td>Significance:</td><td>HMG is a coordinated referral system for developmental screening for children aged birth to eight. It is critical that children receive appropriate services based on the results of their screening to minimize impact of delays.</td></tr>
</table>

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

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase provider training on Bright Futures</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of providers trained on Bright Futures</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Internal program report</td></tr>
<tr><td>Significance:</td><td>The primary goal of Bright Futures implementation is to support primary care practices (medical homes) in providing well-child and adolescent care according to Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents. Settings for Bright Futures implementation include private practices, hospital-based or hospital-affiliated clinics, resident continuity clinics, school-based health centers, public health clinics, community health centers, Indian Health Service clinics, and other primary care facilities.

A complementary goal is to provide home visitors, public health nurses, early child care and education professionals (including Head Start), school nurses, and nutritionists with an understanding of Bright Futures materials so that they can align their health promotion efforts with the recommendations in the Bright Futures Guidelines. This objective will ensure that patients receive information and support that is consistent from family and youth perspectives.</td></tr>
</table>

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:	**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:**
Data Sources and Data Issues:	University of Michigan and Program Data
Significance:	The Adolescent Health Program will partner with the University of Michigan to bring the Adolescent Champion Model to Wyoming. The goal of this program is to train adolescent and family providers and their staffs to create a more adolescent friendly environment in their clinics. By increasing the knowledge of providers and their staffs of caring for adolescents is that more adolescents will receive their recommended annual well visit.

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 to prepare for the transition to adult health care

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the number of eligible CSH parents or youth who complete a transition readiness assessment annually</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>1,000</td></tr>
<tr><td>Numerator:</td><td>Number of eligible CSH parents or youth that completed a transition readiness assessment</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>CSH tracking</td></tr>
<tr><td>Significance:</td><td>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.</td></tr>
</table>

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:	**Unit Type:** Count **Unit Number:** 100 **Numerator:** # of smoking HB clients referred to the Quitline **Denominator:**
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:	**Unit Type:** Count **Unit Number:** 100 **Numerator:** # of providers trained in SCRIPT **Denominator:**
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

Form 12
MCH Data Access and Linkages

State: Wyoming

Annual Report Year 2020

	Access				Linkages	
Data Sources	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
1) Vital Records Birth	Yes	No	More often than monthly	6		
2) Vital Records Death	Yes	No	More often than monthly	6	Yes	
3) Medicaid	Yes	Yes	More often than monthly	4	No	
4) WIC	Yes	No	More often than monthly	4	No	
5) Newborn Bloodspot Screening	Yes	No	More often than monthly	1	Yes	
6) Newborn Hearing Screening	Yes	No	More often than monthly	6	Yes	
7) Hospital Discharge	Yes	Yes	Quarterly	6	No	
8) PRAMS or PRAMS-like	Yes	Yes	Annually	14	Yes	

Form Notes for Form 12:

None

Field Level Notes for Form 12:

None