



State Title V Block Grant Narrative

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Sections 5.4 – 5.7, containing standard forms and detailed descriptions of national and State performance and outcome measures, are not included in this PDF. Data from these sections can be viewed in interactive formats on the Title V Information System Web site (<http://www.mchdata.net>).

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1.4 Overview of the State

Wyoming is the country's ninth largest state with 97,670 square miles. It is bordered by six other states: South Dakota, Nebraska, Montana, Idaho, Utah, and Colorado. Its 23 counties, with the Wind River Indian Reservation, cover a terrain ranging from semi-arid plains and rolling grasslands to snow-covered peaks along the Continental Divide. Each county is larger than many East Coast states.

Wyoming is the least populated state in the union with an estimated population of 480,907 (Census Bureau, 1998). The population density of 4.9 persons per square mile categorizes Wyoming as "frontier;" its communities are few and many miles apart. The size and rural nature of the state, coupled with the sparse population, present obvious geographical barriers to health care access.

According to the Bureau of the Census (1998) the estimated racial/ethnic make-up of the state is non-Hispanic white (90.5%), white Hispanic (5.5%), black (0.8%), Native American (2.2%), and Asian/Pacific Islanders (0.8%). The majority of Native Americans live on the Wind River Reservation, which overlaps Fremont and Hot Springs Counties. The 1997 average unemployment rate for Wyoming was 5.1 percent. According to the Bureau of the Census (1996-1997 statistics), median household income was \$32,543. Total percent of persons with incomes below the federal poverty level (FPL) in 1996-1997 was 12.7 percent. In 1996, the percent of children, ages 0-17 living below the poverty level was 15.7 percent.

In the past year the MCH Program turned its attention to developing the needs assessment required for the FY01 application. The model indicators are a set of broad health measures developed by the Maternal and Child Health Bureau and organized under 5 domains: health status, risk/protective status, health and health-related services, health systems capacity and adequacy, and contextual characteristics. Wyoming's MCH Section went on to use these as a tool for planning and organizing a "stand-alone" community reference guide entitled *Comprehensive Assessment of Wyoming's Maternal and Child Health Needs*.

To augment these indicators, a series of facilitated "mini-retreats" was utilized to determine Wyoming's MCH priorities. Consumers, non-profit organizations such as March of Dimes and Healthy Mothers/Healthy Babies Coalition, other state government agencies, and providers, both public and private, were among the MCH stakeholders invited to the retreats.

Based largely on the results of the needs assessment, MCH has determined their emphasis in the upcoming years to be:

1. Decreasing barriers to accessing health care through state and community capacity building and Systems development efforts;
2. Decreasing incidence of low birth weight babies delivered;

3. Decreasing incidence of youth suicide;
4. Decreasing unintended pregnancy;
5. Decreasing prenatal and youth tobacco and other substance use and abuse;
6. Decreasing preventable disease and injury in our children and youth;
7. Providing care coordination services for at-risk populations including first time teen mothers, High-risk pregnant women, and Children with Special Health Care Needs (CSHCN).

1.5 The State Title V Agency

The Maternal and Child Health (MCH) Section is housed in the Wyoming Department of Health's Community and Family Health Division and is responsible for the administration of the Title V Block Grant. A discussion of the Title V Program's components can be found in Section 1.5.1.2 below. The Division's mission is to assure the development of systems of health services for all Wyoming citizens that are family-centered, coordinated and community-based, culturally appropriate, cost-effective and efficient, provide for improved outcomes, and where all components are accountable to the health of the community.

Wyoming authorized the Wyoming Department of Health to secure Title V funds in W.S. 35-4-401-403; 35-4-801-802 and to operate MCH programs in support of public health and safety in W.S. 35-1-240 and 9-2-106. In March, 2000, Governor Geringer authorized an expansion of the Title V Home Visiting Program for at-risk families in Wyoming (SEA 30/SF038). This legislation provided for administration, funding (TANF) and evaluation of the program. Details can be found in the FY 2001 Annual Plan.

1.5.1 State Agency Capacity

Key to the operation of the State Title V Agency is Wyoming's network of public health nurses (PHN). Also housed in the Community and Family Health Division, PHN offices are located throughout Wyoming's twenty-three counties and provide direct services in the areas of communicable disease, prevention, and health promotion; maternal and child health; pre-admission screening for nursing home placement; and home health care of all ages. PHN serves as the local service provider for many departmental programs.

Additional details regarding the Wyoming Department of Health's impact on the health care delivery system can be found in the Section 3.1.2.1 (Needs Assessment Content) of the Annual Plan and on the Agency Organization chart provided on the follow pages.

1.5.1.1. Organization Structure

The Wyoming Department of Health (WDH) is the primary state agency for providing health and human services. It administers programs maintaining the health and safety of all Wyoming citizens, including its 154,796 children (U.

S. Census Bureau). The WDH employs approximately 1,500 people across the state. The WDH annual budget is a lean \$630 million; the Maternal and Child Health (MCH) Title V federal allocation in FY00 was only \$1.3 million.

Garry L. McKee, Ph.D. (Microbiology), became the Director of the WDH on February 3, 1999. In addition to a Masters in Public Health, Dr. McKee has a Masters in Environmental Science and a Bachelor of Science in Biology. He is a Lt. Commander in the U. S. Public Health Service Reserve and brings to the WDH nearly 30 years of public health experience.

As of the date of this grant submission (7/15/00) there are six divisions within the Department of Health (see attached organizational chart):

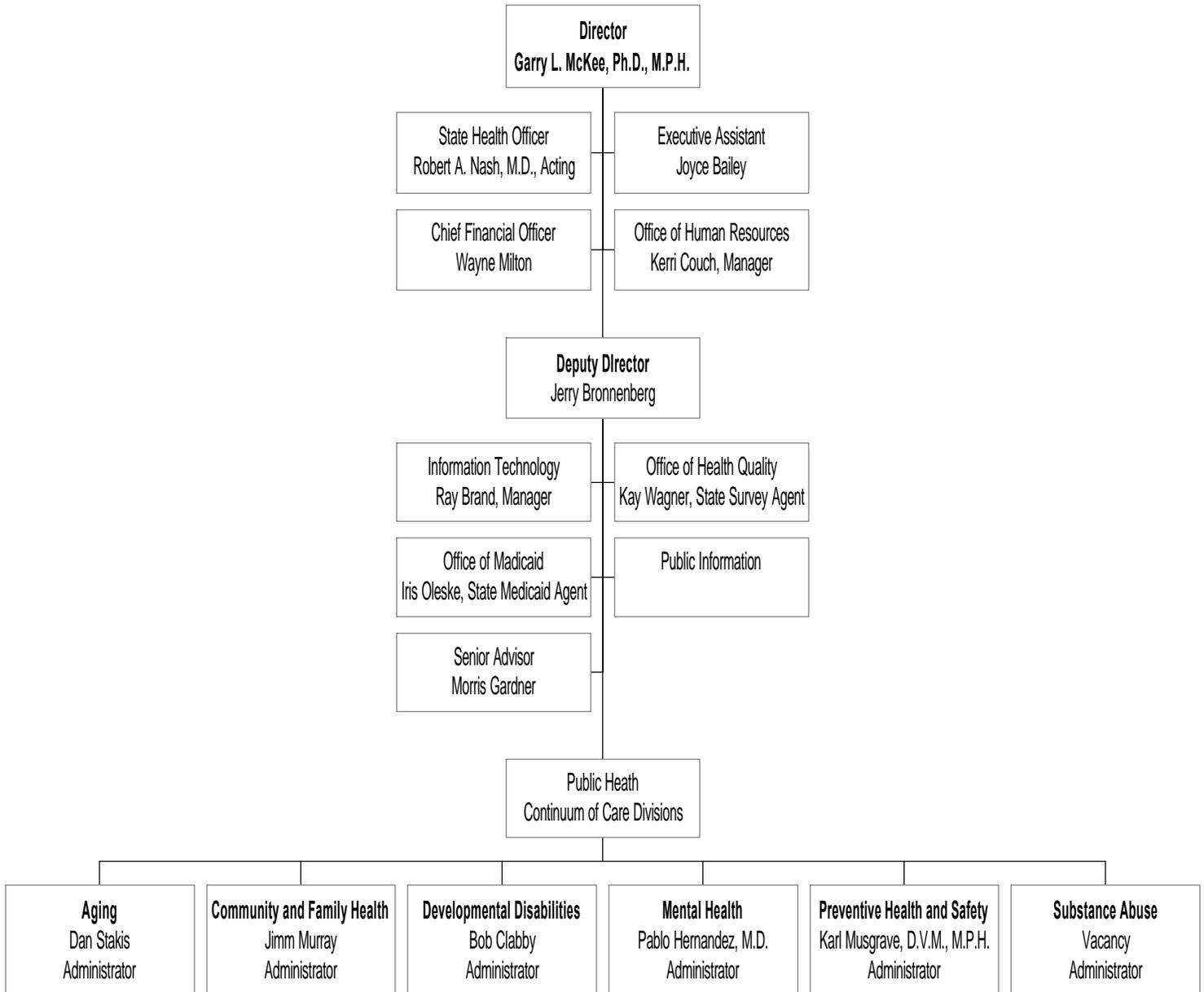
- *Aging Division* develops and administers a statewide comprehensive plan to address programs and services for older adults.
- *Behavioral Health Division* administers the mental health, and family violence/sexual assault authorities within the Department and the Wyoming State Hospital.
- *Substance Abuse Division* is a new division created, in part, with the substance resources formerly housed in the Behavioral Health Division. The new separate standing will provide an additional focus on substance abuse issues and promises more opportunities to maximize current and future resources to fight substance use and addiction.
- *Developmental Disabilities Division* provides services for children and adults with developmental disabilities, beginning with early intervention and preschool programs, including the responsibilities associated with the intermediate education unit; the adult developmental disabilities programs, and the Wyoming State Training School.
- *Community and Family Health Division* houses the MCH Section's services as well as a number of direct service programs including Medicaid Primary Care, Kid Care (Title XXI), Public Health Nursing, WIC, and Immunization.
- *Preventive Health and Safety Division* includes epidemiology, cancer surveillance, diabetes, STD, environmental health (lead and radon), tuberculosis and many of the other programs that focus heavily on prevention and safety.

Both the State Health Officer, as well as a newly created Pediatric Consultant position, serve the entire Department and are supervised directly by Dr. McKee. Shannon Harrison, M.D., resigned his position as State Health Officer

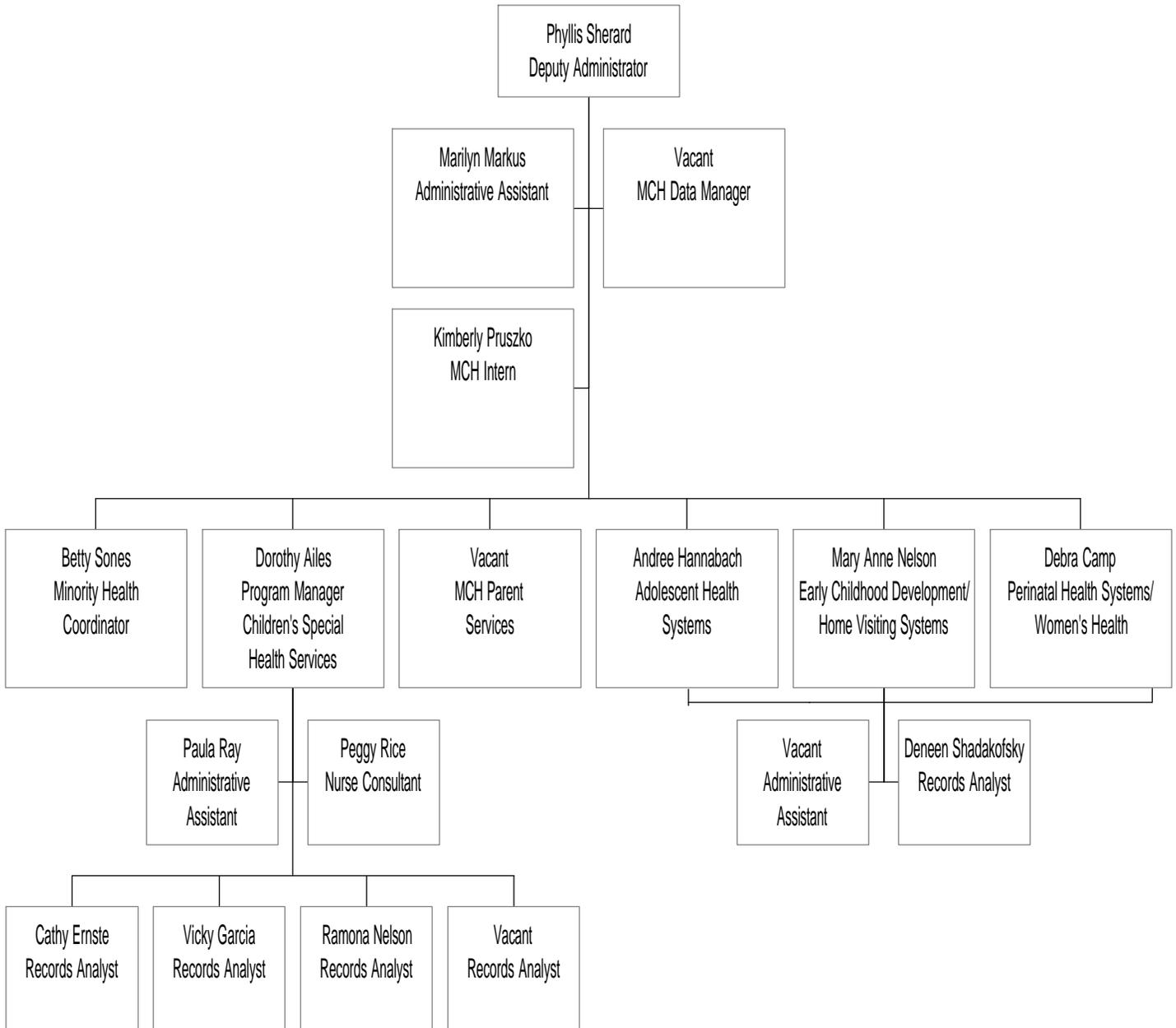
(SHO) in April, 2000 and a replacement has not yet been selected. Dr. Harrison had been providing medical oversight for the MCH Section's Children with Special Health Care Needs (CSHCN) program to ensure appropriate policy development and service delivery for this population; this function is temporarily being fulfilled by a physician from another WDH Division. It is expected that the Pediatric Consultant position will be filled shortly after July 1, 2000; recruitment for the SHO position continues.

Wyoming Department of Health

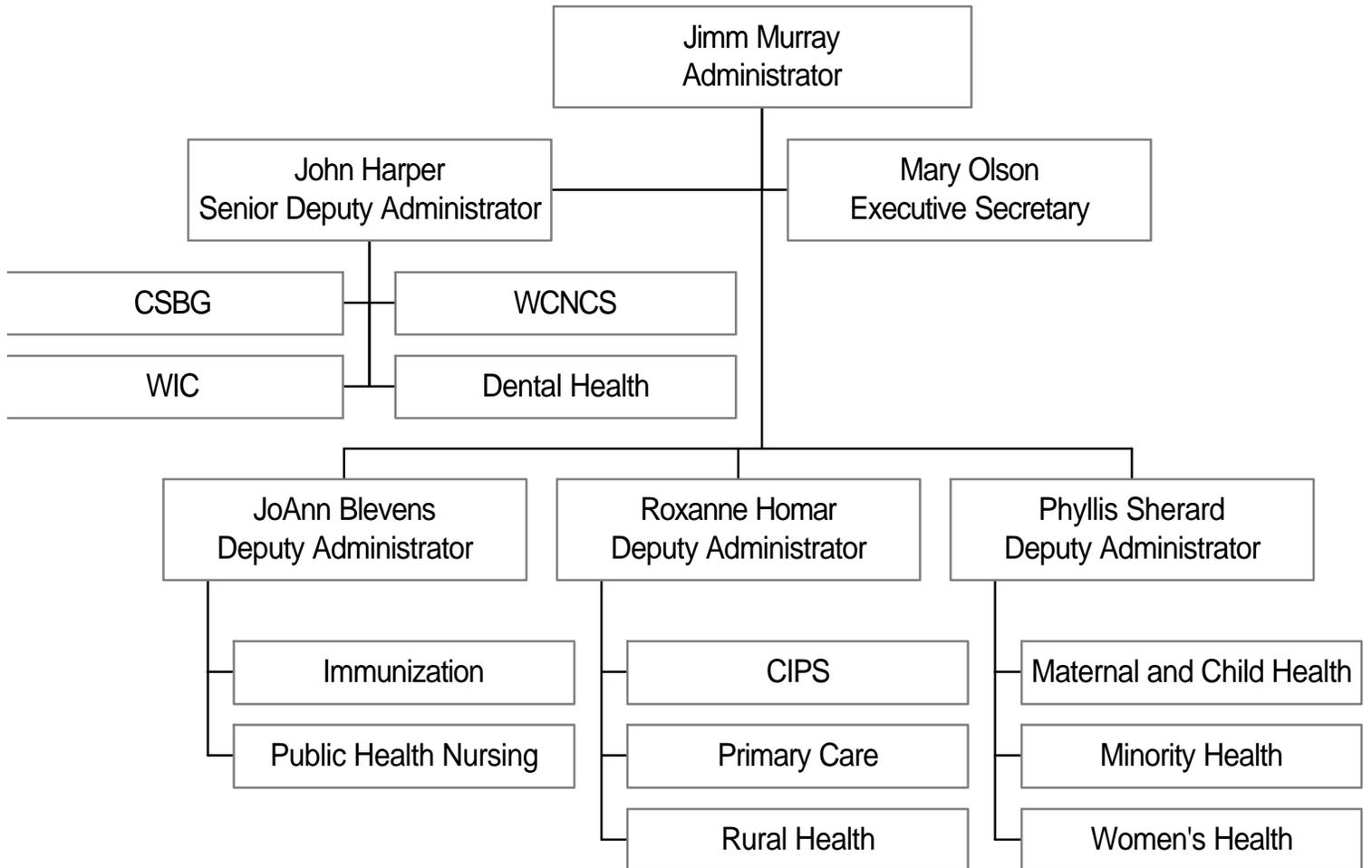
April 20, 2000



Maternal and Child Health



Community and Family Health



1.5.1.2 Program Capacity

Since its inception the Wyoming Department of Health's Maternal and Child Health (MCH) Section has been a network of state and local consortiums of health and social service agencies. Together this network has identified the health needs, service gaps, and barriers to care for families and children and planned community public health and clinical services to meet those needs. As a primarily community-based program, MCH has used a combination of federal and state monies to offer public health and safety-net clinical services for the MCH population.

The following *staff changes* occurred during the annual report/application period:

Debra Camp, RN, BSN, CRRN, CCM joined the MCH Program as Perinatal Systems Manager in March 1999. She brought to this position 24 years of nursing experience and an extensive mix of clinical practice, care coordination and administrative skills that will be invaluable as she manages the Best Beginnings initiative throughout the state. Ms. Camp brought Medicaid experience in both maternal and pediatric utilization review and selective provider contracting to the MCH Section. She assumed the MCH seats on the Healthy Mothers/Healthy Babies Coalition, Newborn Hearing Screening Task Force, March of Dimes Advisory Board and Committee Member, Wyoming Health Council Advisory Board, and the Colorado/Wyoming Annual Perinatal Conference Committee.

Peggy Rice, RN, BSN, assumed the position of CSHCN Nurse Consultant in February 1999. Supervised by the CSHCN Program Manager, Dorothy Ailes, Ms. Rice brings to this position 14 years of nursing experience, most of it in pediatrics, which will be invaluable to the MCH Program's efforts to develop community-based systems of care for CSHCN. She has an extensive mix of clinical practice, care coordination, and administrative skills as well as demonstrated leadership competencies in quality assurance and medical service utilization review that will round out the CHS Program management team.

Shellie Campbell, Coordinator of the state's public/private partnership to raise awareness about the preventable nature of disease and injury, Help Me Grow-Safe Kids (HMG-SK), resigned in August 1999. Many of the Help Me Grow-Safe Kids activities have been contracted out to the private sector. United Medical Center – long time campaign partner – became the Campaign's *Partner Contractor* in January 2000, however, this in no way diminishes the WDH's support of the collaborative effort and the Campaign's efforts. Title V funds continue to support the Partner Contractor's efforts, as well as many of the campaign's population based messages.

Recent assessment activities revealed that Wyoming's MCH population would be better served by concentrating more in the area of adolescent health. Andree Hannabach was hired as the MCH Adolescent Health Systems Manager in January 2000 and brings to this position several years of experience in Health Education related to college students, as well as extensive community service dealing with cancer, tobacco, sexually transmitted diseases, and other health related issues. She has also worked directly with youth on such issues as tobacco, alcohol and drug

use, physical fitness, and teen pregnancy. Her expertise will prove to be invaluable to the MCH Program's efforts to develop community-based initiatives dealing with adolescent health issues.

Betty Sones transferred from the Medicaid Program and assumed the position of WDH Minority Health Coordinator in December 1999. Housed in the MCH Section, Ms. Sones will coordinate language translation services to insure that an inability to speak English does not result in a barrier to services. She will also provide cultural competency education, represent minority populations on various health and social services committees, and educate groups who work with minority and immigrant populations as they collectively strive to clear up some of the confusion surrounding the federal "public charge" definition and its impact on accessing services.

The following partial list identifies staff assignments for key MCH connections:

1. MCH Direction, Administration and Systems Development:

Phyllis Sherard, MPA,

Deputy Administrator, Community and Family Health Division

Governor's Early Childhood Development Council (By Governor's appointment)

Child Care Certification Board (Fulfills the statutory requirement for WDH representative)

Head Start Collaboration Grant Management Team

Youth Policy Team (Appointed to represent WDH by the Governor to this team as it develops a plan for comprehensive youth outcome improvements)

Wyoming Health Resources Network/WDH Contract Development and Evaluation Team

Wyoming Community Coalition for Health Education Board of Directors

State Systems Development Initiative (SSDI) Project Director

Healthier Communities (statewide community health planning development effort)

2. Children with Special Health Care Needs Services Unit (Children's Health Services):

Dorothy Ailes, RN-C, MSN, PNP, Unit Program Manager

Peggy Rice, R.N., BSN CSHCN Nurse Consultant

Community-Based Specialty Care Clinics for CSHCN

High Risk Maternal

Newborn Intensive Care

CSHCN Care Coordination Project

Partnerships Systems Initiative

3. Early Childhood Development Systems and Home Visiting:

Mary Anne Purtzer Nelson, RN, BSN, Program Manager

Home Visiting for Pregnant and Parenting Families (targets first time teen moms)

Children's Trust Fund Board of Directors

Comprehensive Social Services Planning Team
CISS Grant (Healthy Child Care Wyoming) Management Team

4. Adolescent Health Systems:

Andree Hannabach, BSH, Adolescent Health Systems Manager

Adolescent Risk and Protective Factor Development

Abstinence Education Grant

HMG-SK Contract Monitor

MCH point of contact for Tobacco Settlement Strategy

Unintended Pregnancy Prevention Task Force

Youth Suicide Prevention Task Force

5. Perinatal Systems

Debra Camp, RN, BSN, CRRN, CCM, Program Manager

Best Beginnings for Wyoming Babies

Help Me Grow- Safe Kids (SIDS Risk Reduction)

Health Provider Training Coordination

Women's Health Coordinator for the WDH

Wyoming Department of Health Disaster Response Team

Family Planning and the Wyoming Health Council Advisory Board

March of Dimes Advisory Board and Committee Member

Colorado/Wyoming Annual Perinatal Conference Committee

6. Minority Health Coordinator

Betty Sones, BSBA, Program Manager

Language Translation Services

Cultural Competency Training

Minority Health Policy Representation and Development

7. Oral Health

Charles Meyer, DDS, Section Manager

Trish O'Grady

Dental Sealant Program

Orthodontic Program

State Dental Program

Medicaid Dental Program

Even though the Oral Health Program is no longer in the MCH section, it is included here because staff will continue to work closely together, and Oral Health is responsible for one of the National Performance Measures.

Fluoride Program
Cleft Palate Program

8. Other Key Staff:

Vacant at this time are the positions of MCH Parent/Consumer Consultant and MCH Epidemiologist

MCH programs and initiatives include:

- **Adolescent Health Systems:** Andree Hannabach, BSH, (307) 777-3733. This program places emphasis on:
 - A) Systems development and resource planning, as evidenced by the partnership between MCH and the Department of Education (promotes Coordinated School Health)
 - B) Facilitation of various youth issue task forces including, but not limited to Youth Suicide Prevention and Unintended Pregnancy Prevention.
 - C) This position also assists the Deputy Administrator in efforts to write the emerging *Youth Improvement Plan* being developed by the Governor's Human Services Sub-Cabinet and the Youth Policy Team. The resultant plan is expected to have a major impact on the future programmatic approach to assist this population - youth age 8 through 21. (See FY 01 activities for additional information.)
 - D) Community Development, as evidenced by MCH funded seed grants and technical assistance to advance community-based Asset Building Initiatives (Search Institute model will provide the foundation upon which to build the Hawkins/Catalano Risk and Protective Factor Model in FY 2001.)
- **Best Beginnings for Wyoming Babies:** Debra Camp, RN, BSN, CRRN, CCM, (307) 777-7944. Develops state and local community health systems to increase access to services during the critical perinatal period.
- **Children's *Special Health Services*:** Dorothy Ailes, RNC, MSN, PNP (307) 777-7941. Ensures access to Level III critical services that help reduce infant mortality and provides care coordination, limited supplemental income via fee-for-service provider reimbursement for selected diagnoses, and promotes access to specialty services for infants, children, and adolescents with special health care needs within their own communities. (NOTE: The Maternal and Child Health Section recently announced a name change for this program. At forums conducted around the state as part of the Five Year Needs Assessment, providers and consumers urged MCH to change the name to one that more closely reflects the specialty services provided by this program and distinguishes it from other Community and Family Health Division services for children. Effective July 1, 2000, this program will be known as **Children's *Special Health Services***. The program will continue its long tradition of meeting the needs of uninsured and under-insured families to access specialty care for limited diagnoses; promoting the "medical home" concept; and linking parents of special needs children with necessary

family supports. It has also recently enhanced its care coordination and early diagnosis and intervention components.)

For part of this reporting period, the WDH's Lead Program was administered in the CSHCN program. The emphasis of the program while housed in MCH was to focus on: A) Not only adult lead exposures in industry, but on what a parent might bring into the home, and thus to the child, from the work environment; B) Assisting Medicaid to come to full compliance with EPSDT lead screening requirements. A lead testing policy for children with special health care needs began during this reporting period and was completed in FY 2000. (NOTE: The program moved to Preventive Health and Safety Division with the realignment of April 2000.)

- **MCH Data Management and Statistical Services:** Vacant, MCH Epidemiologist. This position coordinates a comprehensive Needs Assessment every five years to monitor the health of all mothers, children, and youth in the state; collects data for responding to inquiries from the media, community health planners, legislators and advocacy groups; designs special studies for MCH issues; monitors progress toward 28 performance objectives; and assists with the evaluation of MCH interventions.
- **Early Childhood Development System.** Mary Anne Nelson, RN, BSN, (307) 777-6474. This program coordinates the provision of home visiting services to at-risk families during pregnancy and the early childhood years, as well as supporting and providing technical assistance to public and private sector efforts to enhance child development pre-birth through age eight. This is accomplished by Ms. Nelson's active participation on the Children's Trust Fund Board; the Head Start Collaboration Grant's Management Team; and efforts to provide assistance to the Medicaid Program when updating EPSDT policies following MCH Bright Futures recommendations for well-child care, etc.

This position also assists the Deputy Administrator in efforts to collaborate with: the Department of Family Services to set safety and quality standards for child care providers through the Child Care Certification Board and, the Governor's Early Childhood Development Council's efforts to enhance the early development of children.

- **Family Planning:** Debra Camp, RN, BSN, CRRN, CCM, (307) 777-7944. Contracts with private and public providers to ensure access to family planning services by augmenting the state's Title X grants.

Healthier Communities (Health Care Delivery “Systems” Development): Phyllis Sherard (307) 777-7942.

Working with our contractor, Wyoming Health Resources Network, MCH provides funding and technical assistance to local communities as they work to build the infrastructure needed to conduct health care planning and address their local health needs. The needs might range from accessing mental health care to improving immunization rates to identifying areas of increased risk for lead poisoning.

- **Help Me Grow-Safe Kids:** Andree Hannabach, (307) 777-3733. Monitors the MCH contract with the Campaign’s private sector *Partner Contractor*, United Medical Center Foundation. The Campaign raises awareness about the preventable nature of infant, child and adolescent disease and injury, i.e. SIDS risk reduction, suicide, child abuse, substance use and abuse, premature sexual activity, and other risk taking behaviors.

Also Housed in the MCH Section:

- **Minority Health:** Betty Sones, (307) 777-5601. Serves as a central point for the exchange of information, expertise, and assistance in improving the health status of Wyoming’s minority populations, i.e. research on minority health issues, cultural and linguistical health care barriers, accessing specialty services such as mental health care, etc.
- **Women’s Health:** Debra Camp, RN, BSN, CRRN, CCM, (307) 777-7944. Serves as a central point for the exchange of information, expertise, and assistance in improving the health status of Wyoming’s women, i.e. research on women’s health issues, accessing specialty services, and developing Healthy People 2010 objectives.

The MCH Block Grant also funds:

- **Oral health services** including dental sealants and other dental services to under-served children.
- **Genetic services** include newborn screening and follow-up for newborns with known or suspected genetic disorders. It also provides genetic evaluations and counseling, and consultation in appropriate treatment and management of genetic disease.

Finally, combined Title V and Wyoming’s maintenance of effort funding ensures:

- The **medical services of two physicians** (State Health Officer and Pediatrician) to assist with systems development, oversight of medical services, and standards development.

1.5.1.3 Other Capacity

Due to scarce federal and state resources, it is necessary for all MCH program personnel to undertake planning and evaluation for the populations that they serve. Toward this end, very few skill building opportunities in areas related to data capacity building, planning and evaluation are overlooked. Wyoming recently received State Systems Development Initiative (SSDI) grant funds to obtain the services of both an MCH Data Manager and a Data Integration Project Coordinator for the Department of Health's several data sources. The Department has begun a data needs assessment and will soon produce a data improvement plan. It is also expected that the MCH Section will develop staff expertise in issues related to broadening the collaboration base to impact Adolescent Health, the Tobacco Settlement; Women's Health; Disaster Planning; transition to adult services and reducing Minority Health Disparities.

1.5.2 State Agency Coordination

The MCH Section coordinates with a myriad of state, county, and local agencies and organizations. The extent of the collaboration is depicted in the chart at the end of this section. The following describes some of the linkages:

Coordination within the Community and Family Health Division. Maternal and Child Health coordinates frequently with the following DH Units: Women, Infants and Children (WIC) (nutrition services and standards for MCH programs); Chronic Disease (tobacco, diabetes and cancer surveillance); Infectious Disease (STDs); and Health Data Analysis (meeting all data collection needs). Co-located on the same floor, program managers from these Units meet regularly to coordinate services and activities related to the population we jointly serve. Regular consultation is sought from the Genetic Services Manager, currently housed in the State Laboratory (Preventive Health and Safety Division).

Coordination with the WIC Program is especially effective and has proven to be essential to the development of standards and policies for the Best Beginnings and the Home Visiting for Pregnant and Parenting Families Program. WIC is also served by the Help Me Grow-Safe Kids information line. WIC and CSHCN coordinate the provision of PKU or other special formulas for families who financially qualify for the programs. Working in a joint effort to obtain further education on the nutritional needs of CSHCN, a satellite down link on nutritional needs of children with cerebral palsy was funded by MCH. Staff from both programs attended.

Coordination with Oral Health Services has resulted in a very successful sealant program in schools throughout the state, cleft palate clinics, and orthodontic care by private providers for severe and crippling malocclusion.

Maternal and Child Health has a long-standing history of collaboration with Public Health Nursing, housed in the same division. At the local level, public health nurses often serve as first contact for families in need of MCH services offered by Best Beginnings, Home Visiting for Pregnant and Parenting Families, Children's Health Services, Genetic Services, as well as many other programs. Coordination at the State level makes the system work at the local level.

Recently, the Health Care Financing Administration (HCFA) approved the state plan for implementing the first phase of the Children's Health Insurance Program (CHIP). Called Kid Care 1, the first phase will be a Medicaid look-alike program and cover children with family incomes from 100% to 133% of federal poverty level (FPL). Kid Care 2, a private insurance buy-in program, has not yet been approved by HCFA but is intended to provide coverage for children in families with incomes from 134% to 149% FPL. MCH personnel worked closely with state officials and the legislature in developing Kid Care. Integration of Kid Care policy with CSHCN program policy has been, and will continue to be a high priority.

Memoranda of Understanding. Maternal and Child Health has an active Memoranda of Understanding stipulating the joint resolution of issues impacting common populations with Medicaid, the Division of Developmental Disabilities, the Department of Education, the Emergency Medical Services for Children Program, and the Primary Care Office (Office of Rural Health).

Coordination with Agencies External to the Community and Family Health Division. Participation on interagency councils, task forces, and committees provide added opportunities to coordinate MCH programs and strategies with agencies outside the Community and Family Health Division. The Deputy Administrator and her staff participate actively on the following: Their activities are either detailed in the Annual Report or summarized below.

1. Governor's Council on Early Childhood Development
2. Healthy Child Care Wyoming (CISS grant)
3. Child Care Certification Board
4. Wyoming Health Council (Formerly known as Wyoming Reproductive Health Council)
5. Unintended Pregnancy Prevention Task Force
6. Governor's Council on Developmental Disabilities
7. Children's Trust Fund Board
8. Child Health Insurance Program Steering Committee (CIPS)
9. Youth Suicide Prevention Task Force
10. Wyoming Community Coalition for Health Education (WCCHE)
11. Wyoming Health Resources Network (WHRN)
12. Wyoming Head Start Collaboration Project (see below)
13. Department of Family Services' Comprehensive Social Services Planning Team

14. Early Intervention (Part B) Council
15. State Diabetes Council
16. State 6B Council (Education)
17. State Hearing Board
18. Newborn Hearing Screening Board
19. Deaf Services Planning Committee

State/Local Coordination. Maternal and Child Health also houses Wyoming's State System's Development Initiative (SSDI) and counts three items as its most significant achievements to-date. First, the adoption of goals and objectives that "institutionalize" systems development theory into the MCH Services. All of the MCH Programs and services now utilize systems theory in their management. Second, the degree to which Community Health Coalitions — which draw on the talents, perspectives, and resources of key community members representing diverse backgrounds — have been established to serve as central health planners for local health boards (75% of Wyoming's communities have established these comprehensive health planning boards). Finally, the degree to both inter- and intra-agency collaboration has been improved at the state level. Details are in the SSDI FY 2000 Application.

Wind River Reservation Initiative. The MCH Initiative to expand services on the Wind River Reservation is part of its mission to work with a broad network of partners to improve the health and well-being of Wyoming's MCH population. This network focuses on strengthening both personal care and public health systems in order to establish an integrated community system of comprehensive services. As always, most of our efforts have been dedicated to building collaborative partnerships at the community level with providers and public/private organizations in an effort to maximize scarce financial and human resources. As detailed in both the FY 98 Annual Report and the FY 2000 Annual Plan, MCH has made significant progress in our infrastructure development efforts related to improving access to primary and preventive services for the MCH Native American population. These efforts are reflected in contractual relationships with 1) the Fremont County Health Department (expand Best Beginnings and Home Visiting Services in partnership with Indian Health Services) and 2) the Wyoming Health Resources Network (for community health systems development, needs assessment, and planning). Additionally, MCH funded a Fremont County-based Help Me Grow - Safe Kids Chapter to serve Lander and the Wind River Indian Reservation.

CSHCN "Partnerships" Initiative. The "Partnerships for Special Needs Children" project facilitates the development of family-centered, community-based, coordinated, culturally sensitive services. The purpose of this infrastructure building initiative is to furnish information to medical providers, educators, parents and other community members on the critical elements of family-centered care and to promote teamwork in the support systems in the communities. The goals are to enhance services and improve outcomes for all children and their

families. Training materials and a resource manual have been developed and are available upon request. Care coordination has focused on the nurse's role in promoting teamwork between community providers.

Tertiary Centers. Children's Special Health Services maintains a strong relationship with tertiary centers in Denver, Colorado; Salt Lake City, Utah; as well as Billings, Montana; and Rapid City, South Dakota facilities. These centers are used as destinations for high-risk mothers pre- and postnatally, newborn intensive care, and for children with special health care needs. Due to the fact that Wyoming has no tertiary care centers for pregnant women and infants, and because of the size of Wyoming, these various sites provide access to care for families, depending on which area of the state they reside. The Children's Hospital and Presbyterian-St. Luke's in Denver provide the majority of services to children and families who live in the eastern and southern areas of the state. Primary Children's Medical Center and The University of Utah in Salt Lake City provide services to those who live in the western part of Wyoming. Other facilities used occasionally are St. Vincent's, Billings, Montana, and Regional Medical Center at Rapid City, South Dakota.

MCH PARTNERSHIPS	Adolescent Health	Best Beginnings	Children's Health	Early Childhood Issues	Help Me Grow-Safe Kids	Home Visiting	Lead Poisoning	Community Planning	Minority Health Disparities	Women's Health
WIC	X	X	X		X	X		X	X	
Best Beginnings	X		X	X	X	X	X	X	X	X
Fremont County Public Health	X	X	X		X	X			X	X
Wyoming Health Resources Network	X	X	X		X	X		X	X	X
UIPPTF (Multi-agency for task force)	X	X				X		X		X
American Cancer Society	X			X	X					X
Help Me Grow-Safe Kids	X	X	X	X	X	X		X		
Home Visiting	X	X	X	X	X			X	X	X
Public Health Nurses	X	X	X	X	X	X	X	X	X	X
University of Wyoming	X	X	X	X	X			X		
Wyoming Health Council	X	X				X		X		X
La Leche League		X			X					X
Prevent Child Abuse Wyoming	X	X		X	X				X	
March of Dimes	X	X	X	X		X			X	
Healthy Mothers/Healthy Babies	X	X	X	X	X	X	X		X	
Medicaid (EPSDT)	X	X	X			X	X	X	X	X
Behavioral Health Treatment Center		X								X
Community Health Coalition	X	X	X	X	X	X	X	X	X	X
Department of Family Services	X	X	X	X	X	X	X	X		
Primary Care Association		X	X	X			X	X	X	
Child Health Services	X	X	X	X	X	X	X			
Tobacco Prevention Project	X	X		X	X	X	X			X
Private Medical Providers		X	X	X	X		X	X	X	X
WY Assoc. of Family Practitioners				X				X	X	X
WY Chapter of American(?)			X	X	X			X	X	
WY Dept. of Agriculture			X				X			
WY Dept. of Environmental Quality							X			
Div. of Developmental Disabilities		X	X	X	X					
Family Support Network			X	X						
Parent Information Center			X							
Social Security Administration			X	X						
Dental Health	X	X	X		X	X				
WCCHE	X				X	X		X	X	X
Hospitals		X	X		X			X	X	
Early Intervention Council		X	X	X						
Division of Behavioral Health	X	X	X		X	X		X		X
Indian Health Services	X	X	X		X	X		X	X	
Emergency Medical Services	X				X	X			X	
DOE-YRBS	X	X				X				
Behavioral Risk Factor Surv. System	X	X			X	X				X
WY Dept. of Education	X	X	X	X	X	X		X		
WY Dept. of Transportation					X					
WY Parent			X	X	X					
WY Trial Lawyers Association					X					
WY Air National Guard					X					
Think First Campaign					X					
State Fire Marshall					X					
WY Dept. of Health (other divisions)					X					
Ronald McDonald House					X					
Sate Farm Insurance					X					
State Nursing Association					X					
State PTO					X					
Shriner's Hospital			X		X					
Shriner's Temple			X							
Family Voices			X							
Uplift			X							

II. REQUIREMENTS FOR THE ANNUAL REPORT

2.1 Annual Expenditures

See Forms 3, 4, and 5.

2.2 Annual Number of Individuals Served

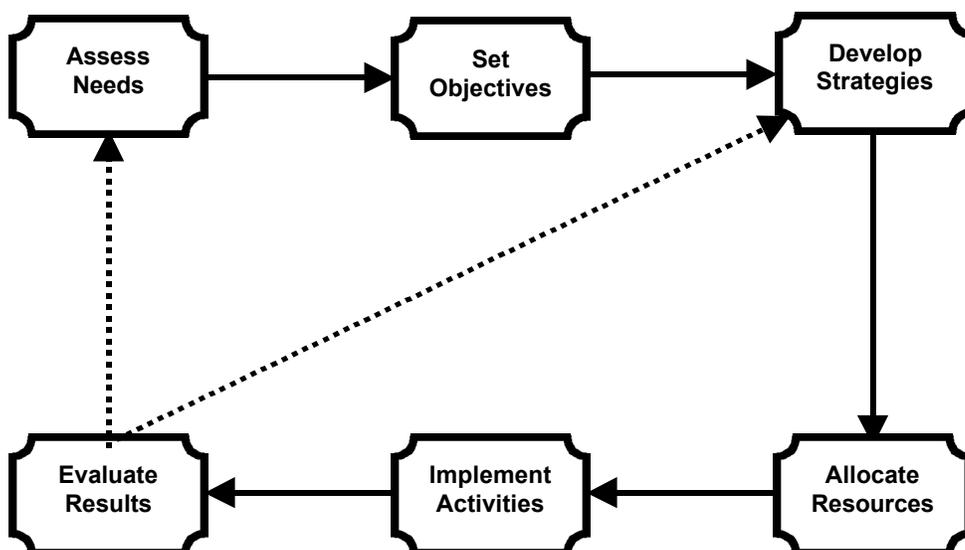
See Forms 6, 7, 8, and 9.

2.3 State Summary Profile

See Form 10.

2.4 Progress on Annual Performance Measures

This section is structured to emphasize links between the various steps in the administrative process (see figure on bottom of page). The charts on the following pages summarize goals, objectives, activities and performance measures. The charts are insightful because they show how the MCH section is structured, and they ascribe primary responsibility for each measure. Listed performance measures are either national performance measures (NPM #1-18) or state performance measures (SPM #1-10). Subsequent narrative provides more detail. A chart at the end of the section discusses unmet performance measures.



HEALTH SYSTEMS INFRASTRUCTURE DEVELOPMENT OUTCOME IMPROVEMENT PLAN (FY99)		
Goal	Broad Objectives	Activities Relating to Each Objective
Improve and institutionalize the State's health service and prevention infrastructure.	Improve access to MCH health services. (Specific objectives listed below.)	<u>Direct Services:</u> None
		<u>Enabling Services:</u> None
		<u>Population Services:</u> None
		<u>Infrastructure Building:</u> Work to improve the effectiveness and efficiency of MCH programs. Medical provider recruitment and assistance contract with WHRN. Assist in the Promotion & development of the Kid Care Program. Contracts with County Public Health Nursing Offices to build mid-level provider capacity.
	Improve the health-planning infrastructure in the Department and in local communities. (Specific objective listed below.)	<u>Direct Services:</u> None
		<u>Enabling Services:</u> None
		<u>Population Services:</u> None
		<u>Infrastructure Building:</u> Conduct five-year comprehensive MCH needs assessment. Provide funding to build local level health planning capacity & coordinate with the Wyoming Health Resources Network (WHRN). Obtain funds to assess data needs and to develop a plan for meeting those needs.
<u>Relevant Performance Measures, Outcome Measures and Objectives:</u>		
NPM #12: Percent of Children without health insurance. (The objective for FY99 was 13%.)		
NPM #13: Percent of Medicaid eligible children who have received a service paid by the Medicaid Program. (The objective for FY99 was 90%.)		
SPM #9: Percent of communities with a community-wide plan for services to the MCH population. (The objective for FY99 was 65%.)		

CHILDREN WITH SPECIAL HEALTH CARE NEEDS OUTCOME IMPROVEMENT PLAN (FY99)
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Goal	Broad Objectives	Activities Relating to Each Objective
<p align="center">Improve the health and well-being of CSHCN and their families.</p>	<p align="center">Increase early screening and provide access to quality medical care. (Specific objectives listed below.)</p>	<p><u>Direct Services:</u> Provide fee-for-service reimbursement for medical services and specialty clinic services.</p>
		<p><u>Enabling Services:</u> Care coordination for CSHCN; Provide translation, transportation/per diem for families to obtain services when necessary.</p>
		<p><u>Population Services:</u> Disseminate educational materials. Administer lead screening and prevention efforts.</p>
		<p><u>Infrastructure Building:</u> Maintain an internal and community-based planning infrastructure. Work with parents to establish a medical health home. Conduct activities relating to eligibility and policy requirements of various CSHCN programs. Participate in outreach with WIC, EIC, Kid Care. Coordinate policies with other entities. Recruit & certify providers. Organize/ promote community-based specialty clinic services.</p>
	<p align="center">Increase the focus on family-centered activities. (Specific objectives listed below.)</p>	<p><u>Direct Services:</u> Provide parents with education, support, referral and care coordination.</p>
		<p><u>Enabling Services:</u> Provide limited assistance for parents to attend activities and conferences. Pay for translation services.</p>
		<p><u>Population Services:</u> Develop educational materials that are widely circulated to parents and relevant organizations.</p>
		<p><u>Infrastructure Building:</u> Sit on numerous boards and committees to help integrate relevant policies.</p>
<p>CSHCN OUTCOME IMPROVEMENT PLAN (FY99) <u>Relevant Performance Measures, Outcome Measures and Objectives:</u></p> <p>NPM #1: The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the CSHCN Program. (The objective for FY99 was 41%.)</p> <p>NPM #2: The degree to which the CSHCN Program provides or pays for specialty and sub-specialty services, including care coordination, not otherwise accessible or affordable. (The objective for FY99 was to provide 9 specialty and subspecialty services.)</p> <p>NPM #3: The percent of CSHCN in the state who have a medical home. (The objective for FY99 was 80%.)</p> <p>NPM #11: The percent of CSHCN in the state with a source of insurance for primary and specialty care. (The objective for FY99 was 75%.)</p> <p>NPM #14: The degree to which the State assures family participation in program policy activities in the CSHCN Program. (The objective for FY99 was achieved a composite score of 14.)</p> <p>SPM #1: The number of specialty/subspecialty clinics offered in the state by tertiary centers. (The objective for FY99 was to have 188 specialty/subspecialty clinics.)</p>		

CHILD AND ADOLESCENT HEALTH OUTCOME IMPROVEMENT PLAN (FY99)		
Goal	Broad Objectives	Activities Relating to Each Objective
Improve comprehensive child and Adolescent outcomes	Decrease preventable childhood illness, injury and death. (Specific objectives listed on the following page.)	<p>Direct Services: Provide Home Visiting for Pregnant and Parenting Families (HVPPF) Program.</p> <p>Enabling Services: Provide translation, transportation, etc. for eligible families to obtain services when necessary.</p> <p>Population Services: Maintaining the HMG-SK Campaign as a statewide media-vehicle to raise awareness about the preventable nature of disease and injury: Assist in the development & circulation of educational materials to parents and relevant organizations around reducing adolescent risk-taking behaviors. Issues addressed include, but are not limited to: substance use; coordinated school health; youth suicide prevention; reducing risk-taking behaviors; abstinence education (Sex Can Wait-Campaign)</p> <p>Infrastructure Building: Provide training and coordination for county public health nurses who conduct home visits and implement community-based strategies. Maintain the necessary MCH internal planning infrastructure, and build local level capacity, through local PHN offices.</p>
	Decrease teen risk-taking behavior. (Specific objectives listed on the following)	<p>Direct Services: None</p> <p>Enabling Services: None</p> <p>Population Services: Conduct activities relating to: adolescent risk reduction; suicide prevention; unintended pregnancy prevention; tobacco & substance reduction; and STD screening. Disseminate educational materials including those for an Abstinence Education Grant.</p> <p>Infrastructure Building: Provide grants and technical assistance to other partners and stakeholders that conduct adolescent related activities including suicide prevention, tobacco use, health education standards, etc. Maintain the necessary internal planning infrastructure, and build local level capacity, through local PHN offices. Coordinate policies with other entities. Facilitate the Youth Suicide Prevention and Unintended Pregnancy Prevention Task Forces. (NOTE: Look for program expansion in FY01 as adolescent health becomes a Wyoming priority.)</p>

CHILD AND ADOLESCENT HEALTH OUTCOME IMPROVEMENT PLAN (FY99) CONTINUED

Relevant Performance Measures, Outcome Measures and Objectives:

NPM #5: Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Hemophilus Influenza, and Hepatitis B. (The objective for FY99 was 80%.)

NPM #6: The birthrate (per 1,000) for teenagers aged 15 through 17 years. (The objective for FY99 was 22 per 1,000.)

NPM #8: The rate of deaths to children aged 1 - 14. Caused by motor vehicle crashes per 100,000. (The objective for FY99 was 10 per 100,000.)

NPM #15: Percent of very low birth weight live births. (The objective for FY99 was 1.0%.)

NPM #16: The rate (per 100,000) of suicide deaths among youth aged 15-19. (The objective for FY99 was 11.0 per 100,000.)

SPM #6: Number of preventable child deaths, other than vehicle crashes. (The objective for FY99 was 19%.)

SPM #7: Rate of adolescent alcohol use. (The objective for FY99 was 50%.)

SPM #8: Rate of adolescent smoking. (The objective for FY99 was 36%.)

SPM #10: Health and safety in child care settings. (The objective for FY99 was that 45% of licensed child-care facilities would access health and safety consultation and training.)

NOM #6: The death rate per 100,000 children aged 1-14. (The objective for CY98 was 33.0 per 100,000.)

PREGNANT WOMEN AND INFANTS OUTCOME IMPROVEMENT PLAN (FY99)		
Goal	Broad Objectives	Activities Relating to Each Objective
Improve the health of pregnant women and infants.	Improve birth outcomes. (Specific objectives listed below.)	<p>Direct Services: Home Visiting for Pregnant and Parenting Families (HVPPF) Program</p> <p>Enabling Services: Best Beginnings programs in every county provide outreach, education and care coordination for all pregnant women; supplemental perinatal funds are available to provide translation, transportation, etc. for families to obtain services when necessary.</p> <p>Population Services: Help Me Grow-Safe Kids Campaign PSAs and information and referral line regarding perinatal issues; Genetic Services</p> <p>Infrastructure Building: Non-Title X Family Planning Grants to local health departments (Contract with the Wyoming [Reproductive] Health Council) emphasizes community-based systems development extends family services to under-served areas; maintain the internal and external planning infrastructure; on-going collaboration with other programs and stakeholders; Best Beginnings System development activities.</p>
	Increase access to prenatal care, screening and early intervention services. (Specific objectives listed below.)	<p>Direct Services: HVPPF.</p> <p>Enabling Services: Provide presumptive eligibility, supplemental funding, translation, transportation, etc. for eligible families to obtain services when necessary through Best Beginnings and CSHCN programs.</p> <p>Population Services: Newborn hearing and genetic screening services. Help Me Grow-Safe Kids <i>Parent's Guide</i> distributed through birthing facilities.</p> <p>Infrastructure Building: Maintain both internal and external planning infrastructure; MCH capacity grants to local health departments; Governor's Early Childhood Development Council; Best Beginnings system development activities.</p>

PREGNANT WOMEN AND INFANTS OUTCOME IMPROVEMENT PLAN (FY 99) (CONTINUED)

Relevant Performance Measures , Outcome Measures and Objectives:

NPM #4: Percent of newborns in the state with at least one screening for each of PKU, hypothyroidism, galactosemia, and hemoglobinopathies. (The objective for FY99 was 98%.)

NPM #9: Percentage of mothers who breastfeed their infants at hospital discharge. (The objective for FY99 was 75%.)

NPM #10: Percent of newborns who have been screened for hearing impairment before hospital discharge. (The objective for FY99 was 97%.)

NPM #17: Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates. (The objective for FY99 was 77%.)

NPM #18: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester. (The objective for FY99 was 87%.)

SPM #2: Percent of high-risk pregnant women and infants receiving care-coordination. (The objective for FY99 was 30%.)

SPM #3: Percent of women using tobacco, alcohol or drugs during pregnancy. (The objective for FY99 was 18%.)

SPM #4: Percent of low birth weight babies delivered in the state. (The objective for FY99 was 6.4%.)

SPM # 5: Rate of fetal deaths per 1,000 live births. (The objective for FY99 was 5 per 1,000 live births.)

NOM #1: The infant mortality rate per 1,000 live births. (The objective for CY98 was 6.4 per 1,000 live births.)

NOM #2: The ratio of black infant mortality rate to white infant mortality rate. (The objective for CY98 was 0.9)

NOM #3: The neonatal mortality rate per 1,000 live births. (The objective for CY98 was 4.0 per 1,000 live births.)

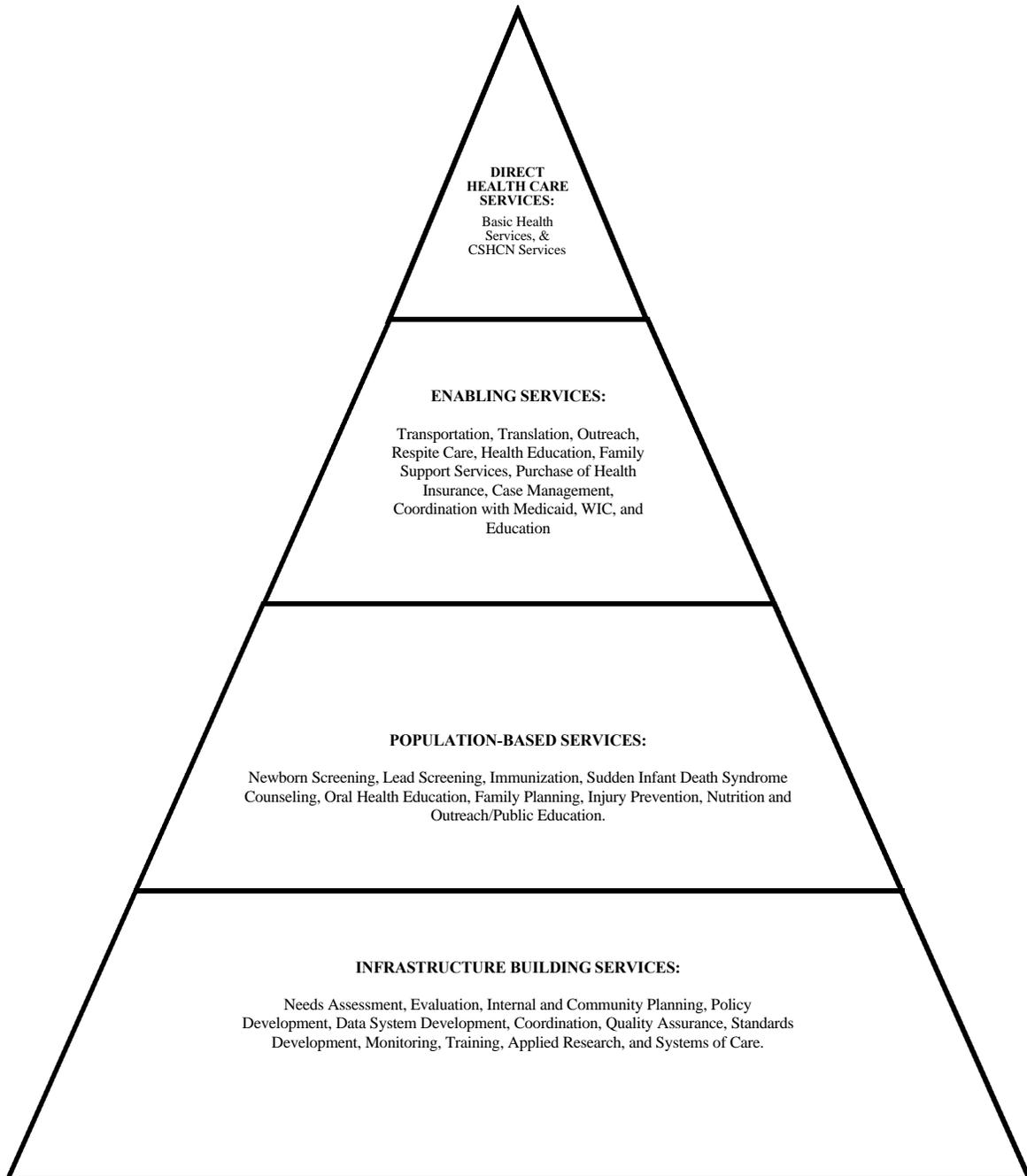
NOM #4: The postneonatal mortality rate per 1,000 live births. (The objective for CY98 was 2.4 per 1,000 live births.)

NOM #5: The perinatal mortality rate per 1,000 live births. (The objective for CY98 was 9.5 per 1,000 live births.)

ORAL HEALTH PROGRAM (FY99)		
Goal	Broad Objectives	Activities Relating to Each Objective
Improve Oral Health	Decrease Occlusal Caries and Smooth Surface Decay. (Specific objective listed below.)	Direct Services: MCH funding of dental sealants; State Dental Program; Medicaid Dental Program; Fluoride treatment in dental offices
		Enabling Services: Promote access to dental providers
		Population Services: Community fluoridation; School fluoride mouth rinse program
		Infrastructure Building: Collaboration with Kid Care (CHIP)
	Reduce Periodontal Disease.	Direct Services: MCH funded orthodontic program; Medicaid funded orthodontic program; and Cleft Lip and Palate Clinic
		Enabling Services: Provide translation, transportation, etc. for families to obtain services when necessary.
		Population Services: Dental education activities
		Infrastructure Building: Collaboration with WIC on nutrition; Collaboration with CSHCN regarding financial assistance.
<u>Relevant Performance Measures, Outcome Measures and Objectives:</u>		
NPM #7: Percent of third grade children who have received protective sealants on at least one permanent molar tooth. (The objective for FY99 was to increase to at least 50% the proportion of children who have received protective sealants on the occlusal surfaces of permanent molar teeth.)		

The following narrative describes the accomplishments of the MCH Program in FY99. The state's activities are categorized by the four levels of service in the MCH pyramid and by required population groups. A table summarizing unmet performance measures is included at the end of the section.

Core Public Health Services Delivered by MCH Agencies



FY 1999 PERFORMANCE MEASURES
Provided here for reference

National "Core" Performance Measures	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
1) The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.	X				X		
2) The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.	X				X		
3) The percent of Children with Special Health Care Needs (CSHCN) in the State who have a "medical/health home."		X			X		
4) Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies (e.g., the sickle cell diseases combined).			X				X
5) Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.			X				X
6) The birth rate (per 1,000) for teenagers aged 15 through 17 years.			X				X
7) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.			X				X
8) The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children.			X				X
9) Percentage of mothers who breastfeed their infants at hospital discharge.			X				X
10) Percentage of newborns who have been screened for hearing impairment before hospital discharge.			X				X
11) Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN Program with a source of insurance for primary and specialty care.				X	X		
12) Percent of children without health insurance.				X	X		
13) Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.				X		X	
14) The degree to which the State assures family participation in program and policy activities in the State CSHCN Program.				X		X	
15) The rate (per 100,000) of suicide deaths among youths 15-19 years.				X			X
16) Percent of very low birth weight live births.				X			X
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.				X			X
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.				X			X

Negotiated Performance Measures	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
1) Number of CSHCN Specialty Clinics	X				X		
2) Percent of high-risk pregnant women receiving care coordination services.		X			X		
3) Percent of women who self-report using alcohol and/or substances during pregnancy.			X				X
4) Percent of low birth weight babies (NPM #16 is for VLBW; not a demonstrated problem in Wyoming.)			X				X
5) Rate of fetal deaths per 1000 live births.			X				X
6) Percent of preventable child death from non-motor vehicle causes.			X				X
7) Percent of adolescents who self-report alcohol use.				X			X
8) Percent of Wyoming high school students who report smoking.				X			X
9) The number of communities in Wyoming with a community-wide plan for services to the MCH population.				X		X	
10) The percent of licensed child care facilities that have accessed health and safety consultation and training.				X		X	

NOTE: DHC = Direct Health Care ES = Enabling Services PBS = Population Based Services
 IB = Infrastructure Building C = Capacity P = Process RF = Risk Factor

A. Direct Health Care Services

A.1 Women and Infants

A.2 Children

A.3 CSHCN

NPM#1: The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program. (The State objective for FY99 was 41%. In FY99, 48% received services from the CSHCN Program.) MCH exceeded this performance objective.

To help accomplish this goal the CSHCN program works with the University Affiliated Programs, WIND, WYNOT, and SOAR, to provide information on a variety of subjects, such as assistive technology and recreational programs. MCH monies were utilized to establish CONNECT WY which has as one of its programs a statewide internet resource for consumers and providers on assistive technology and recreational programs for children with special health care needs.

Full staffing for the first time in three years has helped the CSHCN program analyze patient charts in a continued effort to determine what services our clients are receiving, accessing patterns for other necessary resources, and treatment plan compliance/deficiencies.

NPM#2: The degree to which the State CSHCN Program provides or pays for specialty and sub-specialty services, including care coordination, not otherwise accessible or affordable to its clients. (The objective for FY99 was to provide nine specialty and sub-specialty services. Nine were provided.)

MCH met this objective. The following narrative describes some of the activities relating to this objective.

The CSHCN program covers the following specialty and sub-specialty services:

- 1) Medical and surgical subspecialty services
- 2) Occupational therapy and physical therapy services
- 3) Speech, hearing, and language services
- 4) Respiratory services
- 5) Durable medical equipment and supplies
- 6) Home health care
- 7) Nutrition services
- 8) Care coordination
- 9) Early intervention services

Following are details about how some of these services were delivered.

The CSHCN program reimburses physician providers based on the Medicaid fee schedule for “special consultant services.” These “X codes,” which include care coordination, provide higher reimbursement than the usual Medicaid fee schedule and closely approximates what previous physician charges to CSHCN. Additionally, physicians receive an incentive rate for serving larger numbers of children on both CSHCN and Medicaid. MCH asks providers to sign an agreement that they will not charge families eligible *only for CSHCN* for the difference between the reimbursement rate and the providers’ usual and customary fees.

CSHCN collaborates with the WIC Program to provide formula for clients with PKU who are eligible for this supplemental nutrition program. WIC serves these children until their 5th birthday; CSHCN then coordinates with WIC to assure continuing access to formula. Families who do not qualify for their program or who need other specialty type formulas that may not be purchased by WIC are then served by CSHCN.

The Care Coordination Committee, initiated by CSHCN, continues to bring together representatives from the CSHCN program and state and local public health nursing. The purpose of the committee has been to develop and

implement a statewide care coordination plan and design standardized forms to promote and assess quality of care for CSHCN. In conjunction with the plan, a Care Coordination Program Manual was developed and a 2-day workshop launching the care coordination system and the new data forms was held in September of 1999. Standards of care were emphasized and a number of state agencies presented an overview of their particular services with specific guidelines.

The MCH Parent Consultant made a care coordination link possible between parents, educators and providers. A "Parents Panel" of CSHCN shared their personal experiences emphasizing concerns and systems improvement opportunities from their perspective. The Family Support Network provided disability awareness experiences for all PHN participants. PHN participants left with a fuller understanding of the need to assist parents to find resources within their home communities.

CSHCN staff worked with the Newborn Hearing Screening Board to establish standards for hearing test results and in raising awareness of the need for early referral. Screening Board Members share new cases of newborn hearing loss monthly to stimulate systems discussions and promote coordination of care. Discussion continued between the Board and PHN around the need to follow-up with families not returning for re-testing and to set guidelines for follow-up.

Efforts of the Early Intervention Council to promote awareness of developmental delays and strengthen access to early screening and treatment continue to be supported and implemented by the CSHCN and PHN programs wherever possible.

Collection of data continues to be an emphasis of the program. All MCH program managers continued to work on the identification of key data elements to be collected by the emerging MCH data system related to encounters with CSHCN, as well as high-risk pregnant women, infants, and children served by MCH. The current "Business Systems Development" phase will include the design and development of computer fields for collection and analysis of data, including care coordination.

SPM#1: Number of Specialty Clinics offered throughout the state for CSHCN. (The objective for FY99 was to have 188 specialty/subspecialty clinics. In FY99, 124 specialty/subspecialty clinics were offered. MCH did not meet this objective. (NOTE: This measure is being dropped in FY 01; FY 00 objective has been changed to a maintenance objective.)

Fewer patients resulted in a decrease in the number of clinics being offered by Children's Hospital providers. In the gastroenterology clinic the number of referrals was lower, and the demand for services in the home setting increased, thus forcing the canceling of clinics. Also, two tertiary centers offer services on the East Side of the state and compete for the specialty clinic clients. Numbers from the monthly Presbyterian/St. Luke's Hospital outreach

clinics, are not available to us at this time and could not be included in the present data. Scheduling in some of the clinics is a problem as the physicians do not establish set dates for the clinic – preferring to determine clinic dates only about one month in advance -- which does not allow convenient scheduling for follow-ups for all families an option on dates.

The following narrative provides an overview of activities relating to this objective: The CSHCN Program collaborates with local providers, local public health programs, and pediatric specialists from Wyoming, Colorado and Utah to offer specialty clinics throughout the state. In FY99, 1,242 patients were served during this reporting period. Tertiary centers, which provide outreach clinics in Wyoming include the Children’s Hospital (Denver); Presbyterian-St. Lukes Hospital (Denver); and the Barbara Davis Diabetes Clinic (Denver). CSHCN also works in conjunction with Shriner’s Hospital in Salt Lake City and Seattle to provide services to clients.

CSHCN develops a biannual bulletin of pediatric outreach clinics, including information on how to access these specialty clinics, and distributes the information to all public health nurses and local providers to assist with community referral. MCH contracts with the Natrona County Health Department in Casper to serve as a centrally located host site for specialty clinics, and to provide clinic coordination and follow-up in this centrally located community of approximately 50,000. Physician specialists from the fields of endocrinology, cardiology, gastroenterology, neurology, genetics, pulmonary, and orthopedics staff the clinics. In cooperation with the University of Wyoming’s Family Practice Residency Center, the specialists provide continuing medical education for local providers during their visits to Casper.

CSHCN actively coordinates with the Oral Health Program in offering Cleft Lip and Palate Evaluation Clinics semi-annually for diagnosis and treatment recommendations. Diagnostic services include audiology, dental, genetic, oral surgery, orthodontic, otolaryngology, pediatric, plastic surgery, and speech pathology. To assist with coordination and provision of services, representatives from CSHCN, Genetic Services, the Oral Health Program, and Public Health Nursing participate in the clinics. When orthodontic surgery is required, the Oral Health Program coordinates with CSHCN to facilitate necessary procedures. In FY99, 80 clients were seen at the two Cleft Lip and Palate Clinics.

CSHCN continues to partner with the Oral Health Program to provide low-income children, up to 19 years, with orthodontic care for severe and crippling malocclusion. The program accepts referrals primarily from CHS, local dentists, and public health nurses. In FY99, the program served 128 clients with MCH funding. Maternal and Child Health also coordinates with Dental Health Services to transition clients into other programs as they near their 19th birthdays. This is especially critical when clients are still maturing physically and surgery needs to be postponed beyond the 19th birthday.

The CSHCN Program Manager, the Genetic Services Manager, and the CSHCN Parent Consultant all continued to participate in the Deaf/Blind Diagnostic Clinic offered semi-annually by the Department of Education's Deaf/Blind Project. This project was originally established to coordinate the findings and recommendations of the specialists on the team to other providers. A team of specialists provides medical consultation to assist families in minimizing disabilities related to a child with multi-impairments. The Genetic Services Manager, a trained genetic counselor, consults with the families regarding the diagnosis, etiology, and prognosis of the conditions. In the exit interview from the clinic, the CSHCN Parent Consultant reviews local and state community resources available and promotes advocacy by the family for the needs of their child. It is also the duty of the CSHCN Parent Consultant to assure that the reports from the clinic are sent out to the designated providers for which parents have signed releases.

The Genetic Services Manager coordinates Genetic Clinics held regularly in seven communities throughout the state: Sheridan, Casper, Cheyenne, Cody, Jackson, Riverton, and Green River. Clinic services include genetic evaluations and counseling by physicians out of Denver tertiary care facilities. Twenty-two clinics were conducted in 1999 with an average attendance of 11 clients per clinic. To promote findings for genetic diseases, all new CSHCN referrals that have symptoms with a possible genetic component are referred to the Genetic Services Manager for consultation. All established clients who receive a new diagnosis with a genetic component, also are referred. The Genetic Services Program also provides follow-up for newborns that have been screened and found to have a known or suspected genetic disorder.

B. Enabling Services

B.1 Women and Infants

SPM#2: Percent of High-Risk Pregnant Women served by Care Coordination. (The objective for FY99 was 30%. The percentage served in FY99 was 52.4%.) Maternal and Children's Health exceeded the objective for care coordination for high-risk pregnant women. The following narrative describes some of the activities relating to this objective.

To assist with the identification of high-risk pregnant women, a standardized Data Documentation System was developed for the Best Beginnings Program. The new system includes a standardized assessment of risk factors for pregnant women enrolled in the Best Beginnings Program. MCH reported on the results of the Data Documentation Systems' pilot test at the May 1999 meeting of Best Beginnings coordinators prior to expanding the system statewide. The Data Documentation System assures appropriate pregnancy risk assessment, triage, and care coordination of all Best Beginnings clients and identifies those clients in need of high-risk care coordination. Best Beginnings coordinators at the county level are responsible for high risk care coordination. (It is estimated that approximately 65% of Wyoming births (about 7,200) had one or more medical risk factors defining them as high-risk pregnancies.)

The Home Visiting for Pregnant and Parenting Families (HVPPF) Program continues to provide intensive coordination of care for high risk pregnant women who meet HVPPF criteria; many of whom are referred by Best Beginnings Coordinators. Following the client through pregnancy and the child's first two years of life, nurse home visitors assist pregnant and parenting families in accessing appropriate health and human services and coordinating these services. Program emphasis is on empowering women by increasing their knowledge and skills to assist them in making positive choices and assume responsibility for their behavior, for their health, for changing their environment, and for planning their future.

Genetic counseling was provided to a number of females, both pregnant and not pregnant, who were at risk due to family history or by having a previous child with congenital anomalies. MCH continues to fund travel and per diem to mothers whose babies are hospitalized in a tertiary-care center.

Other Activities:

Wind River Reservation Initiative. As this reporting period was beginning, MCH completed work with consultant, Duncan Perrote, to study the need for maternal and child health service enhancement on the Reservation and to identify an appropriate role for MCH. The process, which began with an inventory of services currently being delivered by the U.S. Indian Health Service (IHS), Tribal Health Services, and the Fremont County Health Department, resulted in several sustainable and successful outcomes. First, MCH recognized that the two tribes (Shoshoni and Northern Arapaho) on the Reservation viewed themselves as distinct communities with unique needs and health access issues which differed from those of the rest of Fremont County. Second, the tribal leaders were responsive to the expansion of Best Beginnings, Home Visiting for Pregnant and Parenting Families, and Help Me Grow-Safe Kids campaign to the Reservation. Third, MCH became aware of existing IHS and Tribal Health data that could be useful for community health planning purposes.

During this reporting period MCH, building upon this foundation, developed contractual relationships with 1) the Fremont County Public Health Department for expansion of Best Beginnings and Home Visiting Services to the Reservation, in partnership with Indian Health Services; and 2) Wyoming Health Resources Network (WHRN) to facilitate community health systems development, needs assessment, and health care planning.

B.2 Children

B.3 CSHCN

NPM#3: The percent of Children with Special Health Care Needs in the state who have a "medical home." (The objective for FY99 was 80%. The percentage with a medical home in FY99 was 80%.)

MCH met the objective for CSHCN who have a medical home. The following narrative describes some of the activities relating to meeting this objective.

The MCH CSHCN program strives to increase the percent of CSHCN with medical homes by educating parents and providers about the importance of a medical home for CSHCN. The enrollment forms for the program ask for a medical home designation; if there is not a medical home, the PHN works with the family to choose one. State CSHCN staff, primarily the Parent Consultant also utilized frequent encounter opportunities with families to promote the medical home concept (i.e. Deaf/Blind Diagnostic Clinic, Cleft Lip and Palate Clinic). In FY99, the CSHCN Parent Consultant also addressed the importance of medical homes at parent group meetings and the annual MEGA Conference, a conference in Cheyenne in October for parents and professionals about disabilities which was attended by over 175 health professionals and parents. Medical home was also addressed at quarterly meetings of the Family Support Network and the Area Resource Specialist Training sponsored by the Division of Developmental Disabilities. The MCH Section actively promotes the importance of parental designation of “medical homes” through both the Best Beginnings and Home Visiting programs that provide care coordination services for high-risk families.

C. Population Based

C.1 Women and Infants

NPM #4: Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, and hemoglobinopathies. (The objective for CY99 was 98%; the percentage screened during the reporting period was 99%.) MCH slightly exceeded this objective.

Wyoming law mandates that all newborns be screened for six inborn errors of metabolism. In 1999, the Genetic Program estimated that over 98 percent of newborns were screened for PKU, hypothyroidism, galactosemia, hemoglobinopathies, biotinidase deficiency, and cystic fibrosis. A total of 5,710 newborns received at least one screening. The following cases were confirmed: congenital hypothyroidism (2), cystic fibrosis (1), and hemoglobinopathy (1).

NPM #9: Percent of mothers who breast-feed their infants at hospital discharge. (The objective for FY99 was 75%. The percentage who breast-fed at hospital discharge in CY98 was 77%.) MCH exceeded this objective. The following narrative describes some of the activities relating to this objective.

Breast-feeding education and support is a priority of the Best Beginnings Program. Best Beginnings, now located in every county in the state, educates women prenatally, provides support during the postpartum period concerning

breast-feeding, and provides referrals for mothers who need more intensive assistance. Several Best Beginnings Coordinators are Certified Breast-Feeding consultants and provide extensive support to breast feeding mothers.

MCH participates in Wyoming's Healthy Mothers/Healthy Babies Coalition that provides a statewide support network to assist mothers with breast-feeding. The coalition includes representatives from MCH, WIC, Public Health Nursing, Immunizations, Home Visiting for Pregnant and Parenting Families, La Leche League, Prevent Child Abuse, the University of Wyoming School of Nursing, and other community organizations. HMG-SK also lends its media expertise and information line in support of WIC's activities related to raising awareness about the importance of breast-feeding.

Additionally, Best Beginnings local Coordinators participated in the annual Breast-Feeding Conference in Casper on September 9-10, 1999 and the HVPPF Program supports and educates mothers prenatally and following the birth of the baby regarding breast-feeding.

NPM #10: Percent of newborns who have been screened for hearing impairment before hospital discharge. (The objective for FY99 was 97%; 942% of newborns were screened for hearing impairment.) MCH made progress and very nearly met this objective during the reporting period. The following narrative describes activities relating to this objective during the reporting period.

Staff from the Best Beginnings, CSHCN Program, and Genetic Services, all sit on the Newborn Hearing Screening Board that was formed originally to provide funds for Automatic Auditory Brainstem Response (AABR) machines. Funding was a collaborative effort of MCH, the Division of Developmental Disabilities, and the Department of Education, and every hospital that performs newborn deliveries now has an AABR machine. Each newborn's medical practitioner makes the decision to screen, and orders the testing to be done. As noted earlier in this report, CSHCN staff are diligently working with the Board to raise awareness of providers about the need for early screening as well as on follow-up of families of newborns who have not returned for testing after hospital discharge for suggested follow-up testing.

SPM#3: Percent of women using tobacco, alcohol or drugs during pregnancy. (The objective for FY99 was 18%. The CY98 indicator was 23.2% based on birth certificate data). In CY98, approximately 23% of women reported smoking during pregnancy; 2.1% reported alcohol use during pregnancy; and 14.5% of pregnant women in one WDH study reported using illicit drugs. Wyoming did not meet this objective. (Note: This objective is being split into two objectives for FY01. A separate objective for alcohol and tobacco use will allow better tracking and reporting of data.) Data used for this objective is primarily obtained from birth certificate data; for collaboration data collected through the Best Beginnings Data Documentation System is also reviewed. The following narrative describes activities relating to this objective.

Both the Best Beginnings Program and the Home Visiting for Pregnant and Parenting Families Program address substance abuse prevention, education and cessation counseling and make referrals for substance abuse treatment, as needed. During October Child Health Month, the Help Me Grow - Safe Kids Campaign targeted tobacco and alcohol use and sent packets to physicians and posters to Public Health Nurses and WIC to promote positive health choices.

SPM#4: Percent of low birth weight babies delivered in the state. (The objective for FY99 was 6.4%. The percentage of low birth weight babies in CY98 was 8.9%.) MCH did not meet this objective in FY99. NOTE: Wyoming originally chose this performance measure, even though it closely resembles the NPM related to **very** low birth weight because it is thought to be more reflective of Wyoming's needs. As Form 11 shows, the state does not have as much of a problem with very low birth weight, but the **low** birth weight rate continues to climb steadily. This objective is being dropped in FY 01 in favor of measuring the behaviors that impact low birth weight.

The following narrative describes some of the activities relating to this objective in FY99.

Through the Best Beginnings Program and Home Visiting for Pregnant and Parenting Families (HVPPF) Program, MCH promotes early access to care, optimal nutrition, substance use prevention and cessation (including tobacco), and care coordination, all known to be associated with healthy pregnancy outcomes. MCH partners with the WIC program and Public Health Nursing to address the problem of low birth weight babies. The WIC Program Manager attends Best Beginnings and HVPPF administrative meetings to provide nutritional input and WIC updates. Best Beginnings disseminates its monthly newsletters to the WIC program, which makes referrals to and accepts referrals from both Best Beginnings and HVPPF. WIC participates on the HMG-SK information line to provide information about nutrition and WIC services.

Maternal and Child Health collaborates with the Public Health Nursing Program in the operation of HVPPF which assists women during pregnancy, postpartum, and until the child is two years of age. In FY99, 15 of Wyoming's 23 counties participated in the program. This is representative of five more counties than in FY98. Training was provided for public health nurses and supervisors, including the NCAST Feeding Scale, NCAST Teaching Scale, the David Olds Home Visitation 2000 program protocols, and Partners in Parenting Education (PIPE).

SPM#5: Rate of Fetal deaths per 1,000 live births. (The objective for FY99 was 5 per 1,000 live births. The fetal death rate for CY98 was 3.8 per 1,000 live births.) MCH exceeded this objective in FY99. For a summary of activities relating to this objective in FY99, please see SPM#4 above. NOTE: MCH subsequently dropped this measure beginning FY 01.

C.2 Children

NPM#5: Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Hemophilus Influenza, and Hepatitis B. (The objective for FY99 was 80%. In FY99, the rate for 4:3:1, plus 3 + 3 was 72% [CASA].) Wyoming did not meet this objective in FY99. The following narrative describes activities relating to this objective.

The Immunization Program is not under the administrative control of the Title V Grant in Wyoming, however MCH does partner with the Immunization Program to promote the importance of timely immunizations. In FY99 the collaboration included educating parents and care providers through the Help Me Grow-Safe Kids (HMG-SK) media campaign and information line, the Health and Safety Tip of the Month Program, the KTVU-TV media campaign which included the need for immunizations in televised health messages, and an annual "Safe Kids Day" event at which the Immunization Program routinely staffs a booth. Additionally, Immunization collaborated with MCH and HMG-SK in the development of the "Parent Guide" to be distributed through birthing facilities to all families of newborns. The book includes the optimal immunization schedule for all children through age five years.

In August 1998, MCH piloted a new program, "Shots and Seats," in Cheyenne in partnership with the Immunization Program, Wyoming Department of Transportation, the local county health department, and local fire department. The goal was to update children's immunizations prior to the start of school and educate parents on the importance of immunizations. Public Health Nurses evaluated immunization status with referrals made when appropriate. Parents and children were also educated about fire safety and Wyoming's new seat belt law. The pilot program was conducted at three different fire stations on three consecutive weekends with an average attendance at each site exceeding 100. MCH shared information about the program with local HMG-SK chapters and fire departments statewide to facilitate replication in other communities.

The HVPPF Program also provides education and referral regarding the importance of age-appropriate well-child exams and immunizations.

NPM#6: The birth rate (per 1,000) for teenagers aged 15 through 17 years. (The objective for FY99 was 22.0 per 1,000. In CY98, the birthrate was 22.9 per 1,000.) MCH very nearly met this objective in FY99. The following narrative describes activities relating to this objective.

Maternal and Child Health continues its partnership with the Wyoming Health Council (formerly the Wyoming Reproductive Health Council) to address adolescent pregnancy prevention. The Wyoming Health Council (WHC) administers Wyoming's Title X funds and is contracted by MCH to cover service needs not fully met by the Title-X grant. The MCH Perinatal Systems/Women's Health Manager sits on the WRC Board of Directors.

In FY98 MCH recognized the need to take a systems approach to family planning, i.e., integrate family planning with primary care and other MCH services, and implemented a corresponding requirement for systems building education of Title X facilities in the FY99 contract.

This long-standing partnership has also effectively standardized policies and procedures related to service delivery. All local family planning programs, both Title X and non-Title X, include teen pregnancy prevention components. WHC requires adherence to CLIA standards in all funded clinics.

MCH also continues to participate on the multi-agency, public/private, Unintended Pregnancy Prevention Task Force. At its quarterly meetings, the Task Force has representation from MCH, Department of Education, Department of Family Services, educators, family planning clinic providers (both Title X and non-Title X), community agencies, and parents. Its guiding tenet is that bearing unintended children may have potentially harmful consequences for the child, the child's parents, and society regardless of age, marital status, or income. The Task Force places special emphasis on the prevention of adolescent pregnancies in response to federal legislation around welfare reform and abstinence education. The approach is to increase awareness among policy makers, providers, and individuals of intended pregnancy and its impact. In August 1999, the Task Force sponsored a second statewide conference, "Intendedness Matters." Held in Casper, the conference featured national speakers, as well as a workshop on finding common ground developed and led by the National Campaign to Prevent Teen Pregnancy staff.

At a June 1998 conference, MCH provided technical assistance to those communities who were interested in submitting applications for community-based unintended pregnancy initiatives. A Request for Proposals was been released collaboratively by MCH and the Department of Family Services with pooled resources from both agencies for community-derived interventions to prevent unintended pregnancies. Six proposals were accepted in FY98 for implementation in FY99. The Unintended Pregnancy Task Force selected and monitored the projects. The most successful grant project was a county "Think it Over" Campaign which involved many community organizations, businesses, schools, churches and individuals enabling the project to reach diverse segments of the community. In addition, collaborative efforts enabled the project to establish a county-wide effort to create awareness of unintended pregnancy issues. The campaign's marketing strategy covered many methods to deliver the message. The grant report included data and information on the project objectives, methods of data collection and analysis, and the method of reporting and using project results.

In FY98, the MCH Program implemented its *Sex Can Wait – Wyoming* (Abstinence Education Grant) which continued in FY99. It includes a media campaign funded by the Maternal and Child Health Bureau to increase the number of abstinence messages aimed at youth ages 9-14 years and their older siblings and parents. The HMG-SK information-line received forty-nine calls for FY99 from children, parents, and other community members requesting information about abstinence related issues. Written information was provided to callers, as well as those in attendance at the Healthy Communities/Healthy Youth Conference held in September 1999.

A recent evaluation of the campaign, completed in May, 2000, revealed that both parents and teens report an interest in abstinence media messages. The study revealed that the majority of teens surveyed (69%) reported hearing or seeing ads that promoted sexual abstinence and 76% recalled the *Sex Can Wait* terminology; 62% reported “learning” from the ads. Most parents (68%) recalled the *Sex Can Wait* message; 82% liked the ads and found them beneficial.

An important goal of the Home Visiting for Pregnant and Parenting Families (HVPPF) program is the reduction of subsequent pregnancies. HVPPF, based on the David Old’s Model, utilizes Bandura’s self-efficacy theory as a foundation for client-centered nursing interventions. These approaches are solution-focused and build on client strengths. The nurse assists the client in setting small, realistic goals regarding parental life-course (education, employment, and subsequent pregnancy) based on the confidence level and commitment of the client.

Many Best Beginnings coordinators are taking an active role in their communities to develop Search Institute Assets Building Programs, which address adolescent problem behaviors by strengthening individuals, families and communities. In FY99 MCH provided small community grants to support the development of Assets Programs. Additionally, Best Beginnings coordinators work with community-based youth organizations, schools, and hospitals to promote teen pregnancy prevention through the “Baby Think It Over” program and other community-based prevention efforts. A major component of the “Baby Think It Over” program is the placement of life-size mannequins which simulate the needs and demands of infants in real-life situations with teens.

NPM#7: Percent of third grade children who have received protective sealants on at least one permanent molar tooth. (The objective for FY99 was to increase to at least 50% the proportion of children who have received protective sealants on the occlusal surfaces of permanent molar teeth. The percent of 3rd graders with sealants on at least one permanent molar tooth in Wyoming in 2000, based on provisional data, was approximately 71.3%.) MCH met their objective during the reporting period.

The survey will be conducted again in FY00, and every three years thereafter, to achieve a longitudinal study of decayed, missing, filled, and sealed teeth among the sample. MCH will utilize the findings for the five-year statewide dental needs assessment. The following narrative describes activities relating to this objective.

Oral Health Services activities in FY99:

1. Dental sealants. The Program provided 12,388 sealants for 2,444 children in FY99.

2. Dental screening. About 5,200 children received a visual dental screen for cavities and occlusion in FY99. The Oral Health Program informed parents on the need for care; school nurses provided follow-up; and some services were reimbursed by the program.
3. Marginal Dental Program. This state-funded program serves low-income children, birth to 19 years, who are not on any other assistance program. In FY99, 411 clients accessed dental care through the Marginal Dental Program.
4. Dental education programs. Dental Health Services works with dental hygienists throughout the state to provide educational sessions to youth in pre-school through 12th grade. The sessions focus on improving oral health, including risks associated with tobacco, and reached over 6,000 youth in FY99.
5. Fluoride mouth rinse program. Dental Health Services provides fluoride mouth rinse to participating schools, grades K-9. School nurses and volunteers supervise the weekly “swish and spit” activity that reached over 2,363 youths in FY99.
6. Severe Crippling Malocclusion. This program includes both MCH funded and Medicaid funded services. In FY99, 128 children were served with MCH funds and 284 children were served with Medicaid funds.

NPM#8: The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children. (The objective for FY99 was 10.0 per 100,000; the CY 98 rate was 10.3 per 100,000.)

Wyoming essentially met this objective in FY99. The following narrative describes some of the MCH activities relating to this objective.

Maternal and Child Health partners with the Wyoming Department of Transportation to promote vehicle safety primarily through the Help Me Grow-Safe Kids (HMG-SK) media campaign and its 800 number. Funded by MCH since 1995, this line provides a one-call information and referral source for twelve child health and safety issues. The HMG-SK media campaign strategies include PSAs, strategically placed billboard messages, and the frequent preparation of newspaper articles on child passenger safety. Extending this media thrust, HMG-SK received a grant from Ronald McDonald House Charities of Denver during the reporting period to develop “fact packs” to be sent to schools, physicians’ offices, and mental health centers across the state. Also privately funded was the development of brochures to be distributed through McDonald’s restaurants statewide in conjunction with Child Health Month in October 1998. These materials covered a myriad of child safety topics; the brochures specifically addressed underage drinking, and drinking and driving.

In FY99, MCH worked with the Department of Transportation to pilot a new program, "Shots and Seats" program described in detail under NPM#5. One of the goals is to educate parents and children about the importance of car seats and Wyoming's new child passenger restraint law. Passed in FY98, the law removed all previous exemptions, increased the child car seat requirement through age 4 years or 40 pounds, required compliance in any vehicle (including trucks), and applies to any adult responsible for transporting a child in a vehicle. In FY99, HMG-SK expanded its car seat inspection training program by sending three volunteers interested in becoming certified to a national "training of trainers." Following their training, trainers trained and certified over 40 volunteers throughout Wyoming to be car seat inspectors.

Help Me Grow - Safe Kids' successful efforts have leveraged significant support from both national and state organizations. In addition to those already identified above, National SAFE KIDS provides technical assistance, training funds, materials, directs a campaign (Safe Kids Buckle Up) for educating parents and children, and provides car seats. The Wyoming Department of Transportation has been a major collaborator in the sponsorship of Safe Kids Day in HMG-SK chapter cities throughout the state. The Wyoming Children's Trust Fund provided funding in FY98 to support Safe Kids Day, the Health and Safety Tip of the Month Program, and October Child Health Month. Finally, through the efforts of the HMG-SK Spokesperson, First Lady Sherri Geringer, the Campaign received a small grant of \$3,000 from United Parcel Service to continue efforts to promote the health and safety awareness campaign.

The Home Visiting Program provides client education regarding the use of car seats for infants and young children.

SPM#6: Preventable Child Death, other than vehicle crashes. (The objective for FY99 was 19%; the CY98 rate was 11.3%) Note: This objective has been dropped beginning FY 01. MCH met this objective in FY99. The following narrative describes some of the activities relating to this program.

The Help Me Grow - Safe Kids Program (HMG-SK) works with all its partners to prevent child death and unintentional injuries in Wyoming. Strategies included: an annual Safe Kids Day Event; statewide placement of video PSAs, development and placement of relevant newspaper articles, Bike Rodeos, and annual October Child Health Month activities. SAFE KIDS Day, which has been discussed elsewhere in this report, is certainly one of the cornerstones of the Campaign's efforts, however, it should be noted that MCH staff, other HMG-SK Agency Partners, and volunteers also lead the October Child Health Month Task Force. Other task force members include representatives from community Best Beginnings programs, School Nurses Association, Parent Teacher Association, Home Visiting Program, Wyoming Prevent Child Abuse, Dental Health Services, Tobacco Prevention Coalition, and the Division of Behavioral Health.

HMG-SK also distributes Health and Safety Tip of the Month packets and the corresponding posters to Best Beginnings coordinators, WIC offices, local health departments, physicians' offices, and HMG-SK local chapters

through-out the year. In addition to continuous news releases on health and safety, HMG-SK cooperates with National SAFE KIDS to disseminate seasonally appropriate information on specific safety issues, e.g., toy safety in December, summer safety, and back-to-school safety in the fall.

HMG-SK also works with the Wyoming Children's Action Alliance and Wyoming Prevent Child Abuse to improve parent skills and prevent child injury and death related to child abuse. Both organizations provide trained staff to HMG-SK information and referral line for calls related to these issues. The Campaign provides publicity for parenting classes, distributes "101 Ways to Praise a Child" and other information on positive parenting. HMG-SK also addresses child abuse and violence prevention through PSAs, Safe Kids Day displays, and packets of information available to schools and parents. Additionally, HMG-SK worked with Wyoming Prevent Child Abuse in FY99 to develop and distribute information on the impact of alcohol on children and the family.

Other Activities:

SIDS Reduction. HMG-SK and the Best Beginnings Program continued the statewide SIDS risk reduction campaign, which includes a PSA and the distribution of educational materials and, upon request, small stipends and technical assistance to fund community efforts. MCH continued the Back to Sleep education program through the Best Beginnings Program.

The HVPPF Program nurses provide safety information regarding infant and toddler physical care, as well as prevention of Shaken Baby Syndrome, other child abuse injuries and environmental safety.

During the reporting period, the former HMG-SK program manager participated on two task forces related to the issues of quality childcare: 1) Child Care Licensing and 2) Early Childhood Development Careers. The Child Care Licensing Task Force was appointed by the Governor to study the need for State licensure of child care facilities and make recommendations as to the appropriate agency to house the responsibility. The Task Force met regularly during the reporting period. A report was submitted to the state legislature in December 1998 recommending, among other things, that this authority remain with the Department of Family services. The Early Childhood Development Careers Task Force continues to meet under the direction of the Department of Health to explore ways to improve the quality of childcare in Wyoming through personnel preparation. Deliberations include the establishment of different levels of childcare training/education, "professional" provider licensing, and salaries commensurate with education and training. (NOTES: 1) With the resignation of the HMG-SK Program Manager in 1999, these early childhood efforts were assumed by other MCH Staff; 2) Effective with the amended legislation passed during the 2000 legislative session, WDH representation on the Child Care Certification Board is now required. The Director assigned this responsibility to the Deputy Administrator, MCH Services in April, 2000.)

MCH took the lead in the development of the Help Me Grow-Safe Kids Parent Guide to be distributed to all new parents through birthing facilities beginning in January 1999. The project demonstrates collaboration among MCH, Immunizations, WIC, the Department of Transportation, the Wyoming Children's Special Trust Fund, and Ronald McDonald House Charities. The goal is to provide parents with a ready reference on child growth and development, health, illness, nutrition, breast-feeding, immunizations, safety, injury prevention, and parenting from birth to age 5 years. Additionally, the book publicizes the array of programs and services available to parents including the information line, WIC, Children's Health Services, and Immunizations. An evaluation card and order form for free literature from HMG-SK concludes the packet.

C.3 CSHCN

The CSHCN program collaborated in the development of the "Parent Guide" discussed above and assisted in the inclusion of information relevant to parents of children with special health care needs, including CSHCN referral information. Additionally, the HMG-SK information and referral line is staffed by the Division of Developmental Disabilities to answer questions from parents concerning developmental delays.

D. **Infrastructure Building**

Please keep the following general note in mind while reading this entire Infrastructure Building section; it applies to all populations served by the MCH Grant:

Since its inception the MCH Program has been a network of local consortiums of health and social service agencies that identified the health needs, service gaps, and barriers to care for families and children and then planned community public health and clinical services to meet those needs. As a community based program, MCH has used a combination of federal and state monies for infrastructure development in an effort to ensure local public health and safety net clinical services for the MCH population.

MCH programs, working with local public health departments, have filled a critical gap over the years by providing family planning, perinatal and child health care services for an MCH population in this state comprised of Medicaid eligible families, as well as those who are uninsured and under-insured. However, a number of national and state level changes have occurred which, beginning in FY 99, will influence the infrastructure focus of the MCH program. These include:

- < A changing landscape of Medicaid providers in many communities
- < Changes resulting from welfare reform, which include severing the link between cash assistance and health insurance (Medicaid)
- < The advent of Kid Care, Wyoming's Children's Health Insurance Program for eligible uninsured children

< MCH Block Grant developments such as the implementation of performance and outcome measures in response to the Government Performance and Results Act (GPRA)

As a result, beginning June, 1999 the MCH program has prioritized a renewed focus on the MCH public health functions of assessment; policy development; assurance of access to health care; and performance measurement. Toward this end, MCH in FY 99 added an additional \$510,000 of its Title V Block Grant funds to assist local public health departments deliver core MCH services. By coupling these funds with the former Best Beginnings grants, MCH brought its total commitment to local communities to one million dollars; nearly 30% of its total budget.

D.1 Women and Infants

NPM#15: Percent of very low birth weight live births. (The objective for FY99 was 1.0%. The CY98 percentage was 1.1%). MCH very nearly met this objective in FY99. The following narrative describes some of the activities relating to this objective.

In addition to the capacity building grants mentioned in the general note that heads this section on Infrastructure Building activities, MCH's Best Beginnings Program is primarily a system's building initiative. Best Beginnings programs, most often based in local health departments, were originally designed to ensure local perinatal needs assessment, planning and policy development, to enhance systems of care.

The Best Beginnings and Home Visiting for Pregnant and Parenting Families (HVPPF) Programs promote optimal nutrition, substance use prevention (including tobacco), and care coordination, all known to be associated with healthy pregnancy outcomes. MCH partners with WIC and Public Health Nursing to address the problem of low birth weight babies. Best Beginnings coordinators disseminate its monthly newsletters to WIC, which makes referrals and accepts referrals from both Best Beginnings and HVPPF. WIC participates on the HMG-SK hotline to provide information about nutrition and WIC services.

Other Activities:

Collaboration with WIC. MCH has a long-standing partnership with the WIC program, which is co-located with MCH in the Community and Family Health Division. Collaboration at the state level translates into coordination at the local level among Best Beginnings coordinators, Home Visiting program nurses, and local WIC offices for cross-referral of clients. At the state level, WIC and Help Me Grow-Safe Kids collaborated on the development of the *Parent's Guide* described previously in this report. WIC provided critical information on breast-feeding and nutrition from birth to age 5 years; WIC services are listed in the Parent Guide. WIC partners with HMG-SK to provide nutrition information for the information and referral line, PSAs, and other materials disseminated statewide, as well as at the WIC booth for Safe Kids Day.

Maternal and Child Health actively supports WIC's efforts to establish Electronic Benefits Transfer (EBT) and Health Passport in Wyoming for about 11,000 women and children served by WIC. Seven of WIC's 17 local agencies have EBT. In addition, a new beta version of EBT is currently being tested in 3 local agencies. When the new beta version has been approved, it will be utilized throughout the state and will replace the old EBT system.

Health Passport is sponsored by the Western Governors' Association with funding from the USDA and involves WIC in three western states: Wyoming, Nevada, and North Dakota. The plan is for WIC clients to eventually carry "smart cards", which serve as portable health records. A beta system is currently being tested in Laramie County. Later, it will be extended to other parts of the state.

NPM#17: Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

(The objective for FY99 was 77.0%. The percentage of very low birth weight infants delivered at facilities for high-risk deliveries in CY98 was 64.8%.)

Wyoming has not yet met this objective in FY99. The following narrative describes some of the MCH activities relating to this objective.

There are no Level III centers in Wyoming. Although the goal is not yet met, the MCH program furthered its advancement toward goal achievement by finalizing the standardized Pregnancy Risk Assessment tool for pregnant women in FY98. The Pregnancy Risk Assessment determines, as early as possible in the pregnancy, the risks of pre-term labor. It is hoped that high-risk mothers will be more quickly transferred to out-of-state Level III centers in Colorado and Utah prior to delivery. All Best Beginnings coordinators and many public health nursing managers were trained in the use of the assessment tool at the semi-annual Best Beginnings coordinators' meeting in Douglas in September 1998. Best Beginnings coordinators subsequently met with their local providers to further assure appropriate assessment and triage of high-risk women at the local level by strengthening referral patterns to the Best Beginnings program.

MCH continues to provide per diem funds for eligible high-risk mothers to stay in or near tertiary care centers prior to delivery. In the spirit of family-centered care, travel is also reimbursed for fathers to visit and provide support for the mothers.

NPM#18: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

(The objective for FY99 was 87%. The percentage born to women receiving prenatal care in CY98 was 81.4%.)

MCH is making progress toward this objective. The following narrative describes some of the activities relating to this objective.

The initiation of prenatal care in the first trimester is a priority of the Best Beginnings program. This goal is contingent on access to prenatal care at the community level. A primary responsibility of the Best Beginnings coordinator is to coordinate with others who provide services in the community to assure that all women can access prenatal care in the first trimester. Toward this end, Best Beginnings has:

1. Promoted statewide program performance standards which address administration, community planning, and service/case management
2. Coordinated with the Home Visiting for Pregnant & Parenting Families Program
3. Developed statewide goals and objectives for the Best Beginnings Program
4. Developed a standardized data collection/documentation system

The percent of pregnant women who access care in the first trimester continues to improve due to the efforts of the Best Beginnings network for care and referral.

Other Activities:

Professional Education. MCH assisted in planning and participated in the annual Perinatal Conference held in Fort Collins, Colorado, on October 16-17, 1998 and in Laramie, Wyoming on October 1-2, 1999. About 150 nurses and physicians attended the Ft. Collins conference and approximately 70 attended the Laramie conference. Topics at the conferences included prevention of prematurity and infant risk, regionalization of health care, legal issues, perinatal substance use, HIV, STDs, and the influence of gang culture on pregnancy and delivery. MCH also participated in the planning and coordination of the next Perinatal Conference to be held in Ft. Collins on October 5-6, 2000.

The MCH Program assisted state Public Health Nursing staff to conduct a survey of public health, WIC, and Best Beginnings managers to assess their continuing education needs in FY98. This information was shared with the Region VIII MCH Office for development of a proposal that was submitted by the Region to the U.S. Department of Health and Human Services, Division of Nursing. The proposal was an outgrowth of a national nursing leadership conference held in Dallas, Texas, in July 1998. Region VIII nurses met as a subcommittee and concluded that attention needed to focus on more training and educational opportunities. The Region VIII proposal addresses these needs and provides in each state, a contact who would participate on a committee to develop and implement a nursing continuing education plan. That contact in Wyoming is Jan Andrews, state PHN staff.

D.2 Children

NPM#12: Percent of children without health insurance. (The objective for FY99 was 13%. In 1998, the last year for which data are available, 12.7% of children were uninsured according to the Behavioral Risk Factor Surveillance System.) MCH met this objective for FY99. For a full narrative describing activities relating to this objective, see NPM #11.

Other Activities:

In the spring of 1999, the Wyoming Legislature authorized a two-phase program and during this reporting period the Health Care Financing Administration (HCFA) approved a state plan for implementing the first phase. Called Kid Care 1 in Wyoming, the first phase will be a Medicaid look-alike program and cover children with family incomes from 100% to 133% of federal poverty level (FPL). Kid Care 2, a private insurance buy-in program, has not yet been approved by HCFA but is intended to provide coverage for children in families with incomes from 134% to 149% of FPL. Caring for Children, a privately funded organization which provides insurance to families who are not eligible for Medicaid or Kid Care, increased their eligibility levels to 165% of poverty. When reviewing the financial information of families, the CSHCN staff regularly refers families to these programs. The CSHCN program sent out letters with an application to all families at 149% or less of poverty informing them of the launching of Kid Care1 and a community location for submitting their applications.

NPM#16: The rate (per 100,000) of suicide deaths among youth aged 15-19 (risk factor). (The objective for FY99 was 11.0 per 100,000; the CY98 rate was 15.9 per 100,000.)

MCH is making progress on the youth suicide objective. The following narrative describes activities relating to this objective.

The Youth Suicide Prevention Task Force, which MCH convened in FY97, recognized the need for a part-time coordinator to assist in advancing its strategic plan. MCH originally assisted with funding a stipend for a Coordinator in October 1, 1998 and continued that support through this reporting period. The Task Force is a public/private partnership formed for the purpose of identifying and reducing barriers to identification and early intervention, as well as primary prevention of adolescent suicide. The Task Force is comprised of representatives from the Departments of Health, Education, and Family Services, along with mental health providers, educators, counselors, parents, and youth. Participants are supported by their sponsoring organizations. A Mental Health Program representative from the Division of Behavioral Health chaired the Task Force with MCH during this reporting period.

In FY98, the Youth Suicide Prevention Task Force conducted a survey of secondary school counselors, social workers, and administrators, which sought to discover:

1. What prevention programs, materials or school activities school are using
2. How satisfied school staff are with what they are currently using
3. What types of policy, procedures or protocol schools have established for interventions

Of the secondary schools surveyed, 100% of the school districts responded. The results have been analyzed by the Task Force Coordinator and include the following: In general, 94% of the schools have developed building intervention teams responsible for intervening with a crisis or suicidal action 11% percent of school personnel are satisfied with their school's suicide/crisis intervention plan; 61% of Wyoming school districts have written plans and procedures to address crisis interventions; and 71% of the plans were specific to suicide. Some preventive measures are employed. For example, a referring process for students was utilized by 45% of the schools, and 32% had standards to identify students at risk. According to the report, continuing education was not highly considered among the schools for community members, school personnel, parents, and students. The Task Force approach included working towards reducing these gaps in prevention and intervention by raising awareness of suicide as a preventable public health problem. The strategy to address this issue and the issue of stigma towards mental illness was to offer a statewide suicide prevention conference for professionals, survivors, community members and school personnel. Planning for a January 2000 state-wide conference was the major activity of the Task Force in 1999. This effort followed the National Suicide Prevention Conference held in Reno, Nevada in 1998. Several members from the Task Force attended utilizing Federal MCH dollars. Although a national plan was developed at this conference, and momentum was moving towards developing a state plan, Task Force members decided to delay the development of a Wyoming State Plan. The strategy of the Task Force was to initially dedicate their efforts to raising awareness of the problem in Wyoming and how individuals, families and communities can build partnerships to impact suicide issues. The statewide conference was designed to create an arena for the development of a network among community members at the local level, which was considered essential before embarking on the development of a state plan.

Preceding the work of the Task Force in planning a statewide conference were the efforts of the Division of Behavioral Health. In FY98 the Division of Behavioral Health recognized the need for added funds to expand suicide prevention activities in communities throughout the state. These activities provided a foundation on which to build the statewide suicide conference in terms of interest and networking at the local level. The Division agreed to make additional resources available to communities in FY 1999. MCH began planning with the Division of Behavioral Health focusing on systems issues as a prelude to integrating local mental health and MCH services related to adolescent suicide prevention.

Other activities include the Wyoming Community Coalition for Health Education (WCCHE) sponsorship of the Healthy Communities/Healthy Youth 3rd Statewide Conference in Casper in September 1999. The focus of the three-day conference was on Youth Asset Building and Coordinated School Health. Over 400 delegates (125 youth and 275 adults) attended the workshop. This conference focused on creating healthy families and communities, which is a primary prevention component to improving healthy relationships and reducing the incidence of depression in children, a significant contributing factor to suicide.

Additionally, MCH partners with the Division of Behavioral Health on the Help Me Grow-Safe Kids (HMG-SK) information line. The Division of Behavioral Health responds to calls regarding mental health and substance abuse. To further the mission of the Youth Suicide Prevention Task Force, state staff addresses questions and concerns with parents and teens who may call the information and referral line, as well as facilitate appropriate community-based referrals. MCH worked with the Division of Behavioral Health to study the feasibility of adding pre-recorded suicide prevention messages, followed by a referral menu for community-based services, to the HMG-SK information and referral line.

SPM#7: Percent of Adolescents using alcohol (The objective for FY99 was 50%. 1999 YRBS survey results show the rate of current alcohol use was 55%).

Wyoming did not meet this objective in FY99. The Youth Risk Behavior Survey, conducted in March 1997, revealed that 55 percent of Wyoming youth reported having at least one drink of alcohol on one or more of the past 30 days. Forty-four percent of male and 37 percent of female students reported having five or more drinks in a row, within a two-hour period, on one or more of the past 30 days.

SPM#8: Percent of Adolescents who report smoking. (The objective for FY99 was 36%. In FY99, the rate was 35%.) MCH exceeded the objective for adolescent smoking. Tobacco settlement funds will help Wyoming continue to reduce the smoking rate in the future. The following narrative describes related activities in FY99.

The following narrative describes activities relating to SPMs 7 and 8 in FY99.

MCH provides funding and actively participates in the public/private Wyoming Community Coalition for Health Education (WCCHE) partnership. This long-standing partnership has pioneered a multiple strategy approach to improve youth outcomes, and reduce adolescent risk-taking behaviors, i.e. advancing the Search Institute's Asset Building theory and promoting coordinated school health to local school districts. In FY99, WCCHE, with support from MCH, conducting the third statewide conference on Asset Building and Coordinated School Health, which was attended by over 400 delegates from communities statewide.

MCH, through HMG-SK, again took the lead on the October Child Health Month Task Force in FY99. The Task Force coordinated activities for the American Academy of Pediatricians' October Child Health Month Campaign to prevent the use of inhalants. The campaign included PSAs and information packets and posters to all middle schools and physicians' offices. Packets also were distributed to persons who called the HMG-SK information line. The topic for FY00 will be alcohol abuse.

MCH partners with the Division of Behavioral Health on the Help Me Grow-Safe Kids information and referral line to assist parents with information and referral for adolescent alcohol and substance use. The Division of Behavioral

Health had primary responsibility for substance abuse prevention during the reporting period and provides information regarding substance abuse and related community services for the information and referral line.

SPM#9: The percentage of communities with a community-wide plan for services to the MCH population. (The objective for FY99 was 65%. The percentage of communities with community-wide plans in FY99 was 75%.) MCH exceeded this objective in FY99. The following narrative describes some of the activities relating to this objective in FY99.

During FY99, the MCH Section continued its effective community collaborative strategy to enhance the capacity of local public health departments to assess, develop, deliver, and evaluate quality MCH services. This included adolescent health, injury and disease prevention, and care coordination for both the CSHCN) and high-risk pregnant women populations. Using MCH SSDI funds disbursed through Wyoming Health Resources Network (WHRN), our long-term partner in the area of health planning and provider for recruitment and retention, we continued to help Wyoming counties build upon our eight year effort to advance the Planned Approach to Community Health (PATCH). Throughout the reporting period, we funded WHRN to provide technical assistance and “mini-grants” to Wyoming communities ready to advance to a *Healthy Communities* model.

The Healthy Communities movement is based on the premise that community-based collaboration and dialogue across sectors is essential to improving health and quality of life. While many resources in Wyoming are aimed at treating disease and infirmity, the healthy community’s movement asks: How can we keep people healthier in the first place? Our aim with this movement is to develop a community infrastructure that encourages health by a) partnering with health care providers to create an environment in which all people can achieve and maintain optimal health; and b) looking "upstream" to identify issues which determine personal and community health--analyzing why certain health conditions and behaviors exist.

Healthy Community collaborations require commitment, persistence, many meetings, and lots of technical assistance from MCH staff and partners. However, together, WHRN and MCH have succeeded in building a network of state-wide coalitions (19 coalitions in 18 counties) and are targeting the remaining counties in the next year. To this network we have: 1) provided training on the process of coalition/partnership development and performance monitoring and evaluation; 2) designed and sponsored state-wide learning forums; 3) provided nationally known speakers to bolster local coalition efforts; and 4) developed a “WDH Grants Clearinghouse” for disbursing grants to communities. Originating from the MCH SSDI grant, this “clearinghouse” was designed to ease the application burden by centralizing pass-through funds and providing standardized applications and assessment forms, thus enhancing communities’ ability to apply for grant funds.

As a result of this effort, Wyoming has seen improved access to services, improved assessment capacity; and improved population-based and prevention activities. The *Healthy Communities Coalitions* have demonstrated their ability to:

1. Strengthen/reorganize local initiatives and pass on the information, references and resources provided by MCH and WHRN to other community groups.
2. Partner with the Community and Family Health Division to conduct public health assessment and planning activities for local communities
3. Generate local passion for local issues
4. Increase the number of local partnership resources. At the local level, we are increasingly seeing more advanced discussions entering the arena of outcome improvement, shared data and performance monitoring, shared application forms, blended funding, and centralized resource centers. Participating in these discussion are: WDH community-based programs, as well as the Departments of Family Services, Transportation, Education, and Agriculture (Rural Development Council); Wyoming Association of Municipalities; hospitals; and the UW Cooperative Extension.
5. Learn their lessons well and provide skills building and networking opportunities to conduct assessments of current and emerging issues in their own local communities

Both the Primary Care Office (PCO) and the Primary Care Association (PCA) continue to be invaluable assets in the development of these community plans. During this reporting period, the long-standing contract between the Wyoming Department of Health and WHRN to facilitate health provider recruitment and retention was renegotiated. The contract tasks WHRN with coordinating the delivery of PATCH and Healthy Community (formerly SSDI resources) to Wyoming communities and also assigns some of the responsibilities associated with the Primary Care Cooperative Agreement to them. Both MCH and PCO continue to believe that this will not only help assure community leadership and participation in health problem identification and resource allocation, but increase opportunities for state level program collaboration as well. The MCH Section Chief and the PCO, along with the WDH Director and the Deputy Administrator of Nursing, serve as planners and evaluators for this contractual partnership. With the recent appointment of Bev Morrow, a former WDH employee, to fill the vacancy left by Joe Golden's retirement, the WDH finds itself looking forward eagerly to strengthened ties with the PCA.

SPM#10: Health and safety in child care settings. (The objective for FY99 was that 45% of licensed childcare facilities would access health and safety consultation and training. In FY99, 100% of facilities accessed consultation and training). MCH far exceeded this objective in FY99. NOTE: This objective is being dropped beginning in FY 01. The following narrative describes activities relating to this objective in FY99.

MCH continued to collaborate with the Emergency Medical Services for Children (EMS-C) Grant, the Department of Family Services, the Wyoming Child Care Association, Children's Nutritional Services, and the University of

Wyoming to provide project oversight for the Healthy Child Care Wyoming (CISS) Grant. Administered by Dr. Karen Williams from the University of Wyoming, the team spent FY99 involved in:

- Researching the best ways to teach child care providers to safely involve CSHCN in play and recreation
- Writing Wyoming specific safe playground guidelines for child care centers and residential programs, i.e., inclusion of information related to wind and harsh weather play conditions
- Literature review in preparation for the development of a child cares center health and safety curriculum

In FY99, Healthy Child Care Wyoming disseminated materials from the “Caring for Our Children” video series and the “Chef Combo” nutrition curriculum to all early childhood associations. The program also distributes injury prevention and playground safety materials to all childcare centers, Head Start programs, developmental centers, and public schools with preschool programs. In FY98, the CISS grant funded a statewide needs assessment of the training needs of a random sample of 500 of the 964 licensed child care providers in the state. The results were reported at the technical assistance meeting on August 27, 1998 in Casper. The grant continues to provide assistance with health and safety training in childcare settings.

As detailed under SPM#6, MCH staff is working with the Child Care Licensing Task Force to determine the need for state licensure of child care providers and to strengthen the qualifications of persons involved in child care. Both activities will directly impact health and safety in childcare settings. The HomeVisiting for Pregnant and Parenting Families (HVPPF) program also supports the same initiatives through home-based intensive parenting services.

Other Activities

Comprehensive Social Services Planning Team: MCH is a member of this committee, which was newly revitalized in June 1998 by the Department of Family Services. Other members include the Department of Education, Child Welfare League, and the University of Wyoming. The goal of the committee is to develop a five-year family preservation plan to include: 1) child safety, 2) child well being, and 3) permanent foster home placements.

The Department of Family Services released an RFP in June 1999 for Family Preservation and Support Grants. The purpose is to strengthen families and prevent the unnecessary removal of children from their homes and communities. The program encourages a holistic approach, which includes families, community resources and state agencies working together to address problems faced by children and families, and reduces the need for state intervention. Funding emphasis is on Goals III and VI of the Five Year Plan for Family Preservation and Support Services, specifically to promote the safety and well being of the child, family and community; and assist communities in strengthening their capacity to respond to the needs of children and families in the community. Funded programs will be closely monitored to evaluate their progress in meeting their goals and objectives.

Governor's Early Childhood Development Council. In FY98, Governor Jim Geringer appointed the Community and Family Health Division's Deputy Administrator to sit on his Early Childhood Development Council, made up of representatives from local government, early childhood educators, child-care providers, the private business sector, service providers, and various state agencies and boards. The Council is charged with creating a strategic plan to design Wyoming's early childhood development efforts toward assisting families and enhancing opportunities for young children to succeed as citizens. Quarterly meetings were held that resulted in a written strategic plan and the identification of the Council's mission and over-arching goal. They are:

- Mission: To maximize the healthy growth and development of Wyoming's children **pre-birth** through age eight within their families and communities.
- Over-arching Goal: To develop a quality, coordinated system, which enhances the potential of Wyoming's children.

The adoption of this particular Mission by the council is considered to be unique among states--defining prenatal efforts as a priority--and is a tribute to both the commitment of Wyoming's Governor and First Lady and to the MCH Section's determined advocacy.

The following elements of the Council's strategic plan were also completed in FY99:

- State government agencies were asked to identify specific legislation for the 1999 legislative session.
- A review of the childcare licensing and certification process was completed.
- Baseline indicators to measure Wyoming's progress in early childhood development were determined.
- Committees were established to formulate recommendations for the Governor; recommendations were published in December 1999.

Head Start State Collaboration Project: Initiated in FY97, the Head Start State Collaboration Project fosters partnerships to build a comprehensive early childhood system to link Head Start services to the broader child care, health, and education services currently available. The University of Wyoming chairs and staffs the project, which brings Head Start leaders together with the Departments of Health, Education, and Family Services. MCH staff represent the WDH on the management team for this project which focuses on building and promoting linkages, assessing the current delivery system, including information about system efficiency, redundancies and capacity.

During the reporting period, the Project continued to rely on its management team and hired full-time staff to enhance collaboration between Head Start, child-care programs, and policy makers. Activities completed included implementation of a system of electronic linkages among Head Start programs and ensuring Head Start representation on the Wyoming Department of Health's Early Intervention Council and the Governor's Early Childhood Development Council. In response to an RFP released in FY98, the project selected a grantee to conduct

an inventory of Head Start programs in FY99. Other FY99 activities included the development of best practice policies to promote collaboration between Head Start and other agencies. This commenced with a survey of all Head Start programs regarding barriers to and elements of successful collaboration. The results were used as background for a working paper on best policies for effective collaboration, disseminated in September to Head Start programs.

Childcare Licensing Task Force. In FY98, Wyoming's Governor directed that research be conducted to determine what level of responsibility for regulating child care rests with parents and what level remains with state or local government. A Child Day Care Licensing Task Force was formed to specifically address the issue of where childcare licensing would best be administered. MCH staff was appointed to this Task Force.

At their initial meeting, nine purposes establishing the baseline for childcare licensing were identified. These prioritized purposes were:

1. Protection of children
2. Education for providers, consumers, and children
3. Recognition of child care as a business
4. Providing peace of mind for parents
5. Offering agency resources for parents
6. Allow funding/participation in other programs
7. Liability
8. Opportunity for technical support
9. Improving quality

D.3 CSHCN

NPM#11: Percent of Children with Special Health Care Needs in the state CSHCN program with a source of insurance for primary and specialty care. (The objective for FY99 was 75%. The percentage with a source of insurance in FY99 is believed to be 71.2 %.) The CSHCN program did not meet this objective in FY99. NOTE: Data collection for this measure is poor. The new MCH client data system, hopefully ready for implementation in late 2000, will assistance with more reliable measurement in the years to come.

With the changes in the TANF program and Wyoming's decrease in the number of families on the Welfare rolls, families do not always understand that they can apply for Medicaid for their children, even though they are not eligible for TANF. Increased progress toward this objective is anticipated in the near future as a result of the recent implementation of the Children's Health Insurance Program (CHIP). In the spring of 1999, the Wyoming Legislature authorized a two-phase program and recently the Health Care Financing Administration (HCFA)

approved a state plan for implementing the first phase, called Kid Care 1 in Wyoming. The first phase will be a Medicaid look-alike program and cover children with family incomes from 100% to 133% of federal poverty level (FPL). Kid Care 2, a private insurance buy-in program, has not yet been approved by HCFA but is intended to provide coverage for children in families with incomes from 134% to 149% of FPL. Promotion of Kid Care by CSHCN program has been, and will continue to be a high priority.

NPM# 13: Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program. (The objective for FY99 was 90%. In State FY 99, the percent was approximately 71%.) Wyoming did not meet this objective in FY99. The following narrative describes the major activities in FY99.

In FY99, MCH supported the development of (and continues to be involved with) the State's new CHIP Program, which is called Kid Care 1. Kid Care 1 provides health benefits to children in families with incomes up to 133% of poverty level. The State is finding that many applicants who apply for Kid Care are eligible for Medicaid services.

The MCH Program has a Memorandum of Understanding with Medicaid to consolidate medical claims processing, utilizing the Medicaid fiscal intermediary, Consultec. The Consultec database enables CHS to identify which of its clients are Medicaid eligible and have received services paid for by the Medicaid program. At the same time, Consultec has successfully billed Medicaid for all transportation for which Medicaid is responsible, a savings to MCH block grant that previously covered these medical expenses through the CHS program and Newborn Intensive Care. With adequate staffing, the CSHCN records analyst have been able to review Consultec reports and find clients who were eligible for Medicaid services, but have not been billed through an error.

NPM #14: The degree to which the State assures family participation in program and policy activities in the State CSHCN program. (The objective for FY99 was to achieve a component score of 14; FY 99 component score was 15.)

MCH exceeded this objective in FY99. The following narrative describes some of the major activities:

- ◆ *Partnerships.* The MCH Section made available a grant to UPLIFT for a summer camp geared toward ADHD children and their families. This camp uses proven intervention techniques to work with the children and their families. Additional monies were used to support another aspect of UPLIFT, an early intervention program for screening of children who may be experiencing adjustment and behavior problems.
- ◆ *Committee Representation.* The MCH Parent Consultant served on a variety of state and local committees. At the state level these include: 1) the Interagency Coordinating Council, which meets quarterly to promote interagency coordination at both the state and community levels; 2) the Early Intervention Council which meets quarterly; and 3) WYNOT - Board of Partners meets quarterly to provide guidance on Assistive Technology and program accessibility.

- ◆ *Direct Parent Contact.* In FY99, the MCH Parent Consultant worked individually with approximately 250 parents. The primary service provided was referral to resources. The Parent Consultant answered questions and liaised with parents and communities through on-site consultation and a toll-free number (1-800-438-5795) for information, resources, and support.
- ◆ *Presentations to professional groups.* In FY99 the Parent Consultant revised “Packaging Wisdom,” and distributed this booklet to 75 public health nurses at a Care Coordination Conference in September. “Packaging Wisdom” helps parents organize critical information about their child’s health needs for respite providers and assists in transitioning of providers. A parent panel, made up of a male Hispanic, a woman living on a ranch, and a white collar professional, presented ideas about what would have been of assistance to them, what was not found to be helpful; and what they perceive as necessary to the care of CSHCN. These parents represented diverse cultures and ethnic groups found in Wyoming, and were paid per diem, travel and an honorarium for presenting. A parent support group gave facilitated a “disability experience” exercise for the conference participants.
- ◆ *Participation at clinics for children with special health care needs.* The Parent Consultant attended the Deaf/Blind Diagnostic Clinic offered by the Department of Education semi-annually. She also participated in the Cleft Palate Clinic conducted semi-annually by Dental Health Services in collaboration with MCH. In both settings, she talked with each individual family to assure their connection the CSHCN services offered by Wyoming MCH and determined their level of awareness of the resources available in their communities and how to access them. The CSHCN Program facilitated the distribution of clinic reports to the professionals designated by the parents. In partnership with the Department of Education, MCH provided funding for the development of an educational video on the Deaf/Blind Diagnostic Clinic for parents and health care providers as to the purpose and staffing of the clinic. Fifty copies were distributed to pediatricians’ offices. The MCH funded Genetic consultant also provides counseling during these special clinics.
- ◆ *Participation at programs for children with special health care needs.* The Youth Leadership Forum sponsored a workshop for participants age’s 15-21 years with special health care needs to develop leadership skills. The CHS Parent Consultant and Nurse Consultant contributed in-kind time during the week to assist the participants with their activities of daily living and with prescribed medications. The Parent Consultant asked the 15 participants complete a survey on their needs that will be used as part of the data collected on the 5-year needs assessment.
- ◆ *Annual MEGA Conference.* MCH helped fund the MEGA Conference held in Cheyenne on October 16-18, 1998. About 175 people attended it. Three medical doctors made presentations on sexuality and disabilities.

- ◆ *The Parent's Guide For Baby And Child Wellness ("Parent Guide")*. The Parent Consultant and other parents provided valuable consultation for the "Parent Guide" which was distributed by Help Me Grow-Safe Kids to all families of newborns in FY99. The book was distributed through hospitals and Child Care Development Centers. It contains a wealth of information on growth, development, health, safety, and parenting. The section on "Special Care for Special Babies" directs parents of children with special health care needs to the Parent Consultant for support and information on resources, including enrollment in Children's Health Services.

SUMMARY OF UNMET PERFORMANCE MEASURES & PROPOSED IMPROVEMENTS:
<p><i>NPM#5: Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Hemophilus Influenza, and Hepatitis B.</i> (The objective for FY99 was 80%. In FY99, the rate was 72%.)</p> <p>Recent re-organization within the Health Department has placed the Immunization Program under Public Health Nursing. It is anticipated that this will improve coordination with public health field personnel, the Home Visiting Program, Best Beginnings, etc. and has the potential to improve the immunization rate in the future.</p>
<p><i>NPM#6: The birth rate (per 1,000) for teenagers aged 15 through 17 years.</i> (The objective for FY99 was 22 per 1,000. In CY98, the birthrate was 22.9 per 1,000.)</p> <p>While MCH is closing in on this objective, the recent needs assessment process revealed that more emphasis should be placed on several adolescent health issues. As a result, an adolescent health systems manager has been hired. It is anticipated that this will result in an improvement in all adolescent health status indicators.</p>
<p><i>NPM#13: Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid program.</i> (The objective for FY99 was 90%; State FY 99 proportion was 71%.)</p>
<p><i>NPM#11: Percent of Children with Special Health Care Needs in the state CSHCN program with a source of insurance for primary and specialty care.</i> (The objective for FY99 was 75%. The percentage with a source of insurance in FY99 was 71.2%.)</p> <p>The State intends to improve its data system. This will allow better identification of uninsured CSHCN children. Along with information about family income, it will allow targeted referral to Kid Care, Caring for the Children or Medicaid. With the annual visits for Care Coordination, families can be referred to appropriate programs.</p>
<p><i>NPM #15: Percent of very low birth weight live births.</i> (The objective for FY 99 was 1.0; CY 98 percentage 1.1%.)</p> <p>MCH very nearly met this objective during the reporting period. Improvement is expected as the affect of the MCH capacity building grants to local health department and home visiting legislation is realized in FY 2000; and as population-based efforts influence maternal behaviors impacting LBW in FY01.</p>
<p><i>NPM#16: The rate (per 100,000) of suicide deaths among youth aged 15-19 (risk factor).</i> (The objective for FY99 was 11. In CY98, the rate was 15.9.)</p> <p>The recent needs assessment process revealed that more emphasis should be placed on adolescent health issues. As a result, an adolescent health systems manager has been hired. It is anticipated that this will result in an improvement in numerous adolescent health status indicators.</p>
<p><i>NPM#17: Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.</i> (The objective for FY99 was 77%. The percentage of very low birth weight infants delivered at facilities for high-risk deliveries in FY99 was 64.8%.)</p> <p>In the future, the State intends to standardize prenatal classes, which will assure the delivery of information to pregnant women regarding the risks of pre-term labor and the need to deliver in a facility with specialized neonatal care. The State also intends to expand the availability of smoking cessation classes.</p>

SUMMARY OF UNMET PERFORMANCE MEASURES & PROPOSED IMPROVEMENTS
(CONTINUED)

NPM#18: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester. (The objective for FY99 was 87%. The percentage born to women receiving prenatal care in FY99 was 81.4%.)

In the future, the State intends to expand the Home Visiting Program for Pregnant and Parenting Families, which will increase the number of pregnant women receiving care coordination services. It is anticipated that this will result in improved progress toward this objective.

SPM#1: Number of Specialty Clinics offered throughout the state for CSHCN. (The objective for FY99 was to have 188 specialty/subspecialty clinics. In FY99, 124 specialty/subspecialty clinics were offered.)

This performance measure has been dropped for FY01 as it duplicates part of NPM # 2 but the provision of clinics will be addressed as to the problems there by maintaining access.

SPM#3: Percent of women using tobacco, alcohol or drugs during pregnancy. (The objective for FY99 was 18%. In CY98, 23.2% of women with live births reported using either alcohol or tobacco during their pregnancy.)

In FY01, the State will separate this performance measure into two performance measures (one for alcohol and one for tobacco use). This will allow better tracking of progress. In addition, the Legislature has authorized an expansion of home visiting services, which will increase the number of pregnant women receiving care coordination services. It is anticipated that this will result in less tobacco and alcohol use during pregnancy.

SPM#4: Percent of low birth weight babies delivered in the state. (The objective for FY99 was 6.4%. The percentage of low birth weight babies in CY98 was 8.9%.)

In the future, because the Legislature has authorized an expansion of home visiting services, more pregnant women will receive care coordination services. It is anticipated that this will result in less tobacco and alcohol use during pregnancy.

SPM#7: Adolescent alcohol use. (The objective for FY99 was 50%. In 1999, the current alcohol use rate was 55%.)

The recent needs assessment process revealed that more emphasis should be placed on adolescent health issues. As a result, an adolescent health systems manager has been hired. It is anticipated that this will result in an improvement in numerous adolescent health status indicators.

NOM #2: The ratio of black infant mortality rate to the white infant mortality rate. (The objective for CY 98 was 0.9; the 1996-98 average was 3.2.)

Reported here is the race of infant on the death certificate. There was one black infant death in 1995; 1 in 1997; and 2 in 1998 in Wyoming. The HP 2010 target is to eliminate disparities.

2.5 Progress on Outcome Measures.

There are six national outcome measures. Each is listed below along with the related objective.

Wyoming has met objectives for all outcome measures except one. All outcome data are provided as three year rolling averages 1996-98; data for 1999 is not available. (See below. Similar information is also provided in Form 12.)

NOM #1: The infant Mortality rate per 1,000 live births. (The objective for CY 98 was 6.4 per 1,000 live births. The 1996-98 average death rate was 6.4 per 1,000 live births.)

NOM #2: The ratio of black infant mortality rate to the white infant mortality rate. (The objective for CY 98 was 0.9; the 1996-98 average was 3.2.) Reported here is the race of infant on the death certificate. There was one black infant death in 1995; 1 in 1997; and 2 in 1998 in Wyoming. The HP 2010 target is to eliminate disparities.

NOM #3: The neonatal mortality rate per 1,000 live births. (The objective for CY98 was 4.0 deaths per 1,000 live births. The 1996-98 average was 3.8 per 1,000 live births.)

NOM #4: The postneonatal mortality rate per 1,000 live births. (The objective for CY98 was 2.4 deaths per 1,000 live births. The 1996-98 average was 2.6 per 1,000 live births.)

NOM #5: The perinatal mortality rate per 1,000 live births. (The objective for CY98 was 9.5 deaths per 1,000 live births. In CY98, the 1996-98 death rate was 9.0 per 1,000 live births.)

NOM #6: The child death rate per 100,000 children aged 1 - 14. (The objective for CY98 was 33.0 deaths per 100,000. In CY96-98, the death rate was 33.1 per 100,000.)

III. REQUIREMENTS FOR THE APPLICATION

3.1 Needs Assessment of the Maternal and Child Health Population

Please note that Wyoming has produced a stand-alone needs assessment document (attached). The following information presents an overview of the needs assessment document.

3.1.1 Needs Assessment Process

In the fall of 1999, an MCH Needs Assessment Steering Committee was established to serve as a resource and to help direct the Needs Assessment process. Steering committee members included: MCH program managers, the parent consultant for CSHCN, the state epidemiologist, the state health officer, and representatives from the Department of Health's Oral Health Program, the Public Health Nursing Program, Medicaid, WIC, CISS/Child Care Industry, the Department of Education, the Office of Primary Care, the Primary Care Association, and the Wyoming Health Resources Network.

State performance measures were determined by a review of existing and newly collected data, as well as through input from MCH stakeholders. In late 1999, stakeholders (including consumers and professionals) were surveyed and lists of top issues were obtained. These issues, along with issues identified through a review of the data, were compiled into issue briefs. Retreats were held with stakeholders around the state and, using the issue briefs, stakeholders provided their input of assist in determining the top future issues for the MCH population. Subsequently, MCH managers met and developed seven priority areas from the list of issues; ten state performance measures were developed from these priorities.

3.1.2 Needs Assessment Content

3.1.2.1 Overview of the MCH Population Health Status

Data for the Wyoming MCH population are summarized in Table 1. For most parameters, Wyoming rates are near national averages.

While Wyoming is fortunate to be similar to or better than national averages in most areas, the state has worse than the national average in: 1) tobacco use during pregnancy; 2) alcohol use during pregnancy; 3) low birth weight; 4) unintentional injury death rate for children and teens; 5) motor vehicle crash death rate for children and teens; 5) teen suicide; 6) adolescent tobacco use and smokeless tobacco use; and 7) adolescent drug and alcohol use. Additional discussion of these areas follows.

TABLE 1: OVERVIEW OF MCH RELATED DATA IN WYOMING

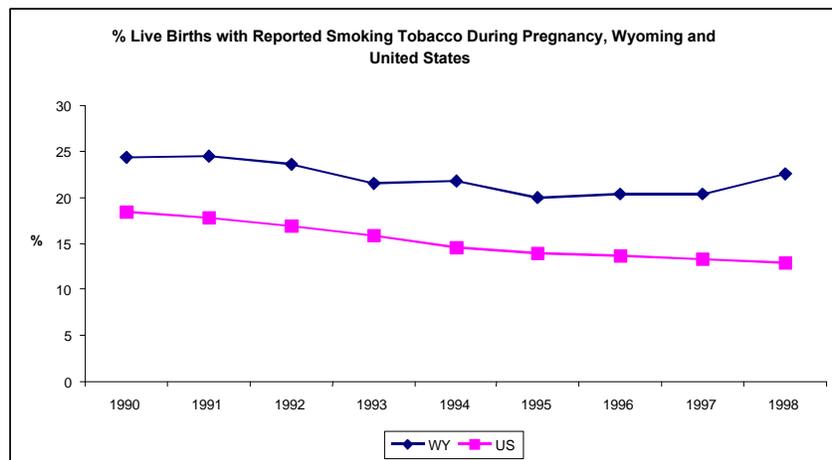
Birth Rate: From 1996 through 1998, there was an average of 6,300 births annually in Wyoming. The crude birth rate decreased from 15.4 per 1,000 in 1990 to 13.0 per 1,000 in 1998, compared to 14.6 nationally in 1998.
Unintended Pregnancy: Unintended pregnancy rates range from 77% for Best Beginnings clients to close to 88% of Home Visiting Program clients. In 1998, 74% of Title X family planning clinic clients reported their current pregnancy was unplanned.
Tobacco Use in Pregnancy: From 1996-98, an average of 21.1% of pregnant women reported smoking during pregnancy in Wyoming. The national average for 1998 was 12.9%. Forty-seven percent of pregnant women in the Home Visiting for Pregnant and Parenting Families Program reported smoking when entering the program and 41.2% of Best Beginnings clients reported smoking during pregnancy.
Alcohol Use in Pregnancy: In Wyoming from 1996-98, 1.9% of women reported using any alcohol during pregnancy. However, according to a Wyoming Department of Health (WDH) Study, 42% of pregnant women in the study were using alcohol. According to data from the state's Home Visiting Program, 37.5% of pregnant women reported having at least one drink during pregnancy and 7.1% reported at least monthly drinking during pregnancy.
Illicit Drug Use in Pregnancy: A WDH Study revealed that 14.5% of pregnant women in the study were current illicit drugs user including: marijuana (13%); methamphetamine (4.3%); and cocaine (2.4%).
Prenatal Care: From 1996-98, 82.0% of pregnant women in Wyoming received first trimester prenatal care compared to 82.8% for the United States in 1998. During 1996-98, 12.5% of Wyoming births were reported to have inadequate prenatal care compared to 11.9% nationally in 1998.
Preterm Birth: From 1996-98, 11.6% of Wyoming births were pre-term compared to 11.6% nationally in 1998.
Low Birthweight: From 1996-98, Wyoming averaged 8.8% LBW and 1.1% VLBW. The 1998 national rates were 7.6% for LBW and 1.5% for VLBW. In 1998, Wyoming was tied for sixth among the 50 states in LBW, and first for LBW for whites. Wyoming was in a three-way tie for 32 nd for VLBW in 1998.
Breast-feeding: In 1998, 77% of Women surveyed reported breast-feeding at hospital discharge, compared to 64.3% nationally. At six months after discharge, 36.6% reported breast-feeding compared to 28.6% nationally.
Infant Mortality: The infant mortality rate in Wyoming from 1996-98 was 6.4 per 1,000 live births, compared to a national rate of 7.2 in 1998.
Poverty: From 1996-98, there were 63,000 Wyoming children (43%) at or below 200% of FPL, up from 37.8% during 1993-94. An estimated 9.4% (14,000 children) were either at or below FPL and uninsured in Wyoming during 1996-98.
Insurance: 12.7% of families responding to the 1998 BRFSS reported their children had no health insurance coverage.
Health Care Utilization: According to 1999 BRFSS data, 85% of children with Medicaid had a medical checkup in the past year compared to 56% of uninsured children and 72% of those with insurance.
Leading Causes of Death: Unintentional injuries, primarily motor vehicle crashes, are the leading cause of death for all Wyoming children and youth. The 1996-98 unintentional injury death rate for ages 5-14 was 17.1 per 100,000 compared to 8.6 per 100,000 nationally. The unintentional injury death rate for ages 15-24 was 59 per 100,000 compared to 36.4 nationally.
Physical Activity: In 1999, 71% of high school students reported vigorous physical activity, up from 64% in 1997. About 80% of middle school students reported vigorous physical activity.
Nutrition/Weight: According to the 1999 YRBS of high school students, 5.5% of students were overweight ($\geq 95\%$ percentile BMI). This included 2.1% of females and 8.8% of males. An additional 11.9% of students were at risk of becoming overweight ($\geq 85\%$ to $< 95\%$ percentile BMI). This included 9.8% of females and 13.8% males.
Immunizations: Wyoming's FY99 immunization rate for 4:3:1:3:3: was 72% (CASA). For 4:3:1 only, the FY 99 National Immunization Survey reported an immunization rate of 77.8% for Wyoming, compared to 78.1% nationally (for 4:3:1).
Asthma: In 1998, 181 children ages 0-4 were hospitalized for asthma, for a hospitalization rate of 59.2 per 10,000, compared to 60.1 nationally in 1997.
Lead: Thirty-seven Wyoming children have been identified with elevated blood lead levels ($\geq 10\mu\text{g}/\text{dL}$) since 1995. Wyoming ranks 29 th among states for percentage of older housing with lead-based paint.
Oral Health: In a 1999 mouth examination survey done by the Department of Health Oral Health Program, 71% of surveyed third grade children had at least one protective sealant on a permanent molar.
Tobacco Use: According to the 1999 YRBS, 36% of high school females and 35% of high school males reported current cigarette use. Eighteen percent (29% males, 6% females) reported current smokeless tobacco use.
Alcohol Use: In 1999, 55% (56% males, 53% females) of Wyoming students responding to the YRBS reported current alcohol use. Wyoming teen binge drinking increased from 19.7% in a 1991 survey to 40% in the 1999 YRBS (43% males, 35% females).
Suicide: In 1997, Wyoming ranked fourth among the 50 states in suicide mortality. The overall age-adjusted suicide rate was 18.5 per 100,000 in 1997, compared to 10.6 nationally. The 1998 Wyoming suicide rate for ages 15-19 was 15.9 per 100,000.
Motor Vehicle Crashes: In 1998, motor vehicle crashes (MVC) were the leading cause of death for ages 1-24. In 1997, Wyoming had an overall MVC death rate of 25 per 100,000 population, compared to 16.5 nationally.
Reproductive Health: The 1999 YRBS indicates that 48% of high school students had ever had sexual intercourse. In 1997, 45% of Wyoming teens reported that had ever had sexual intercourse.
CSHCN Prevalence: In 1998, there were an estimated 48,046 Wyoming children and youth with a chronic physical condition and 27,898 with a special health care need. In FY99, the CSHCN Program had an average enrollment of 2,556, ages 0-18. Of these 56% had Medicaid, 15% had SSI, 23% had insurance, and 29% had neither Medicaid nor insurance.

Tobacco Use During Pregnancy:

According to birth certificate data, in 1998, 22.5% of mothers in Wyoming smoked during pregnancy compared to 12.9% nationally. However, birth certificate data are generally believed to underestimate the number of smokers. According to a 1999 Wyoming Department of Health study, 43% of the pregnant women in the study were smokers.

In 1998, based on birth certificate data, 13.3% of infants born to Wyoming smokers were low birth weight compared to 7.6.2% of infants born to non-smokers, and the average birth weight of infants born to smokers was 8 ounces less than that of infants born to nonsmokers. Most Wyoming pregnant smokers (67.7%) smoked less than a pack a day or less, and 2.3% smoked greater than a pack a day.

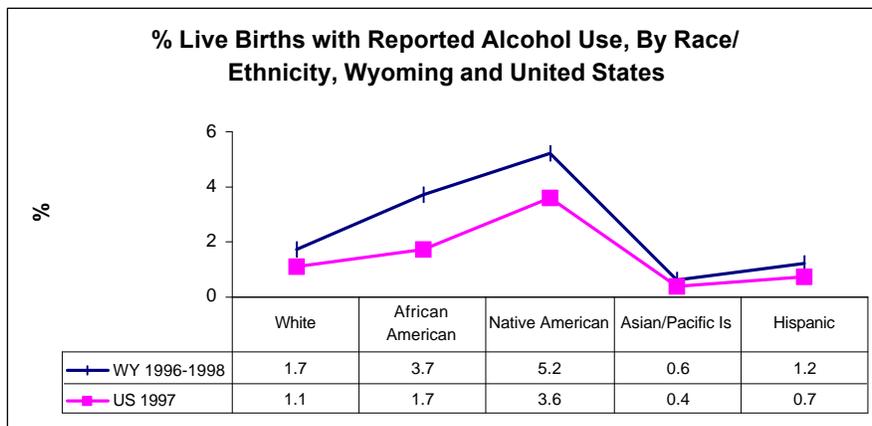
From 1996-98, Native American mothers had the highest proportion (33%) of smoking during pregnancy followed by Whites (20.7%), African Americans (16%), Hispanics (13.6%) and Asians (7.1%). Wyoming smoking rates decrease as level of education increases. About 42% of women with 9-11 years of education reported smoking on the birth certificates, compared to 3.4% of women with a college degree.



Alcohol Use During Pregnancy:

According to birth certificate data, 1.9% of Wyoming births reported alcohol use during pregnancy from 1996-98, compared to 1.1% nationally in 1998. However, alcohol use in pregnancy is thought to be under reported. A 1999 Wyoming Department of Health study found that 42% of pregnant women enrolled in the study were using alcohol. Related to alcohol use in pregnancy, Fetal Alcohol Syndrome (FAS) is reported on birth certificates at a rate of 0.16 per 1,000 live births in Wyoming (1996-98) compared to 0.07 per 1,000 live births nationally in 1998.

From 1996-98, Native American mothers had the highest rate (5.2%) of reported alcohol use during pregnancy followed by African Americans (3.7%), Whites (1.7%), Hispanics (1.2%), and Asians (0.6%). Reported alcohol use during pregnancy generally decreased as level of education increased.



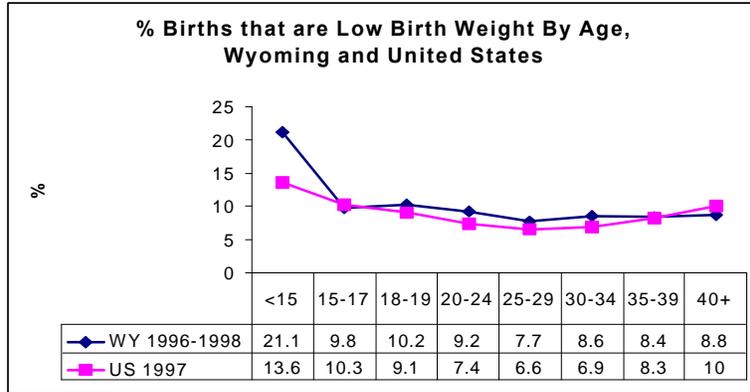
Illicit Drug Use

A 1999 WDH study revealed that 14.5% of pregnant women in the study were current users of illicit drugs. The most used drugs were marijuana (13%) followed by methamphetamine (4.3%) and cocaine (2.4%). Pregnant women less than 21 years of age had the highest rates of illicit drug and tobacco use.

Low Birth Weight:

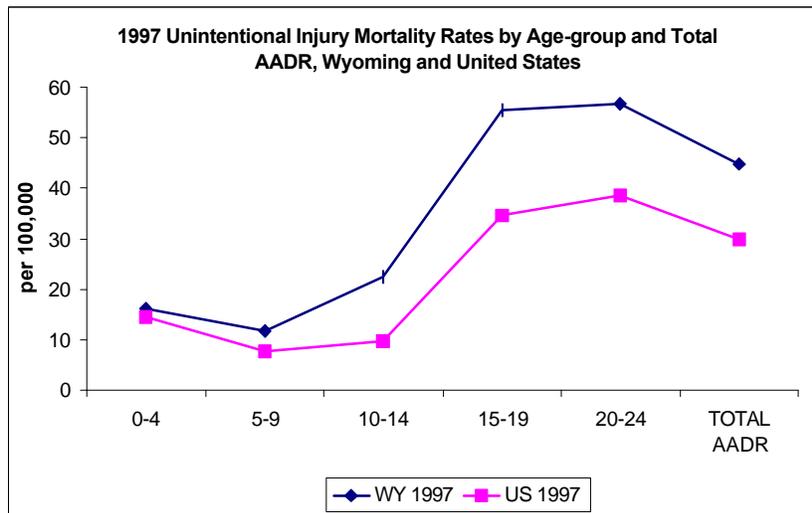
In 1998, the Low Birth Weight (LBW) rate for Wyoming was 8.9% compared to 7.6% nationally. Wyoming was tied for sixth out of 50 states in LBW births and was first for LBW births to whites.

For 1996-98, African Americans in Wyoming had the highest proportions of LBW births (15.4%), followed by Asians (11.7%), Hispanics (9.1%), Whites (8.7%), and Native Americans (7.4%).



Unintentional Injury Death Rate for Children and Teens:

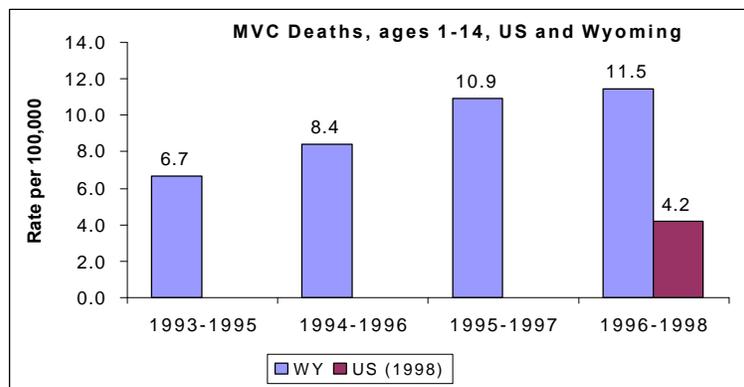
Wyoming children and youth have higher age-specific injury mortality rates than the national average. Unintentional injury mortality is lowest in the 5-9 age group and highest in adolescents and young adults. Wyoming females ages 0-9 have slightly higher injury mortality rates than males, while the mortality rate in males ages 10-24 is much higher than females. Based on hospital discharge data, motor vehicle traffic accidents and falls were the most common type of unintentional injury hospitalizations for those children age 0-19, followed by poisoning and pedestrian-related injuries.



Motor Vehicle Crash Death Rate for Children and Teens:

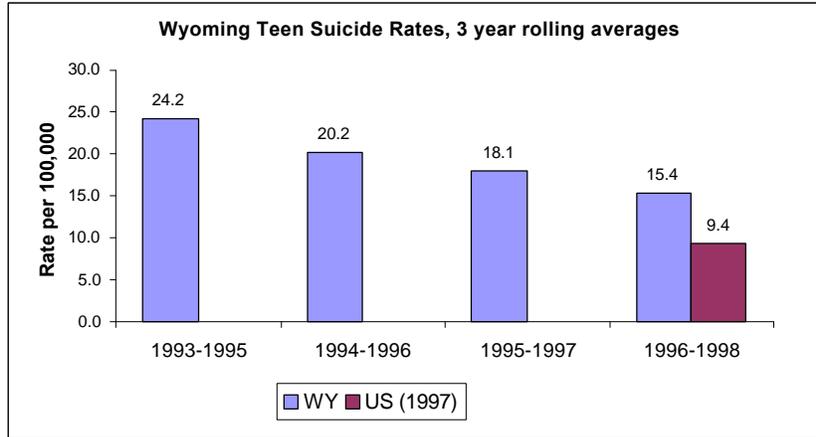
In 1998, unintentional injuries, primarily motor vehicle crashes (MVC), were the leading cause of death for ages 1-24. In 1997, Wyoming had an overall MVC death rate of 25 per 100,000 people compared to a national rate of 16.5. Only five other states had worse MVC death rates.

The proportion of Wyoming high school students reporting they never or rarely wore seatbelts when riding in a vehicle was 24.0% in 1999 compared to 16% nationally. Wyoming teens are more likely (39%) to ride with a driver who had been drinking than their national counterparts (33%). About 23% report driving after drinking alcohol compared to a national rate of 13%.



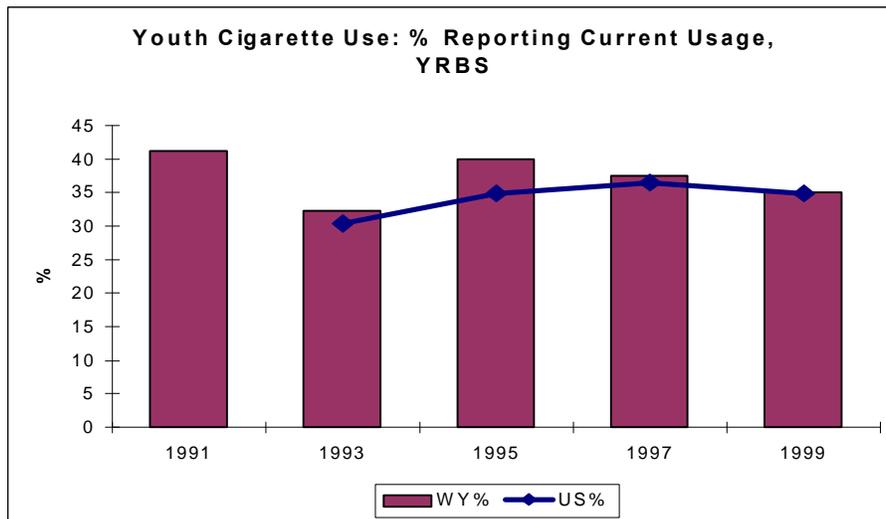
Teen Suicide:

In 1997, Wyoming ranked fourth among the 50 states in suicide mortality for all ages. The overall age-adjusted suicide rate was 18.5 per 100,000 compared to 10.6 nationally. Teen suicide rates are also high, as the 1998 rate for 15-19 year olds was 15.9 per 100,000 compared to a 1997 national rate of 9.4 per 100,000. The 1994-98 Wyoming suicide rate for 15-24 year olds was 23.7 per 100,000 compared to a US rate for this age group of 12.0 per 100,000.



Adolescent Tobacco Use and Smokeless Tobacco Use:

In 1999, 35% of Wyoming Teens (36% of females and 35% of males responding to the YRBS) reported current cigarette smoking, compared to 35% nationally. About 18% of these Wyoming teens had used smokeless tobacco in the past 30 days, compared to 7.8% nationally.



Adolescent Drug and Alcohol Use:

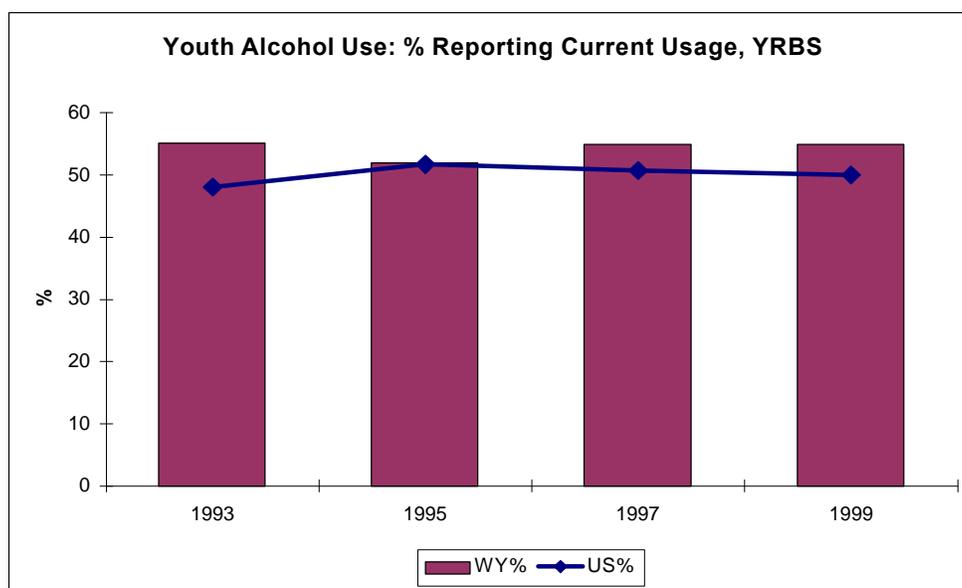
In 1999, 21% of high school students reported on the YRBS they were current marijuana users, 3.7% reported current cocaine usage, and 4.2% reported current inhalant use. Nationally in 1999, 31% of students reported current marijuana use, 4.0% reported current cocaine use, and 4.2% reported current inhalant use. Wyoming has some of the highest rates of illicit drug use among youth in the nation.

Table 26: Illicit Drug Use % Responding Yes, 1999 YRBS	Wyoming	U.S.	WY Rank (out of 22*)
Ever Used Cocaine	9.8	9.5	4
Current Cocaine Use	3.7	4.0	10
Ever Used Heroin	2.9	2.4	13
Ever Used Illegal Steroids	4.9	3.7	7
Ever Injected Drugs	2.8	1.8	6
Ever Sniffed Drugs/ Substances	17.6	14.6	4
Ever Used Methamphetamine	12.6	9.1	5

*out of 22 states with weighted data

Source: YRBS

In 1999, 55% (56% males and 53% females) of Wyoming students reported current alcohol use, compared to 50% nationally (52% males and 48% females). The 1999 YRBS reported that 82% of Wyoming high school students had at least one drink of alcohol during their life and 36% had their first drink before age 13.



* * *

In addition to examining health status data, the needs assessment process included a written survey of stakeholders and the results of group discussions at three retreats. Two of the retreats included stakeholders and the public sector, while primarily MCH staff who analyzed the data and public input attended the final retreat.

Responses to the written survey were placed into the following three categories and ranked: 1) Maternal and Infant Health (MIH); 2) Children with Special Health Care Needs (CSHCN); and Children and Adolescent Health (CAH). The number one ranked problem in each of these categories was as follows: MIH) alcohol use during pregnancy; CSHCN) access to special care; and CAH) adolescent drug and alcohol use (Table 2).

Rank	Maternal & Infant Health	Children with Special HC Needs	Children & Adolescent Health
1	Alcohol Use During Pregnancy	Access to Specialty Care	Adolescent Drug & Alcohol Use
2	Smoking During Pregnancy	Access to Financial Assistance	Teen Pregnancy
3	Drug use During Pregnancy	Health Insurance	Adolescent Tobacco Use
4	Education for Parents	Access to Primary Care	Sexually Transmitted Diseases
5	Health Insurance	Access to Early Intervention	Domestic Violence
6	Teen Pregnancy	Child Care	Health Insurance
7	Prenatal Care Access	Child Safety	Youth Suicide
8	Child Care	Regular Health Care Provider	Violence
9	Child Abuse Deaths	Access to Mental Health Services	Child Abuse
10	Birth to Single Mothers	Coordination Between Agencies	Motor Vehicle Crashes

Retreat participants were also asked to rank issues in the same three categories. Top issues that emerged in each category were: MIH) teen pregnancy; CSHCN) Early identification, diagnosis, intervention; and CAH) adolescent drug and alcohol use (Table 3).

Rank	Maternal & Infant Health	Children with Special HC Needs	Children & Adolescent Health
1	Teen pregnancy	Early identification, diagnosis, intervention	Drug and Alcohol Use
2	Alcohol and drug use	Support services for families	Family Violence
3	Pregnancy intention	Access	Tobacco Use
4	Access	Coordination of services	Suicide
5	Tobacco use	Family friendly and culturally competent care	Teen pregnancy
6	Health insurance	Health insurance	Injury/ violence
7	PNC Access	Transition to Adult Care	Pregnancy intention
8	LBW	Data availability	Motor vehicle Crashes
9	Infant mortality/ SIDS	Information services	Health insurance
10	Data availability		Overweight/ nutrition

MCH staff subsequently analyzed mortality, morbidity, and behavioral data along with results from the written survey results and the retreats. All information and data were used to develop ten priority areas upon which to build state performance measures for FY01. The resulting ten areas are:

1. Home Visiting Services;
2. Care Coordination for High Risk Pregnant Women;
3. Alcohol Use During Pregnancy;
4. Smoking During Pregnancy;
5. Adolescent Nutrition;
6. Adolescent Methamphetamine Use;
7. Adolescent Smoking;
8. Adolescent Alcohol Use;
9. Community Planning;
10. Language Translation Services.

3.1.2.2 Direct Health Care Services

The following needs have been identified that have special relevance to direct health care services provided by MCH:

- **Tobacco Use in Pregnancy:** From 1996-98, an average of 21.1% of pregnant women reported smoking during pregnancy in Wyoming. The national average for 1998 was 12.9%. Forty-seven percent of pregnant women in the Home Visiting Program reported smoking when entering the program, and 41.2% of Best Beginnings clients reported smoking during pregnancy.
- **Alcohol Use in Pregnancy:** In Wyoming from 1996-98, 1.9% of women reported using any alcohol during pregnancy. However, according to a Wyoming Department of Health (WDH) Study, 42% of pregnant women were using alcohol at the time of the study. According to data from the state's Home Visiting Program, 37.5% of pregnant women reported having at least one drink during pregnancy and 7.1% reported at least monthly drinking during pregnancy.
- **Illicit Drug Use in Pregnancy:** A WDH Women's Reproductive Health Study revealed that 14.5% of pregnant women in the study were current illicit drugs users including: marijuana (13%); methamphetamine (4.3%); and cocaine (2.4%).
- **Infant Mortality:** The infant mortality rate in Wyoming from 1996-98 was 6.4 per 1,000 live births, compared to a provisional national rate of 7.2 in 1998.
- **Unintended Pregnancy:** Unintended pregnancy rates range from 77% for Best Beginnings clients to near 88% of Home Visiting Program clients. In 1998, 74% of Title X family planning clinic clients reported their current pregnancy was unplanned.

- **CSHCN Prevalence:** In 1998, there were an estimated 48,046 Wyoming children and youth with a chronic physical condition and 27,898 with a special health care need. In FY99, the CSHCN Program had an average enrollment of 2,556, ages 0-18. Of these 56% had Medicaid, 15% had SSI, 23% had insurance, and 29% had neither Medicaid nor insurance.
- **Preterm Birth:** From 1996-98, 11.6% of births were preterm compared to 11.6% nationally in 1998.
- **Low Birth Weight:** From 1996-98, Wyoming averaged 8.8% LBW and 1.1% VLBW. The 1998 national rates were 7.6% for LBW and 1.5% for VLBW. In 1998, Wyoming was tied for sixth among the 50 states in LBW, and first for LBW for whites. Wyoming was in a three-way tie for 32nd for VLBW in 1998.
- **Breastfeeding:** In 1998, 77% of those surveyed reported breastfeeding at hospital discharge, compared to 64.3% nationally. Six months after discharge, 36.6% reported breast-feeding compared to 28.6% nationally.
- **Oral Health:** In a 1997 mouth examination survey done by the Department of Health Oral Health Program, 36% of surveyed third grade children had at least one protective sealant on a permanent molar. About 5% of molars seen had decay.
- **Immunizations:** The FY99 National Immunization Survey reported an immunization rate of 77.8% for Wyoming compared to 78.1% nationally (for 4:3:1).
- **Lead:** Thirty-seven Wyoming children have been identified with elevated blood lead levels ($\geq 10\mu\text{g/dL}$) since 1995. Wyoming ranks 29th among states for percentage of older housing with lead-based paint.

Please note that many of these needs will be addressed through enabling services and population based services as well as direct care services.

The Home Visiting Program will be utilized to meet many of these needs utilizing primarily a direct service approach. This program provides a service delivery vehicle to achieve objectives relating to following performance measures: NPM#5; NPM#6; NPM#8; NPM#15; and SPM#1.

The State plans to expand this program in FY01. The 2000 Wyoming Legislature provided additional funding to substantially expand this program which is based on the model developed and researched by David Old's, Ph.D. Home visits will be made by registered nurses that have a strong background in health education and promotion, communication, and human development, as well as specific training regarding the program model and theoretical basis. The program is expected to have an impact on: increase in immunization rates; decrease in teen pregnancies (especially second pregnancies); decrease in low birth weight births; decrease in use of alcohol, tobacco and illicit drugs in pregnancy; decrease in infant mortality; and increase in breast-feeding rate.

Direct service needs will also be addressed through the Best Beginnings Program. This program provides a service delivery vehicle to achieve objectives relating to following performance measures: NPM#9; NPM#10; NPM#17; NPM#18; SPM#2; SPM#3; and SPM#4. It is expected to have an impact on: breastfeeding; newborn hearing

screening; low birth weight births; prenatal care; care coordination; alcohol use during pregnancy; smoking during pregnancy; and infant mortality.

Other programs providing direct services include: CSHCN; Oral Health; WIC; Lead; and Genetics. Again, it should be noted that each of these programs has enabling and population based functions in addition to direct client services.

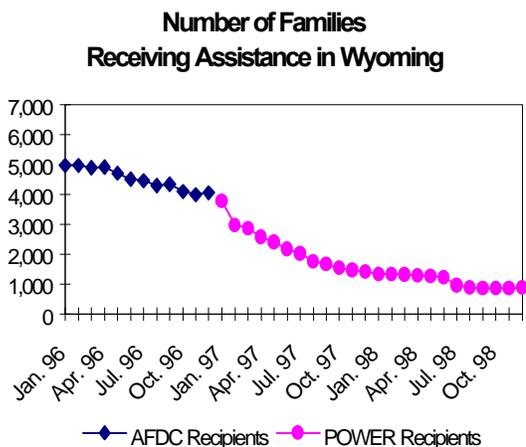
3.1.2.3 Enabling Services

The following needs have been identified that have special relevance to enabling services:

- **Poverty:** From 1996-98, there were 63,000 Wyoming children (43%) at or below 200% of FPL, up from 37.8% during 1993-94. An estimated 9.4% (14,000 children) were both at or below FPL and uninsured in Wyoming during 1996-98.
- **Prenatal Care:** From 1996-98, 82.0% of pregnant women in Wyoming received first trimester prenatal care compared to 82.8% for the United States in 1998. During 1996-98, 12.5% of Wyoming births were reported to have inadequate prenatal care compared to 11.9% nationally in 1998. Native Americans had the highest rate of inadequate prenatal care at 28%, followed by African Americans (22.9%), Hispanics (21.2%), whites (11.3%); and Asians (9.1%)
- **Insurance:** 12.7% of families responding to the 1998 BRFSS reported their children had no health insurance coverage.
- **Health Professional Shortage Areas:** In 1999, 21 Wyoming counties were wholly or partially designated as Health Professional Shortage Areas (HPSA) for primary care; 1 (Niobrara) was designated as a dental HPSA; and all were designated as Mental Health HPSAs.
- **Health Care Utilization:** According to 1999 BRFSS, 85% of children with Medicaid had a medical checkup in the past year compared to 56% of uninsured children and 72% of those with insurance.

Welfare reform has had a big impact in Wyoming.

Immediately prior to welfare reform, approximately 4,500 families received AFDC. One year after welfare reform, the number of families receiving TANF (called POWER in Wyoming) had dropped to about 1,500. Currently, the number is about 800. In recent years, Medicaid eligibility rules have been separated from TANF eligibility rules in order to allow families to continue to receive Medicaid even though they may be no longer eligible for TANF. However, many families appear to have left Medicaid



when they became ineligible for TANF. The State's new Kid Care outreach efforts are discovering that many applicants for Kid Care are actually eligible for Medicaid.

MCH was a leader in promoting the development of the new Children's Health Insurance Program (in Wyoming it is called Kid Care). Now that the program is up and running, MCH continues to coordinate with Medicaid and Kid Care managers in order to refer needy children to the appropriate program (including CSHCN).

MCH also works closely with WIC and local public health offices to assure that professionals are knowledgeable about eligibility requirements for CSHCN, Kid Care 1 and Medicaid. Education of professionals is an important part of building and maintaining a referral network in the state.

In addition to Kid Care 1, Wyoming is currently developing Kid Care 2. While Kid Care 1 is a Medicaid look-alike program serving children in families from 100% to 133% FPL, Kid Care 2 will be state subsidized private insurance program serving families from 133% to 149% FPL. MCH is participating in the development of the rules for this new program. In the near future, the state will have the following options to offer children: CSHCN; Medicaid; Kid Care 1; and Kid Care 2. These options are expected to substantially improve children's access to health care.

Wyoming has chronically experienced health professional shortages, especially in specialty areas. In 1999, 21 Wyoming counties were wholly or partially designated as Health Professional Shortage Areas (HPSA) for primary care; 1 (Niobrara) was designated as a dental HPSA; and all were designated as Mental Health HPSAs. MCH mitigates these shortages by contracting with out-of-state specialists to perform certain services. Also, the Department of Health has contracted with the Wyoming Health Resources Network to recruit physicians and other professionals.

While a sparse population has the disadvantage of making it difficult to attract service providers, especially in specialty areas, it has the advantage of having a 'small town atmosphere.' This lends itself to the development of a good referral system. MCH devotes much time and effort to coordinating the referral system as it relates to services for children and mothers in the state. Recently, MCH hired a minority health coordinator who will improve the referral system for minority populations. The minority health coordinator will also develop a referral system for language translation services (SPM#10).

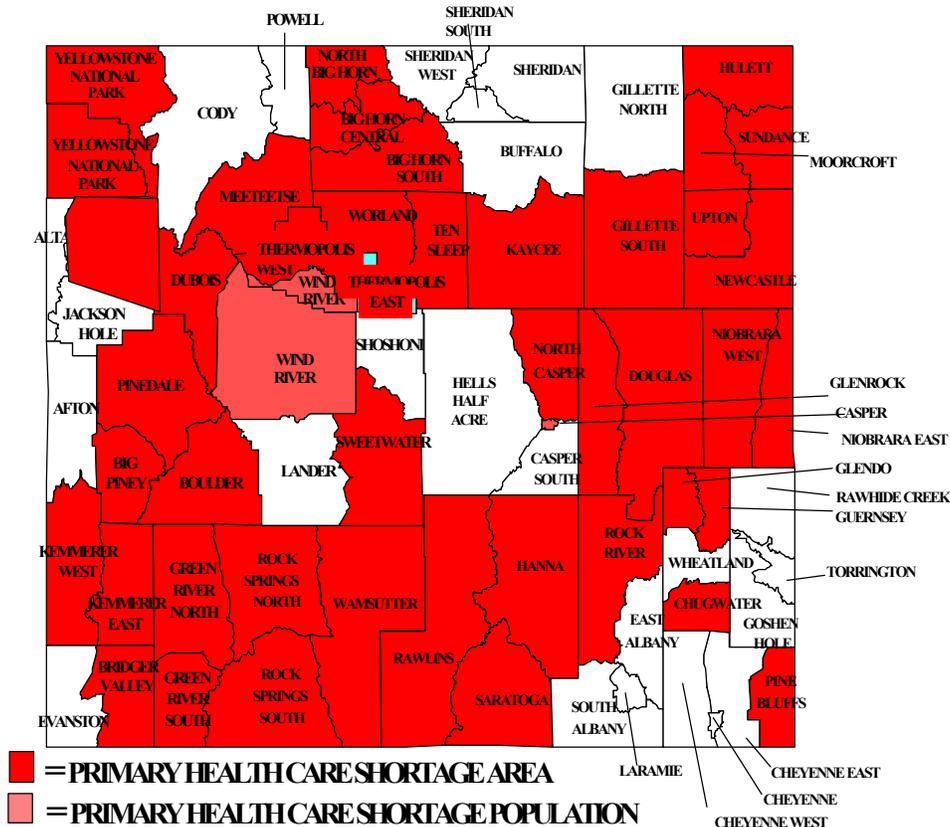
Wyoming Licensed Physicians, July 1999

SPECIALTY	Number	Wyoming Rate per 100,000 *	US Rate per 100,000 (1997)
Anesthesiology	48	9.98	9.6
Cardiology	13	2.70	5.6
Dermatology	8	1.66	2.8
Emergency Room Medicine	57	11.85	4.7
Gastroenterology	4	0.83	3
General Surgery	40	8.32	10.4
Internal Medicine	93	19.34	30.4
Neurology	8	1.66	3.1
Obstetrics and Gynecology	42	8.73	11.2
Pediatrics	43	8.94	13.8
Plastic Surgery	4	0.83	2
Pulmonary Diseases	4	0.83	1.9
Psychiatry	39	8.11	9.1
Radiology	38	7.90	2.4
Family Practice/ General Practice	190	39.5	23.2
TOTAL	836	173.8	282.74

Source: Wyoming Board of Medicine July 1999 and Health United States, 1999.

WYOMING

HEALTH PROFESSIONAL SHORTAGE AREAS



1/15/99

3.1.2.4 Population-Based Services

The following needs have been identified that have special relevancy to population based services:

- **Birth Rate:** From 1996 through 1998, there was an average of 6,300 births annually in Wyoming. The crude birth rate decreased from 15.4 per 1,000 in 1990 to 13.0 per 1,000 in 1998, compared to 14.6 nationally in 1998.
- **Leading Causes of Death:** Unintentional injuries, primarily motor vehicle crashes, are the leading cause of death for all Wyoming children and youth. The 1996-98 unintentional injury death rate for ages 5-14 was 17.1 per 100,000 compared to 8.6 per 100,000 nationally. The unintentional injury death rate for ages 15-24 was 59 per 100,000 compared to 36.4 nationally.
- **Physical Activity:** In 1999, 71% of high school students responding to the YRBS reported vigorous physical activity up from 64% in 1997. About 80% of middle school students reported vigorous physical activity.

- **Tobacco Use:** In 1999, 36% of high school females and 35% of high school males responding to the YRBS reported current cigarette use. Eighteen percent (29% males, 6% females) reported current smokeless tobacco use.
- **Nutrition/Weight:** According to the 1999 YRBS, 5.5% of high school students were overweight ($\geq 95\%$ percentile BMI). This included 2.1% of females and 8.8% of males. An additional 11.9% of students were at risk of becoming overweight ($\geq 85\%$ to $< 95\%$ percentile BMI). This included 9.8% of females and 13.8% males.
- **Alcohol Use:** In 1999, 55% (56% males, 53% females) of Wyoming students responding to the YRBS reported current alcohol use. Wyoming teen binge drinking increased from 19.7% in a 1991 survey to 40% in the 1999 YRBS (43% males, 35% females).
- **Illicit Drug Use:** According to the 1999 YRBS, 21% of high school students reported they were current marijuana users, 4.7% reported current cocaine use, and 4.2% reported current inhalant use.
- **Suicide:** In 1997, Wyoming ranked fourth among the 50 states in suicide mortality. The overall age-adjusted suicide rate was 18.5 per 100,000 in 1997, compared to 10.6 nationally. The 1998 Wyoming suicide rate for ages 15-19 was 15.9 per 100,000.
- **Motor Vehicle Crashes:** In 1998, unintentional injuries, primarily motor vehicle crashes (MVC). were the leading cause of death for ages 1-24. In 1997, Wyoming had an overall MVC death rate of 25 per 100,000 population, compared to 16.5 nationally.
- **Reproductive Health:** The 1999 YRBS indicates that 48% of high school students had ever had sexual intercourse. In 1997, 45% of Wyoming teens reported that had ever had sexual intercourse.

Recently, MCH hired an Adolescent Health Systems Manager. Previously, about 1/2 of the staff was devoted to this function. The new manager will devote full time effort to adolescent health issues. The program will provide largely population based services relating to the following performance measures: NPM#8; NPM#16; SPM#5; SPM#6; SPM#7; and SPM#8. It is expected to have an impact on: the child motor vehicle death rate; teen suicide; teen obesity; teen reproductive health; teen methamphetamine use; teen smoking; and teen alcohol use.

Many other MCH activities have a population-based component. For example: 1) In addition to direct services in the form of sealants, Dental Health provides extensive education services; 2) In addition to the direct care provided by Best Beginnings and the Home Visiting Program, staff also have developed an education and referral system that reaches beyond those who are receiving direct services; and 3) In addition to the direct family planning services provided by the Wyoming Health Council (WHC), as contracted through the Perinatal Systems Manager, WHC provides population based educational services.

3.1.2.5 Infrastructure Building Services

Many of the access to services issues discussed in the Enabling Services section are addressed through infrastructure building efforts. Due to the fact that MCH has limited budget and staff, it is difficult to address statewide issues relating to lack of insurance or shortages of health professionals through direct services. Instead, these issues are dealt with through infrastructure building arrangements with other organizations. For example, these include: 1) participating with the development of the new Kid Care 1 and Kid Care 2 programs; 2) developing contracts with out of state professionals to provide services in Wyoming; 3) supporting a Department of Health contract with the Wyoming Health Resources Network to recruit health professionals. While direct services are often more visible, it should be noted the MCH devotes extensive effort to infrastructure building efforts. Because many of these efforts involve numerous other organizations that are beyond the direct control of MCH, much time is often needed to provide the glue to build and maintain these systems.

A specific example of an infrastructure building activity is an MCH contract with the Wyoming Health Resources Network (WHRN) to provide community-planning services (SPM#9). As a result of this contract, WHRN is working with communities to conduct health-planning activities and secure implementation resources. The popularity of this program has been growing and other programs within the Department of Health are now contributing to the planning effort. Recently, the Department of Health signed a contract with WHRN to function as a grant clearinghouse, which will improve community access to financial resources and improve health outcomes.

The recent needs assessment process identified availability of health planning and evaluation data as a problem. MCH staff have recognized this for some time. Last year, MCH applied for and was awarded a SSDI grant to improve the data system within MCH and within the Department as a whole. Staff has been hired and in the near future the data infrastructure will be substantially improved.

MCH has received numerous requests for language translation services. MCH intends to build an infrastructure of local translators as well as individuals who are familiar with cultural customs.

Finally, MCH is constantly working to improve the internal administrative infrastructure. Staff has been and will continue to be involved with the annual report; the five-year needs assessment and block grant application. Through extensive involvement, staff hones their administrative skills and develops a comprehensive view of the MCH mission.

Wyoming Minority Population Estimates for 1998 by County (U.S. Census Bureau)

County	Total Population	White Hispanic	African American	Native American	Asian/ Pacific Islander	Total Minority	% Minority
Wyoming	480,907	26,769	4,082	10,607	4,022	45,480	9.3%
Albany	29,185	1,893	283	243	757	3,176	10.9%
Big Horn	11,380	630	3	65	39	737	6.5%
Campbell	32,465	959	50	404	135	1,548	4.8%
Carbon	15,575	2,188	130	159	133	2,610	16.8%
Converse	12,337	634	19	128	48	829	6.7%
Crook	5,829	31	2	29	4	66	1.1%
Fremont	36,044	1,010	97	6,728	170	8,005	22.2%
Goshen	12,886	1,166	25	113	23	1,327	10.3%
Hot Springs	4,727	53	18	112	1	184	3.9%
Johnson	6,824	78	3	67	12	160	2.3%
Laramie	78,872	7,891	2,454	701	1,265	12,311	15.6%
Lincoln	13,876	284	8	82	50	424	3.1%
Natrona	63,341	2,266	532	478	417	3,693	5.8%
Niobrara	2,706	38	11	21	5	75	2.8%
Park	25,782	935	23	154	163	1,275	5.0%
Platte	8,626	428	6	25	11	470	5.5%
Sheridan	25,165	474	43	228	141	886	3.5%
Sublette	5,738	79	6	83	17	185	3.2%
Sweetwater	39,780	3,711	295	341	371	4,718	11.9%
Teton	14,163	201	28	129	85	443	3.1%
Uinta	20,465	894	22	143	104	1,163	5.7%
Washakie	8,669	832	21	80	59	992	11.4%
Weston	6,472	94	3	94	12	203	3.1%

3.2 Health Status Indicators

See forms in appendix.

3.2.1 Priority Needs

Based on the outcome of the comprehensive assessment of Wyoming's MCH needs (2001-2005), Wyoming has identified the following priority needs. Please see section for 3.4.2.1 for a summary list of how these needs were translated into state performance measures across all levels of the pyramid of services.

1. Decreasing barriers to accessing health care through state and community capacity building and systems development efforts
2. Decreasing incidence of low birth weight babies delivered
3. Decreasing incidence of youth suicide
4. Decreasing unintended pregnancy
5. Decreasing prenatal and youth tobacco and other substance use and abuse
6. Decreasing preventable disease and injury in our children and youth
7. Providing care coordination services for at-risk populations including first time teen mothers, high-risk pregnant women, and CSHCN

3.3 Annual Budget and Budget Justification

The state budgets are located in Forms 2-5, a brief narrative follows:

Form 2 is believed to provide detail sufficient to demonstrate budget components of the block grant; Form 3 to show spending trends. Naturally, adjustments will be made as necessary when the FY 2001 grant is received to reflect the actual grant award.

Form 4 provides detail sufficient to demonstrate distribution of funds across the population we serve. Please note that the \$302,907 shown in Le: "All others", is money expended on infrastructure development efforts which include, but are not limited to, Wyoming Health Resources Network (Community health planning and provider recruitment and retention), Wyoming Reproductive Health Council (Coordinating limited MCH family planning funds with Title X dollars and data collection), Wyoming Community Coalition for Health Education (dual strategies for improving adolescent outcomes), and participation in various other systems building coalitions and committees. A reviewer unfamiliar with Wyoming's financial limitations should also please note that this small expenditure of MCH dollars allows us to maximize funds from many other public/private partners which is largely the reason why Wyoming's "pyramid" is right-side up — much of the collaborative infrastructure building efforts in Wyoming should be classified as "in-kind."

3.3.1 Completion of the Budget Forms

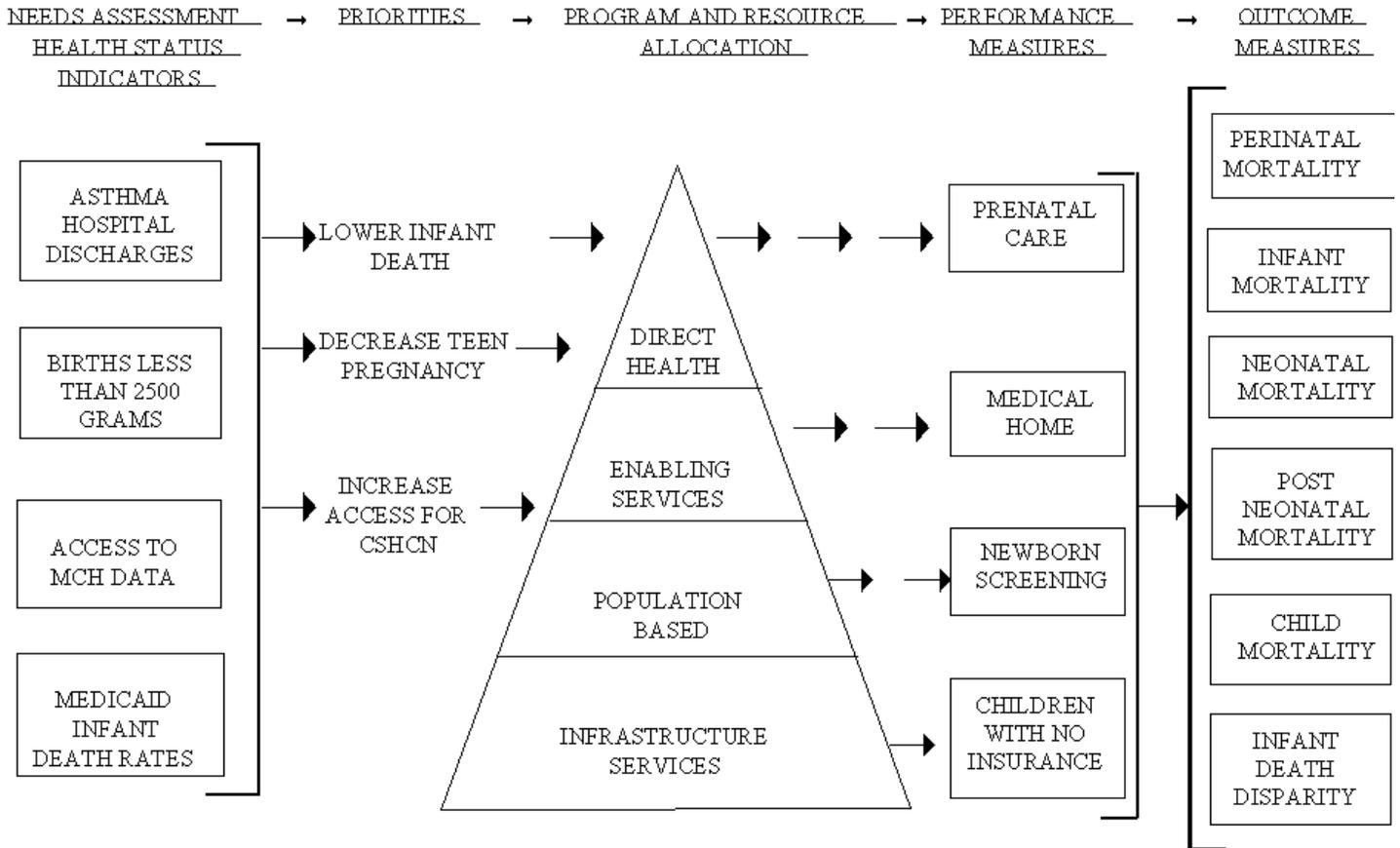
See forms 2 through 5.

3.3.2 Other Requirements

The Wyoming Maintenance of Effort requirement is \$2,375,591; overmatch is \$93,927.00. This is state general fund Money that was appropriated directly to the MCH Program for FY 89. Administrative costs are within the 10% cap.

3.4 Performance Measures

TITLE V BLOCK GRANT PERFORMANCE MEASUREMENT SYSTEM



3.4.1 National "Core" Five Year Performance Measures

PERFORMANCE MEASURES SUMMARY SHEET

National "Core" Performance Measures	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
1) The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.	X				X		
2) The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.	X				X		
3) The percent of Children with Special Health Care Needs (CSHCN) in the State who have a "medical/health home."		X			X		
4) Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies (e.g., the sickle cell diseases combined).			X				X
5) Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.			X				X
6) The birth rate (per 1,000) for teenagers aged 15 through 17 years.			X				X
7) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.			X				X
8) The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children.			X				X
9) Percentage of mothers who breastfeed their infants at hospital discharge.			X				X
10) Percentage of newborns who have been screened for hearing impairment before hospital discharge.			X				X
11) Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN Program with a source of insurance for primary and specialty care.				X	X		
12) Percent of children without health insurance.				X	X		
13) Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.				X		X	
14) The degree to which the State assures family participation in program and policy activities in the State CSHCN Program.				X		X	
15) The rate (per 100,000) of suicide deaths among youths 15-19.				X			X
16) Percent of very low birth weight live births.				X			X
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.				X			X
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.				X			X

3.4.1.1 Five Year Performance Targets (See Form 11)

3.4.2 State “Negotiated” Five Year Performance Measures

3.4.2.1 Development of State Performance Measures

FY 2001 SUMMARY OF STATE PERFORMANCE MEASURES

Negotiated Performance Measures	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
1) INACTIVE: Number of CSHCN Specialty Clinics	X				X		
2) Number of high-risk pregnant women provided care coordination services.		X			X		
3) INACTIVE: The percent of women who self-report using alcohol and/or substances during pregnancy		X					X
4) INACTIVE: The percent of low birth weight babies.			X				X
5) INACTIVE: Rate of fetal deaths per 1000 live births.			X				X
6) INACTIVE: Percent of child death due to non vehicle-related causes that is preventable.			X				X
7) Percent of Wyoming high school students who drink alcohol.			X				X
8) Percent of Wyoming high school students who smoke.			X				X
9) The number of communities in Wyoming with a community-wide plan for services to the MCH population.				X	X		
10) INACTIVE: Percent of licensed child care facilities that have accessed child care and safety training.							
11) Percent of first-time mothers who are at 185% of the federal poverty level who are offered home visiting services.	X				X		
12) Percent of women smoking tobacco during pregnancy.			X				X
13) Percent of drinking alcohol during pregnancy.			X				X
14) Percent of Wyoming high school students who are overweight.			X				X
15) Percent of Wyoming high school students who use methamphetamine.			X				X
16) The percentage of Wyoming counties with access to translation services.				X		X	

NOTE: DHC = Direct Health Care ES = Enabling Services PBS = Population Based Services
 IB = Infrastructure Building C = Capacity P = Process RF = Risk Factor

3.4.2.2 Discussion of State Performance Measures

The ten performance measures were taken directly from the list of seven priority needs. Explanation of the priority needs is covered in section 3.1.2.1.

3.4.2.3 Five Year Performance Targets (See Form 11)

3.4.2.4 Review of State Performance Measures

3.4.3 Outcome Measures (See Form 12)

IV. REQUIREMENTS FOR THE ANNUAL PLAN

4.1 Program Activities Related to Performance Measures

The following charts summarize goals, objectives, activities and performance measures. The charts are insightful because they show how the MCH section is structured, and they ascribe primary responsibility for each measure.

Listed performance measures are either national performance measures (NPM #1-18) or state performance measures (SPM #1-10). Subsequent narrative provides more detail.

HEALTH SYSTEMS INFRASTRUCTURE DEVELOPMENT OUTCOME IMPROVEMENT PLAN SUMMARY (FY01)		
Goal	Broad Objectives	Activities Relating to Each Objective
Improve and institutionalize the State's health service and prevention infrastructure.	Improve children's access to health services. (Specific objectives listed below.)	<u>Direct Services:</u> None
		<u>Enabling Services:</u> None
		<u>Population Services:</u> None
		<u>Infrastructure Building:</u> Work to improve the effectiveness and efficiency of MCH programs. Medical provider recruitment and assistance contract with WHRN. Assist in the promotion & development of the Kid Care Insurance initiative by serving on the Steering and Evaluation Committees. Maintain capacity building contracts with local public health departments to build mid-level provider capacity.
	Improve the health-planning infrastructure in the Department and in local communities. (Specific objective listed below.)	<u>Direct Services:</u> None
		<u>Enabling Services:</u> None
		<u>Population Services:</u> None
		<u>Infrastructure Building:</u> Conduct 5 years MCH needs assessment. Provide funding and TA to build Healthy Community Coalitions and enhance local health planning capacity through contract with the Wyoming Health Resources Network (WHRN). Obtain funds to assess data needs and to develop a plan for meeting those needs.
<u>Relevant Performance Measures, Outcome Measures and Objectives:</u>		
NPM #12: Percent of Children without health insurance. (The objective for FY01 is 11%.)		
NPM #13: Percent of Medicaid eligible children who have received a service paid by the Medicaid Program. (The objective for FY01 is 90%.)		
SPM #9: Percent of communities with a community-wide plan for services to the MCH population. (The objective for FY01 is 80%)		

CHILDREN WITH SPECIAL HEALTH CARE NEEDS OUTCOME IMPROVEMENT PLAN (FY01)		
Goal	Broad Objectives	Activities Relating to Each Objective

<p>Improve the health and well-being of CSHCN and their families.</p>	<p>Increase early screening and provide access to quality medical care. (Specific objectives listed below.)</p>	<p><u>Direct Services:</u> Provide fee-for-service reimbursement for medical and specialty clinics including Genetic services.</p> <p><u>Enabling Services:</u> Care coordination for CSHCN; Provide transportation/per diem for children to obtain services when necessary. Provide needed translation services.</p> <p><u>Population Services:</u> Disseminate educational materials; support newborn hearing and lead screening for children with developmental delays; fund newborn screening services.</p> <p><u>Infrastructure Building:</u> Maintain an internal planning infrastructure. Work with PHNs and parents to establish medical homes for CSHCN. Conduct activities relating to eligibility and policy requirements of various CSHCN initiatives. Participate in outreach with WIC, EIC, Kid Care. Coordinate policies with other stakeholders. Recruit and certify providers. Organize/promote community-based specialty clinics. Recruit & certify specialty providers.</p>
	<p>Increase the focus on family-centered activities. (Specific objectives listed below.)</p>	<p><u>Direct Services:</u> Meet directly with parents to provide education, support, referral and care coordination (NOTE: A programmatic decision has been made to emphasize parental reliance on local care coordinators and local support systems rather than fostering an over-dependence on the state MCH Program's Parent Consultant to provide family support.)</p> <p><u>Enabling Services:</u> Provide supplemental financial assistance for parent activities and conferences; pay for family transportation services where indicated.</p> <p><u>Population Services:</u> Develop educational materials that are widely circulated to parents and relevant organizations re: CSHCN issues.</p> <p><u>Infrastructure Building:</u> Develop local parent support systems. Actively participate with other programs and public/private coalitions, advisory boards and committees to help integrate relevant policies and services.</p>

CHILDREN WITH SPECIAL HEALTH CARE NEEDS OUTCOME IMPROVEMENT PLAN (FY01) (CONTINUED)	
Relevant Performance Measures, Outcome Measures and Objectives:	
NPM #1:	The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the CSHCN Program. (The objective for FY01 is 50%.)
NPM #2:	The degree to which the CSHCN Program provides or pays for specialty and sub-specialty services, including care coordination, not otherwise accessible or affordable. (The objective for FY01 is to provide 9 such services.)
NPM #3:	The percent of CSHCN in the state who have a medical home. (The objective for FY01 is 90%.)
NPM #11:	The percent of CSHCN in the state with a source of insurance for primary and specialty care. (The objective for FY01 is 75%.)
NPM #14:	The degree to which the State assures family participation in program policy activities in the CSHCN Program. (The objective for FY01 is achieve a composite score of 15.)
NOM #6:	The child death rate per 100,000 children aged 1 - 14. (The objective for CY01 is 25 deaths per 100,000.)

EARLY CHILDHOOD/HOME VISITING SYSTEMS OUTCOME IMPROVEMENT PLAN (FY01)		
Goal	Broad Objectives	Activities Relating to Each Objective
Improve the Health and development of children pre-birth through age 8	Decrease preventable childhood illness, injury and death. (Specific objectives listed below.)	Direct Services: Provide Home Visiting for Pregnant and Parenting Families (HVPPF) utilizing the David Olds model.
		Enabling Services: Provide training for county public health nurses who conduct the home visits. Referrals to appropriate community resources.
		Population Services: Develop & circulate educational materials to parents and relevant organizations. Conduct newborn screening.
		Infrastructure Building: Expansion of the HVPPF Program. On-going capacity planning with county public health nurses who conduct the home visits. Collaboration with Best Beginnings, CSHCN, WIC and the Immunization Programs.
Relevant Performance Measures, Outcome Measures and Objectives:		
NPM #5: Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Hemophilus Influenza, and Hepatitis B. (The objective for FY01 is 80%.)		
NPM #6: The birthrate (per 1,000) for teenagers aged 15 through 17 years. (The objective for FY01 is 21 per 1,000.)		
SPM #11: Percent of first-time mothers who are 185% of the federal poverty level who are offered home visiting services. (The objective for FY01 is to offer home visiting services to 95% of first time mothers at or below 185% FPL.		
NOM #6: The death rate per 100,000 children aged 1-14. (The objective for CY01 is 25 deaths per 100,000.)		

Please keep the following general note in mind while reading the Adolescent Health Outcome Improvement plan:

Wyoming’s MCH Program believes that early adolescence — the years from ten to fifteen — are critical years for the formation of behavior patterns in both health and education. At no other time in the developmental life span are individual and social changes as intensely concentrated as they are from twelve to eighteen years. At the end of FY 2000 we made a compelling argument for the need to develop a long-term strategy through which we could dramatically enhance our capacity to reduce adolescent risk-taking behaviors. Failure to do so would risk a vastly diminished existence for our youth. The WDH responded with the resources and backing necessary to add a full-time position dedicated to improving adolescent health outcomes to the MCH Section.

ADOLESCENT HEALTH OUTCOME IMPROVEMENT PLAN (FY01)		
Goal	Broad Objectives	Activities Relating to Each Objective
Improved adolescent health	Reduce teen pregnancy Decrease adolescent suicide Decrease adolescent drug and alcohol use Improve adolescent nutrition Reduce the incidence of adolescents smoking tobacco (Specific objectives listed below.)	Direct Services: Operate HMG - SK information line.
		Enabling Services: Provide grants to other entities that conduct adolescent related activities including suicide prevention, health education standards, etc.
		Population Services: Conduct activities relating to: adolescent risk reduction; suicide prevention; unintended pregnancy prevention; tobacco & substance reduction; and unhealthy dietary patterns associated with becoming overweight. Disseminate educational materials including those from the Abstinence Education Grant. Conduct HMG – SK multi-agency media campaign.
		Infrastructure Building: Coordinate policies and services, providing grants and TA where possible and indicated to other partners and stakeholders that conduct adolescent related activities including suicide prevention, tobacco use, health education standards, etc. Maintain the necessary internal planning infrastructure and build local level capacity through local PHN offices. Participate on the Youth Suicide Prevention and Unintended Pregnancy Prevention Task Forces.
ADOLESCENT HEALTH OUTCOME IMPROVEMENT PLAN (FY 01) (CONTINUED) Relevant Performance Measures, Outcome Measures and Objectives: NPM #6: The birthrate (per 1,000) for teens 15 through 17 years of age. (The objective for FY01 is 21 per 1,000.) NPM#8: The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000. (The objective for FY01 is 10 per 100,000.) NPM #16: The rate (per 100,000) of suicide deaths among youth aged 15-19. (The objective for FY01 is 11 per 100,000.) SPM#14: Percent of 15-18 year old high school students who are overweight. (The objective for FY01 is 3.5%) SPM#15: Percent of 15-18 year old high school students who report using methamphetamine. (The objective for FY01 is 10%). SPM #8: Percent of 15-18 year old high school students who report that they smoke. (The objective for FY01 is 33%). SPM #7: Percent of 15-18 year old high school students who report that they drink alcohol. (The objective for FY01 is 50%).		

PREGNANT WOMEN AND INFANTS OUTCOME IMPROVEMENT PLAN (FY01)		
Goal	Broad Objectives	Activities Relating to Each Objective
Improve the health of pregnant women and infants.	Improve birth outcomes. (Specific objectives listed below.)	<p>Direct Services: Home Visiting for Pregnant and Parenting Families (HVPPF) Services</p> <p>Enabling Services: Best Beginnings Provide translation, transportation, etc. for eligible families to obtain services when necessary.</p> <p>Population Services: Help Me Grow-Safe Kids Campaign PSAs and information and referral line regarding perinatal issues; Genetic Services.</p> <p>Infrastructure Building: Non-Title X Family Planning Grants to local health departments (Contract with Wyoming [Reproductive] Health Council emphasizes community-based systems development and extends family planning services to under-served areas.); maintain the internal and external planning infrastructure; on-going collaboration with other programs and stakeholders; and Best Beginnings Systems development activities.</p>
	Increase access to prenatal care, screening and early intervention services. (Specific objectives listed below.)	<p>Direct Services: HVPPF</p> <p>Enabling Services: Best Beginnings provides: information and referral; presumptive Medicaid eligibility; supplemental prenatal care funding; and translation, transportation, etc. for eligible families to obtain necessary services.</p> <p>Population Services: Best Beginnings <i>ABC Baby Book</i> Help Me Grow-Safe Kids <i>Parent's Guide</i></p> <p>Infrastructure Building: Maintain both an internal and external planning infrastructure; MCH capacity grants to local health departments; Best Beginnings system development activities.</p>

PREGNANT WOMEN AND INFANTS OUTCOME IMPROVEMENT PLAN (FY01) (CONTINUED)

Relevant Performance Measures , Outcome Measures and Objectives:

NPM #4: Percent of newborns in the state with at least one screening for each of PKU, Hypothyroidism, galactosemia, and hemoglobinopathies. (The objective for FY01 is 98%.)

NPM #9: Percentage of mothers who breast-feed their infants at hospital discharge. (The objective for FY01 is 80%.)

NPM #10: Percent of newborns who have been screened for hearing impairment before hospital discharge. (The objective for FY01 is 97%.)

NPM #17: Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates. (The objective for FY01 is 79%.)

NPM #18: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester. (The objective for FY01 is 89%.)

SPM #2: Percent of high-risk pregnant women and infants receiving care coordination. (The objective for FY01 is 95%.)

SPM #13: Percent of women drinking alcohol during pregnancy. (The objective for FY01 is 1.9%.)

SPM #12: Percent of women smoking tobacco during pregnancy. (The objective for FY01 is 20%.)

SPM #11: Percent of first-time mothers at or below 185% of the federal poverty level who are offered home visiting services.

NOM #1: The infant mortality rate per 1,000 live births. (The objective for CY00 is 6.4 per 1,000 live births.)

NOM #2: The ratio of black infant mortality rate to white infant mortality rate. (The objective for CY00 is .9)

NOM #3: The neonatal mortality rate per 1,000 live births. (The objective for CY00 is 3.5 per 1,000 live births.)

NOM #4: The postneonatal mortality rate per 1,000 live births. (The objective for CY00 is 1.4 per 1,000 live births.)

NOM #5: The perinatal mortality rate per 1,000 live births. (The objective for CY00 is 9.0 per 1,000 live births.)

MINORITY HEALTH OUTCOME IMPROVEMENT PLAN (FY01)		
Goal	Broad Objectives	Activities Relating to Each Objective
Improve minority health	Provide language translation services.	Direct Services: Provide state level translation services when not otherwise available.
		Enabling Services: Provide fees for translators on a limited basis. Referrals.
		Population Services: None
		Infrastructure Building: Identify community translation services needs. Develop and maintain a statewide list of translators.
	Improve health policies relating to minorities.	Direct Services: None
		Enabling Services: None
		Population Services: Provide education relating to minority health issues and cultural competency.
		Infrastructure Building: Maintain internal administrative infrastructure. Work with other health and social services programs in State government to improve policies relating to minority populations.
Relevant Performance Measures, Outcome Measures and Objectives:		
SPM #16: Number of counties with adequate language translation services. (The objective for FY01 is 45%.)		

ORAL HEALTH PROGRAM OUTCOME IMPROVEMENT PLAN (FY01)		
Goal	Broad Objectives	Activities Relating to Each Objective
Improve Oral Health	Decrease Occlusal Caries and Smooth Surface Decay. (Specific objective listed below.)	<p>Direct Services: MCH funding of dental sealants; State Dental Program; Medicaid Dental Program; and Fluoride treatment in dental offices</p> <p>Enabling Services: Promote access to dental providers</p> <p>Population Services: Community fluoridation; and School fluoride mouth rinse program</p> <p>Infrastructure Building: Collaboration with Kid Care (CHIP)</p>
	Reduce Periodontal Disease.	<p>Direct Services: MCH funded orthodontic program; Medicaid funded orthodontic program; and Cleft Lip and Palate Clinics</p> <p>Enabling Services: With MCH, coordinate the delivery of translation, transportation, per diem etc. for eligible families to obtain services when necessary.</p> <p>Population Services: Dental education activities</p> <p>Infrastructure Building: Collaboration with multiple stakeholders, including Medicaid, Kid Care WIC and MCH, on related service capacity development and eligibility policies.</p>
Relevant Performance Measures, Outcome Measures and Objectives:		
<p>NPM #7: Percent of third grade children who have received protective sealants on at least one permanent molar tooth. (The objective for FY01 is to increase to at least 75% the proportion of children who have received protective sealants on the occlusal surfaces of permanent molar teeth.)</p>		

A. Direct Health Care Services

A.1 Women and Infants

SPM#11: Percent of first-time mothers at or below 185% of the federal poverty level who are offered home visiting services. (The objective for FY01 is 95%. This is a new performance measure; objective set by state statute.) The following narrative discusses proposed activities relating to this performance measure.

The 2000 Wyoming Legislature passed legislation (Enrolled Act No. 30) with the intent of substantially expanding the size of the Home Visiting for Pregnant and Parenting Families (HVPPF) Program. Much of this expansion will be paid for through unutilized federal TANF funds (Temporary Assistance to Needy Families).

MCH is currently collaborating with the Department of Family Services and Public Health Nursing regarding the logistics of obtaining the TANF funds and building capacity. It is anticipated that much time will be spent in late FY00 and early FY01 developing the expanded program.

Currently, the HVPPF Program serves approximately 200 first time mothers using the David Olds early intervention model. Overall, more families will be served over the next two years, possibly as many as 1,000, including populations in the following priority order; low-income first-time pregnant women under the age of 20, any pregnant women or family referred by an attending physician, first-time births regardless of age (Medicaid or WIC eligible), premature births, victims of domestic violence, women with mental illness or substance abuse problems, incarcerated women, and subsequent pregnancies or births where the woman is eligible for Medicaid or WIC.

The Legislature believes that early intervention through the HVPPF Program can greatly reduce a number of health and societal problems. Anticipated benefits (demonstrated by the Old's research) include: improved pregnancy outcomes, improved child health and development, and improved parental life-course development, such as decreased subsequent unintended pregnancy, decreased welfare dependence and increased self-sufficiency. Data and information collection related to the visited families will be utilized for evaluation purposes.

A.2 Children

A.3 CSHCN

NPM#1: The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program. (The State objective for FY01 is 50%. In FY99, 48% received services from the CSHCN Program.) The following narrative discusses proposed activities relating to this performance measure.

Problems in the past have resulted in difficulty obtaining accurate data relating to this performance measure. The current data system does not accurately capture this information as the report captures all recipients 18 years and younger and without the download from the MMIS system, our records are not current as to who is eligible (See note on Form 11). Reports needed to obtain this data are being reviewed for incorporation into our new computer system. With the addition of another records analyst, a more in depth analysis of information on clients will be available giving a more accurate picture of how many families the program is serving, for what conditions, and what services they are receiving. In addition, data will be obtained as to ineligible referrals CSHCN services and causes.

In October 1999, after extensive planning meetings, a new initiative was launched to improve care coordination among CSHCN clients. Public Health Nurses in each county are now required to visit with all enrolled clients on an annual basis to provide care coordination. All referrals require an annual visit and re-assessment of services needed

and explanation of how to access the needed resources. Results from the evaluations of the first year of care coordination will be available denoting strengths and gaps in the program. Plans will then be made to address these areas.

Finally, in FY 01 the CSHCN program will be implementing recommendations made on June 21, 2000 by our CSHCN Advisory Group that we raise the benefit caps on both asthma and diabetes.

NPM#2: The degree to which the State CSHCN Program provides or pays for specialty and sub-specialty services, including care coordination, not otherwise accessible or affordable to its clients. (The objective for FY01 is to provide specialty and sub-specialty services in nine areas. In FY99, services were provided in all nine areas. The following narrative discusses proposed activities relating to this performance measure.

In the past, the CSHCN Program covered specialty and sub-specialty services and will continue to do so. The CSHCN staff is working with tertiary care centers to re-evaluate the number and locations of clinics, as well as problems encountered. Negotiations with private providers are also being held to address the problems that have arisen with clinic scheduling fee-for-services. Historically about 130 clinics have been offered each year, however, the CSHCN Program is collecting client statistics to better determine the appropriate number of clinics necessary in the future. While no final decisions have been made, the number of clinics and number of locations will likely increase somewhat in FY01, especially in light of a recent recommendation from our CSHCN Advisory Board to add clinics for the early screening of serious emotional disorders.

The CSHCN Program will continue to collaborate with the WIC Program to provide formula for clients with PKU. WIC serves these children to their 5th birthday; the CSHCN program then coordinates with WIC to assure continuing access to formula. The CSHCN Program picks up other specialty type formulas that are not purchased by WIC.

The recent work of the Care Coordination Committee will improve care coordination in the state. The committee, consisting of representatives from the CSHCN Program, the State Public Health Nursing Program, and local public health nursing, has developed and implemented a statewide care coordination plan. In conjunction with the plan, a Care Coordination Program Manual has been developed. A 2-day workshop launching the care coordination system and the new forms for collecting data was held in September of 1999. Standards of care were explained and state agencies outlined services that are available. Also during the workshop, parents presented on major concerns and needs. Implementation of the Care Coordination Plan will be continued in FY01 and evaluations of the process will be done. CSHCN staff plans to conduct regional meetings with public health nursing staff to discuss coordination issues and community resources, plus promote coordination of services among community providers.

The CSHCN Program is initiating/expanding two activities. 1) Staff will work more closely with the Cancer Surveillance, Diabetes, and Cardiovascular Programs to improve coordination between the programs; and 2) Staff will work more closely with tertiary providers to make sure that they are aware of eligibility rules for CSHCN, Medicaid, SSI and Kid Care.

B. Enabling Services

B.1 Women and Infants

SPM#2: Percent of High-Risk Pregnant Women served by Care Coordination. (The objective for FY01 has been changed to 95%, which is quite ambitious in light of the fact that the percentage served in FY99 was 52.4%. This performance standard has been mandated by the recent passage of state legislation to use TANF dollars for this purpose.) The following narrative describes some of the activities relating to this objective.

To assist with the identification of high-risk pregnant women, MCH recently developed a Data Documentation System for the Best Beginnings Program. The system includes a standardized assessment of risk factors among pregnant women enrolled in the Best Beginnings Program. MCH reported on the results of a pilot test at the September 1998 meeting of Best Beginnings Coordinators prior to expanding the system statewide. The Data Documentation system assures appropriate triage, risks assessment, and care coordination of all Best Beginnings clients and identifies those clients in need of high-risk care coordination. Best Beginnings Coordinators at the county level are responsible for high risk care coordination.

The Home Visiting for Pregnant and Parenting Families (HVPPF) Program continues to provide intensive coordination of care for high risk pregnant women referred by Best Beginnings for follow-up. Following the client through the child's first two years of life, nurse home visitors assist pregnant and parenting families in accessing appropriate health and human services and coordinating these services. Planned expansion of this program in FY01 is expected to have a positive impact on this performance measure.

Other Activities:

Wind River Reservation Initiative. In FY98 MCH completed work with consultant, Duncan Perrote, to assist MCH with its approach to the reservation and identify an appropriate role for MCH, including the delivery of MCH services to the Reservation. The process began with an inventory of services currently being delivered by the U.S. Indian Health Service (IHS), Tribal Health Services, and the Fremont County Health Department. The process resulted in several successful outcomes. First, MCH recognized that the two tribes (Shoshone and Northern Arapaho) on the reservation viewed themselves as distinct communities with unique needs and health access issues which differed from those of the rest of Fremont County. Second, the tribal leaders were responsive to the expansion of Best Beginnings, Home Visiting for Pregnant and Parenting Families, and the Help Me Grow-Safe Kids campaign to the reservation. Third, MCH became aware of existing IHS and Tribal Health data that could be useful for community health planning purposes.

Maternal and Child Health laid the foundation for contractual relationships with 1) the Fremont County Public Health Department to expand Best Beginnings and Home Visiting Services to the Reservation, in partnership with Indian Health Services; and 2) Wyoming Health Resources Network (WHRN) to facilitate community health systems development, needs assessment, and health care planning. WHRN, acting on behalf of MCH, was invited to be part of a delegation making presentations on the reservation.

B.2 Children

B.3 CSHCN

NPM#3: The percent of Children with Special Health Care Needs in the state who have a “medical home.” (The objective for FY01 is 90%. The percentage with a medical home in FY99 was 80%.)

The following narrative discusses proposed activities relating to this performance measure.

Recently the Wyoming Department of Health was reorganized into a number of divisions including a the Community and Family Health Division. It is anticipated this will improve coordination and communication between the CSHCN Program, Kid Care and Medicaid. Referrals between these programs are expected to increase, providing more Children with Special Health Care Needs a medical home.

MCH will soon be acting on a recent recommendation by the CSHCN Advisory Group that MCH study the feasibility of implementing a Primary Care Case Manager (PCCM) model for both Medicaid and non-Medicaid CSHCN. If successful, we are hopeful that we would see improvement in this measure within the next two to three years.

Meanwhile, the MCH Programs will continue to strive to increase the percent of CSHCN with medical homes by educating parents and providers about the importance of a medical home. By the beginning of FY01, a new parent consultant will be hired. One of the consultant's duties will be to educate parent support groups in promoting a medical home.

The program enrollment forms for the program ask for the medical home and if there is not a medical home reported, the PHN promotes establishment of a medical home. State CHS staff will continue to utilize numerous speaking opportunities to promote the medical home concept (i.e. Deaf/Blind Diagnostic Clinic, Cleft Palate Clinic).

It is anticipated that the new MCH computer system will be useful in tracking medical home information. Along with family income data, the system will be used to identify whether each child may be eligible for CSHCN, Medicaid, Caring for the Children, Kid Care1 or Kid Care 2. The identification of children without a medical home will also be put on a GIS system to determine how many live in an area of primary health care shortage.

C. Population Based

C.1 Women and Infants

NPM #4: Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, and hemoglobinopathies. (The objective for CY01 is 98%. The percentage screened in CY99 was 99.2%.) The following narrative discusses proposed activities relating to this performance measure.

Wyoming law mandates that all newborns be screened for six inborn errors of metabolism: PKU, hypothyroidism, galactosemia, hemoglobinopathies, biotinidase deficiency, and cystic fibrosis. There is a possibility that screening for congenital adrenal hyperplasia will be added in FY01 (pending approval by WDH Medical staff). Blood samples are sent to a laboratory in Denver and the MCH program covers costs, in part.

The Genetic Program also intends to continue the Genetic Clinics. The clinics are held in seven locations in the state and serve about 200 people per year. MCH funds are used to contract with staff from the Children's Hospital in Denver to come to the state and conduct the clinics.

The Genetic Program is also talking with CDC about developing a Birth Defects Surveillance System. If funding becomes available, this database will record birth defects throughout the state and would be useful for future planning activities.

NPM #9: Percent of mothers who breast-feed their infants at hospital discharge. (The objective for FY01 is 80%. The percentage who breast-fed at hospital discharge in CY98 was 77%.)

The following narrative discusses proposed activities relating to this performance measure.

Breast-feeding education and support is a priority of the Best Beginnings Program. Best Beginnings, now located in every county in the state, educates women prenatally and provides support during the postpartum period concerning breast feeding and provides referrals for mothers who need more intensive assistance. Several Best Beginnings Coordinators are Certified Breast-Feeding Consultants and provide extensive support to breast-feeding mothers and more Coordinators are becoming certified each year.

MCH will continue to participate in Healthy Mothers/Healthy Babies, a coalition which promotes a statewide support network to assist mothers with breast-feeding and addresses other Maternal Child Health issues. The coalition includes representatives from MCH, WIC, Public Health Nursing, Immunizations, Home Visiting for Pregnant and Parenting Families, La Leche League, Prevent Child Abuse, the University of Wyoming School of Nursing and other community organizations. HMG-SK also lends its media expertise and information line in support of WIC's activities related to raising awareness about the importance of breast-feeding.

The HVPPF Program will continue to support and educate mothers prenatally and following the birth of the baby regarding breast-feeding.

NPM #10: Percent of newborns who have been screened for hearing impairment before hospital discharge. (The objective for FY01 is 97%. 94.2% of newborns were screened for hearing impairment in FY99.) The following narrative discusses proposed activities relating to this performance measure.

MCH Section staff from the Best Beginnings, CSHCN, and Genetic Programs will continue to sit on the Newborn Hearing Screening Board that sets standards for the screening program and provides funds for Automatic Auditory Brainstem Response machines. Funding is a collaborative effort of MCH, the Division of Developmental Disabilities, and the Department of Education. Every hospital in the state of Wyoming that performs newborn deliveries now has equipment to test newborn hearing. Each newborn's medical practitioner must write the order for the screening to be performed and the parent(s) must consent to having the procedure done.

SPM#13: Percent of women drinking alcohol during pregnancy. (The objective for FY01 is 1.9%. The percentage using alcohol in CY98 was 2.1%.)

And

SPM#12: Percent of women smoking tobacco during pregnancy. (The objective for FY01 is 20%. The percentage smoking in CY98 was 22.5%.) The following narrative discusses proposed activities relating to these two performance measures.

Both the Best Beginnings Program and the Home Visiting for Pregnant and Parenting Families Program will continue to address substance use prevention in pregnancy. This will include education, support and cessation counseling, on an individual and group basis, as well as making referrals for substance abuse treatment. Additionally, MCH is working closely with the Healthy Mothers/Healthy Babies Coalition to address substance use in pregnancy related to self-esteem issues. MCH will continue to strengthen its relationship with Healthy Mothers/Healthy Babies Coalition related to substance use in pregnancy, with the goal of preventing young girls from initiating alcohol use, and promotion of a healthy lifestyle. An additional partner is the Tobacco Prevention Project housed in the Substance Abuse Division. A Calendar of Events has been developed by The Project which focuses on a different theme of tobacco use prevention every month. The intent is that professionals interfacing with pregnant women, children and their families will deliver consistent messages regarding the effects of smoking, second-hand smoke and smokeless tobacco. Examples include the following: September is “Baby Safety Month” and March is “National Women’s History Month” (focus is on education of women regarding the marketing strategies that have been utilized to influence their choices). MCH has requested that The Project fund materials to be used by the public health nurses in classes and one-on-one client interactions regarding the harmful effects of smoking, as well as second-hand smoke.

C.2 Children

NPM#5: Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Hemophilus Influenza, and Hepatitis B. (The objective for FY01 is 80%. In FY99, the rate was 72%.)

The following narrative discusses proposed activities relating to this performance measure.

Maternal and Child Health partners with the Immunization Program to promote the importance of timely immunizations. Recently, the Immunization Program was moved to Public Health Nursing. This move is expected to increase coordination with public health field staff and Best Beginnings staff. Collaboration with the Immunization Program includes educating parents and care providers through the Help Me Grow-Safe Kids (HMG-SK) media campaign and hotline, the Health and Safety Tip of the Month Program, the KTWO-TV media campaign, which included the need for immunizations in televised health messages, and “Safe Kids Day.” The latter is an all-day event, which is held statewide in HMG-SK chapter cities. Additionally, MCH collaborates with the Immunization Program in the development of the “Parent Guide” and “The ABC Baby Book” to be distributed

to all families of newborns and young children. The books include the optimal immunization schedule for children through age five years.

While the Immunization Program provides most of the immunization services in the state, immunization screening and education will continue to be part of the educational efforts of the Home Visiting and Best Beginnings programs in FY01.

In August 1998, MCH piloted a new program, "Shots and Seats," in Cheyenne in partnership with the Immunization Program, Wyoming Department of Transportation, the local county health department, and local fire department. The goal was to promote updating children's immunizations prior to the start of school and educate parents on the importance of immunizations. Public Health Nurses evaluate immunization status with referrals made when appropriate. Another goal of the program was to educate parents and children on fire safety and Wyoming's new seat belt law. The pilot program was conducted at three different fire stations on three consecutive weekends with an attendance exceeding 100. MCH shared information about the program with local HMG-SK chapters and fire departments statewide.

NPM#6: The birth rate (per 1,000) for teenagers aged 15 through 17 years. (The objective for FY01 is 21.0 per 1,000. In FY99, the birthrate was 22.9 per 1,000.)

Maternal and Child Health will continue its partnership with the Wyoming Health Council (WHC) to address adolescent pregnancy prevention. WHC administers the limited MCH funds available to cover services not covered by Title-X and has effectively standardized policies and procedures related to funding. All local family planning programs, both Title X and non-Title X include teen pregnancy prevention components. WHC requires adherence to CLIA standards in all funded clinics. The Perinatal Program Manager sits on the WHC Board of Directors. In FY98 MCH recognized the need to take a systems approach to family planning, i.e., integrate family planning with primary care and other MCH services. This was pursued in FY99 and continues.

MCH will also continue to participate on the multi-agency Unintended Pregnancy Prevention Task Force that meets quarterly. The Task Force has representation from MCH, Department of Education, Department of Family Services, educators, family planning clinic providers (both Title X and non-Title X), community agencies, and parents. Its guiding tenet is that bearing unintended children is likely to have harmful consequences for the child, the child's parents, and society regardless of age, marital status, or income. The Task Force places special emphasis on the prevention of adolescent pregnancies in response to federal legislation around welfare reform and abstinence education. The approach is to increase awareness among policy makers, providers, and individuals of unintended pregnancy and its impact.

In FY98, the MCH Program implemented its Abstinence Education project, which will be continued in FY01. It includes a media campaign funded by the Maternal and Child Health Bureau to increase the number of abstinence messages aimed at youth ages 9-14 years and their older siblings and parents. Also, the HMG-SK information-line receives calls from children and parents and provides information.

HVPPF will be expanding services to additional families with the recent legislation authorizing the use of Temporary Assistance to Needy Families (TANF) to fund components of the program. An important goal of the Home Visiting for Pregnant and Parenting Families (HVPPF) program is the reduction of subsequent pregnancies. HVPPF, based on the David Old's Model, utilizes Bandura's self-efficacy theory as a foundation for client-centered nursing interventions. These approaches are solution-focused and build on client strengths. The nurse assists the client in setting small, realistic goals regarding parental life-course (education, employment, and subsequent unintended pregnancy) based on the confidence level and commitment of the client.

Many Best Beginnings Coordinators are taking an active role in their communities to develop Search Institute Assets Building Programs, which address adolescent problem behaviors by strengthening individuals, families and communities. In FY01 MCH will provide small community grants to support the development of Assets Programs. Additionally, Best Beginnings Coordinators work with community-based youth organizations, schools, and hospitals to promote teen pregnancy prevention through the "Baby Think It Over" program and other community-based prevention efforts. A major component of the "Baby Think It Over" program is the placement of life-size mannequins with teens, ages 13-19, to simulate the needs and demands of infants.

SPM #14: Percent of 15-19 year old high school students who are overweight. (The objective for FY01 is 3.5%; FY99 percentage was 5.5%.) Note: This is a new objective.

SPM #15: Percent of 15-19 year old high school students who report using methamphetamine. (The objective for FY01 is 10%. The percentage in FY99 was 12.6%.) Note: This is a new objective.

SPM#7: Percent of 15-19 year old high school students who report using alcohol. (The objective for FY01 is 50%. The percentage in FY99 was 55%.)

SPM #8: Percent of high school students who report using smoke tobacco. (The objective for FY01 is 33%. In FY99, the percentage was 35%.)

The following narrative describes activities relating to these adolescent objectives in FY01.

Sounding a "wake-up call" to agencies serving youth, earlier this year, Governor Geringer appointed a multi-agency team to address youth outcome improvement planning. The Community and Family Health Division's Deputy Administrator for MCH Services was appointed to this team. As a result of this team's collaborative effort to write an application to the National Governor's Association, Wyoming is one of only 10 states selected to receive a two year technical assistance grant from the NGA for the purpose of creating a comprehensive strategy to improve health and enhance the potential of Wyoming adolescents. Clearly, Wyoming has the combined agency will to embark on

efforts to establish a collaborative approach to improving youth outcomes across our service system. In order to be successful, however, this multi-agency effort — and any plan it conceives — will find it must depend upon the active participation of many partnerships previously built through MCH.

In FY01, MCH will continue its long-standing partnership with Wyoming Community Coalition for Health Education (WCCHE). The WCCHE community-based mission is two-fold: to spearhead the Search Institute's Asset Development Initiatives in Wyoming and to promote coordinated school health, including comprehensive health education. Risk behaviors impacted by these two strategies include alcohol, and other drug use, tobacco, and unhealthy dietary patterns (overweight). In addition, a WCCHE conference is held annually to promote asset building and coordinated school health and is attended by professionals, parents and youth representing local communities.

Maternal and Child Health also partners with the Wyoming Department of Education to promote coordinated school health programs and the implementation of health education standards. This partnership creates an opportunity to advance core curriculum in the state to influence positive eating habits, physical activity patterns, and the promotion of a positive body image. MCH supports the Department of Education's Summer Institute for Health Education by serving on the planning committee and coordinating the Resource Fair.

An additional partner is the Tobacco Prevention Project housed in the WDH Substance Abuse Division. A Calendar of Events has been developed by The Project which focuses on a different theme of tobacco use prevention every month. The intent is that professionals interfacing with adolescents will give a consistent message regarding the harmful effects of tobacco products. March has been designated "Through with Chew" month and the theme for April is "Wyoming Youth Take Action on Tobacco."

Adolescent access to mental health and substance abuse services continues to be a concern to the MCH Section. Recent efforts to collaborate on this need include the addition of the Mental Health Division's Deputy Administrator to our monthly MCH Services Coordination Team. This promises to provide a springboard for future discussions regarding access to mental health services for the MCH population. Capacity planning is also underway to address a statewide shortage of qualified mental health providers to treat children and adolescents. MCH continues to partner with the Mental Health Division for staff support of the Help Me Grow-Safe Kids information line. This menu driven 800 number provides a means for community-based referral to mental health services. The Wyoming Methamphetamine Initiative provided funds for the Boys and Girls Schools to provide substance abuse treatment to those institutions, as well as funds for the Department of Education to use in prevention services focused on methamphetamine use. Efforts are also underway to address the SYNAR penalty against our Substance Abuse Prevention and Treatment Block Grant that resulted from a high youth tobacco buy rate.

The Help Me Grow-Safe Kids Campaign will be continued. In January 2000, in order to reallocate staff to adolescent health initiatives, MCH contracted with United Medical Center, a long-time private sector Campaign partner, to coordinate some administrative functions associated with the Campaign. Private sector coordination by the new *Partner Contractor* is expected to enhance many opportunities not otherwise available to public sector administered initiatives. Raising awareness about the preventable nature of disease and injury will continue to be the focus of the Campaign. Strategic planning was completed in the Spring of 2000 which revealed a need to enhance the Campaign's leadership and decision making capacity; better market the Campaign's services; and facilitate growth and development of the HMG-SK Chapters established in 8 of Wyoming's 23 counties.

NPM#7: Percent of third grade children who have received protective sealants on at least one permanent molar tooth. (The objective for FY01 is to increase to at least 75% the proportion of children who have received protective sealants on the occlusal surfaces of permanent molar teeth. The percent of 3rd graders with sealants on at least one permanent molar tooth in Wyoming in 2000, based on provisional data, was approximately 71.3%.)

The following narrative discusses proposed activities relating to this performance measure.

A survey will be conducted in FY00 and again every three years to achieve a longitudinal study of decayed, missing, filled, and sealed teeth among the sample. This data, along with other information, will be used to improve the Dental Health database which will be included in the MCH data system which is currently being developed. The following narrative describes activities relating to this program.

Oral Health Services activities proposed for FY01:

1. Continue to apply dental sealants.
2. Continue to do dental screening.
3. Continue the Marginal Dental Program. This state-funded program serves low-income children, birth to 19 years, who are not on any other assistance program.
4. Continue dental education programs. Dental Health Services will work with dental hygienists throughout the state to provide educational sessions to youth in pre-school through 12th grade. The sessions will focus on improving oral health and include risks associated with tobacco.
5. Continue the fluoride mouth rinse program. Dental Health Services will provide fluoride mouth rinse to participating schools, grades K-9.

6. Continue services for Severe Crippling Malocclusion. Dental Health Services will provide funding for this service through the MCH budget, Kid Care and Medicaid.

NPM#8: The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children. (The objective for FY01 is 10.0 per 100,000. In CY98, the rate was 10.3%.)

The following narrative discusses proposed MCH activities relating to this performance measure.

MCH will continue to partner with the Wyoming Department of Transportation to promote vehicle safety among children through several approaches, including the Help Me Grow-Safe Kids (HMG-SK) media campaign and the information and referral line. Representatives from the Department of Health, Department of Family Services, and the Department of Transportation staff the toll-free hotline. It serves as a one-call information and referral source for children's safety and health issues. The HMG-SK media campaign includes PSAs, billboard messages, and newspaper articles on child passenger safety.

In FY01, MCH will continue to work with the Department of Transportation to implement a new program, "Shots and Seats" program described in detail under NPM#5 in the annual report. One of the goals is to educate parents and children about the importance of car seats and Wyoming's new child passenger restraint law. In FY99, HMG-SK expanded its training program by sending three volunteers to a national training for trainers to certify car seat checkers. Following their training, trainers trained and certified over 40 volunteers throughout Wyoming to be car seat checkers.

Help Me Grow - Safe Kids' successful efforts have leveraged significant support from both national and state organizations. In addition to those already identified above, the National SAFE KIDS provides technical assistance, training funds, materials, directs a campaign (Safe Kids Buckle Up) for educating parents and children, and provides car seats. The Wyoming Department of Transportation is a major collaborator in the sponsorship of Safe Kids Day in HMG-SK chapter cities throughout the state.

The HVPPF Program provides client education regarding the use of car seats for infants and young children.

Other Activities:

SIDS Reduction. HMG-SK and the Best Beginnings Program will continue the statewide SIDS risk reduction campaign, which includes a PSA and the distribution of educational materials. Also, MCH will continue the Back to Sleep education program through the Best Beginnings Program.

The HVPPF Program nurses provide safety information regarding infant and toddler physical care, as well as prevention of Shaken Baby Syndrome, other child abuse injuries and environmental safety.

C.3 CSHCN

Recently, the CSHCN program collaborated in the development of the “Parent Guide”. The book was piloted in FY98 and will continue to be distributed to new parents in FY01.

D. Infrastructure Building

In addition to the activities outlined below, MCH will continue its capacity building grants to local health departments described in the FY 99 Annual Report’s Infrastructure Building Section.

D.1 Women and Infants

NPM#15: Percent of very low birth weight live births. (The objective for FY01 is 1.0%. In CY98, the rate was 1.1%).

The following narrative discusses proposed activities relating to this performance measure.

Through the Best Beginnings Program and Home Visiting for Pregnant and Parenting Families (HVPPF) Program, MCH will continue to promote early access to care, optimal nutrition, substance use prevention (including tobacco), and care coordination, all known to be associated with healthy pregnancy outcomes. MCH partners with the WIC program and Public Health Nursing to address the problem of low birth weight babies. Best Beginnings disseminates its newsletters to the WIC program, which makes referrals and accepts referrals from both Best Beginnings and HVPPF. WIC participates on the HMG-SK hotline to provide information about nutrition and WIC services.

Other Activities:

Collaboration with WIC. MCH has a long-standing partnership with the WIC program, which is housed, in the same Division and geographically on the same floor as MCH within the Department of Health. Collaboration at the state level translates into coordination at the local level among Best Beginnings coordinators, HVPPF nurses, and local WIC offices for cross-referral of clients. WIC provides critical information on breast-feeding and nutrition from birth to age 5 years; Women, Infants and Children program services that are listed in the Parent Guide. WIC will continue to partner with HMG-SK to provide nutrition information for the information line, PSAs, and other materials disseminated statewide as well as at the WIC booth for Safe Kids Day.

MCH actively supports WIC’s efforts to establish Electronic Benefits Transfer (EBT) and Health Passport in Wyoming for about 11,000 women and children served by WIC. Seventeen of WIC’s 19 local agencies have EBT.

Health Passport is sponsored by the Western Governors' Association with funding from the USDA and involves WIC in three western states: Wyoming, Nevada, and North Dakota. The plan is for WIC clients to eventually carry smart cards, which will serve as portable health records.

NPM#17: Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

(The objective for FY01 is 79%. The percentage of very low birth weight infants delivered at facilities for high-risk deliveries in CY98 was 64.8%.)

The following narrative discusses proposed activities relating to this performance measure.

The Best Beginnings Program will continue to pursue this objective. The program finalized the standardized Pregnancy Risk Assessment tool in FY98. Early assessment of pre-term labor risk is especially important in Wyoming, since there are no Level III centers in the state, and, high-risk mothers must be transferred to out-of-state Level III centers in Colorado and Utah prior to delivery. All Best Beginnings coordinators and many public health nursing managers were trained in the use of the assessment tool at the semi-annual Best Beginnings coordinators' meeting in Douglas in September, 1998.

NPM#18: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

(The objective for FY01 is 89%. The percentage born to women receiving prenatal care in CY98 was 81.4%.)

The following narrative discusses proposed activities relating to this performance measure.

The initiation of prenatal care in the first trimester is a priority of the Best Beginnings program. This goal is contingent on access to prenatal care at the community level. A primary responsibility of the Best Beginnings coordinator is to coordinate with others who provide services in the community to assure that all women can access prenatal care in the first trimester. To this end, Best Beginnings has: 1) promoted statewide program performance standards which address administration, community planning, and service/case management; 2) coordinated with the Home Visiting for Pregnant & Parenting Families Program; 3) developed statewide program goals and objectives; 4) developed a standardized data collection/documentation program and 5) is developing a standardized curriculum for prenatal classes. The percent of pregnant women who access care in the first trimester continues to improve as a result of the Best Beginnings network of care and referral.

Other Activities:

Professional Education. MCH will assist in planning and participating in the annual Perinatal Conference to be held in Fort Collins, Colorado, on October 6, 2000. Topics at the conferences will include management of diabetes in pregnancy, neonatal delivery emergencies and follow-up care, value of clinical judgement and recognition and management of maternal and infant lactation risk factors.

The MCH Program assisted state Public Health Nursing staff to conduct a survey of public health, WIC, and Best Beginnings managers to assess their continuing education needs in FY98. This information was shared with the Region VIII MCH Office for development of a proposal, that was submitted by the Region to the U.S. Department of Health and Human Services, Division of Nursing. The proposal was an outgrowth of a national nursing leadership conference held in Dallas, Texas, in July 1998. Region VIII nurses met as a subcommittee and concluded that attention needed to focus on more training and educational opportunities. The Region VIII proposal would address these needs and provide, in each state, a contact who would participate on a committee to develop and implement a nursing continuing education plan. That contact is Wyoming in Jan Andrews, state PHN staff.

D.2 Children

NPM#12: Percent of children without health insurance. The objective for FY01 is 11%. In 1998, the last year for which data are available, 12.7% of children were uninsured. (Source: Behavioral Risk Factor Surveillance System.) The following narrative discusses proposed activities relating to this performance measure.

Wyoming has recently implemented a Children's Health Insurance Program (CHIP). Called Kid Care 1, the new program will serve families with incomes from 100% to 133% FPL. The State is in the process of working out the details of another program called Kid Care 2. This program will serve families with incomes from 133% to 149% FPL. CSHCN program will send out to all families within the income levels and higher a notice of the launching of Kid Care 2.

MCH has been involved with policy development for both of these programs. Staff have been trained regarding eligibility guidelines and will continue to refer children to Kid Care 1, Kid Care 2, CSHCN, or Medicaid in FY01.

NPM#16: The rate (per 100,000) of suicide deaths among youth aged 15-19 (risk factor). (The objective for FY01 is 11.0. In FY98, the rate was 15.9 per 100,000.)

The following narrative discusses proposed activities relating to this performance measure.

The Youth Suicide Prevention Task Force, which MCH convened in FY97, recognized the need for a part-time coordinator and implemented this position on October 1, 1998. The position will be continued in FY01. The Task Force is a public/private partnership with the purpose of identifying and reducing barriers to identification and early intervention, as well as primary prevention of adolescent suicide. The Task Force is comprised of representatives from the Departments of Health, Education, and Family Services, along with mental health providers, educators, counselors, parents, and youth. Participants are supported by their sponsoring organizations or by MCH if agency support is not available. A Mental Health Program representative from the Mental Health Division chairs the Task Force. The Task Force has agreed that the next step is to draft a State Plan on suicide prevention. Input will be

solicited regarding the draft via public meetings at the local level, and assistance will be offered to communities to determine what their technical assistance needs are regarding suicide prevention.

Wyoming's Mental Health Division Administrator is requesting funding from the Legislature to support expanded suicide prevention activities. This will provide the Youth Suicide Prevention Task Force with the opportunity to define the nature of suicide prevention plan activities. The Task Force will also be writing the section on suicide prevention for the Mental Health Division's *Public Mental Health System of Care Plan*. The core function of this section is dependent upon the Task Force statewide suicide prevention plan.

MCH applied to the MCHB Information Resource Center 2000 Graduate Student Internship Program and an intern became available to MCH in May 2000. The summer intern is reanalyzing Wyoming school's awareness of and readiness for youth suicide prevention strategies utilizing a survey completed by school personnel. The intern will also research effective school interventions and best practice for youth suicide prevention that can be shared with local schools and communities.

MCH will continue to work with the Youth Suicide Prevention Task Force and the Task Force Coordinator in FY01. Because the new Adolescent Health Coordinator is now a full time position, more time will be devoted to this activity.

In FY98 the Mental Health Division recognized the need for added funds to expand suicide prevention activities in communities throughout the state. The Division continues to identify suicide as a priority and anticipates that additional resources will be available to communities in FY 2001. The Task Force and MCH will continue to support suicide prevention activities generated as a result of these funds.

Additionally, MCH will continue to partner with the Mental Health Division on the Help Me Grow-Safe Kids (HMG-SK) information and referral line to respond to calls regarding mental health and substance abuse. To further the mission of the Youth Suicide Prevention Task Force, state staff discusses questions and concerns with parents, and teens, which may call the information and referral line and facilitate appropriate community-based referrals.

Finally, the new Adolescent Health Coordinator will expand activities relating to suicide prevention. Many of these activities are in the planning stage.

SPM#9: The percentage of communities with a community-wide plan for services to the MCH population. (The objective for FY01 is 80%. The percentage of communities with community-wide plans in FY99 was 75%.) The following narrative discusses proposed activities relating to this performance measure.

The long-standing contract between the Wyoming Department of Health and the Wyoming Health Resources Network (WHRN) is expected to continue. WHRN will coordinate the delivery of PATCH and Healthy Community (formerly SSDI resources) to Wyoming communities. Also, WHRN will continue to facilitate health provider recruitment and retention.

During FY01, the MCH Section will continue its effective community collaborative strategy to enhance the capacity of local public health departments to assess, develop, deliver, and evaluate quality MCH services, including adolescent health, injury and disease prevention, and care coordination for children with special health care needs and high risk pregnant women. Using SSDI funds disbursed through WHRN, MCH will continue to help Wyoming counties build upon the Planned Approach to Community Health (PATCH) model we've taught for the past 8 years, as well as providing technical assistance with other planning tools such as *Healthy Communities* model standards.

Discussed in detail in the annual report section is the commitment, persistence and technical assistance that building *Healthy Community* collaborations require. However, WHRN and MCH together have succeeded in building a network of state-wide coalitions (19 coalitions in 18 counties) and are targeting the remaining counties in the next year. To this network we have: 1) provided training on the process of coalition/partnership development and performance monitoring and evaluation; 2) designed and sponsored state-wide learning forums; 3) provided nationally known speakers to bolster local coalition efforts; and 4) developed a "WDH Grants Clearinghouse" for disbursing grants to communities. Originating from the MCH SSDI grant, this "clearinghouse" was designed to ease the application burden by centralizing pass-through funds and providing standardized applications and assessment forms, thus enhancing communities' ability to apply for grant funds.

As a result of this effort, Wyoming has seen improved access to services, improved assessment capacity; and improved population-based and prevention activities. (Please see the annual report for more success stories.)

Our coalition development/community health planning work is not yet done, however. Many challenges are still ahead of us including:

1. Delivering the message about the value of *Healthier Communities* development in a clear and compelling manner to other state agencies with a stake in outcome improvement for women, infants, children, adolescents and families — the MCH population.
2. Increasing the degree of collaboration and integration with other initiatives at both the state and local level, i.e. Covering Kids outreach pilots, school-to-career projects, substance use and abuse projects, etc.
3. Finding a way to sustain systematic training and support for both state-level buy-in and the collaborative process at the local level — *blending funding streams* wherever possible.

4. Identifying on-going funds for local interventions which may not fit current federal or state funding streams.

Both the Primary Care Office (PCO) and the Primary Care Association (PCA) will continue to be invaluable assets in the development of community plans. The Deputy Administrator of MCH Services and the PCO, along with the WDH Director and the Deputy Administrator of Nursing, serve as planners and evaluators for this contractual partnership. With the recent appointment of Bev Morrow as executive director of the PCO, a former WDH employee, the WDH finds itself looking forward to strengthened ties with the PCA.

SPM #16) The percentage of Wyoming counties with access to translation services. (This is a new SPM; the objective for FY01 is to increase to 45 percent the number of counties that identify translation services as adequate. This will be determined via a written survey. A survey will also be used to determine current level of coverage.) The following narrative discusses proposed activities relating to this performance measure.

In October 1999, MCH hired a Minority Health Coordinator. Previously, the minority health function had been performed by the Department's Diabetes Program manager on a part-time basis. The new Minority Health Coordinator, Ms. Betty Sones, will devote full-time effort to this function.

In recent years, the need for translation services has been identified numerous times by MCH field staff and public health nurses. In 1999, all 23 counties responded to an MCH survey on this topic. Ninety-five percent of survey respondents reported that translation services were either "not available" or "some available, but inadequate". While the predominant need relates to the Hispanic population, assistance with other languages and cultures is needed as well.

During FY01, the Minority Health Coordinator will be developing the details of the new program. Translation services will be an important part of the program. Already, surveys have been conducted to identify needs and resources. A resource database is being developed that will identify the locations and areas of expertise of translators throughout the state. The objective is to develop a resource base that covers the entire state.

Additionally, the Minority Health Coordinator has applied for a grant of \$30,000 from the Office of Minority Health. If funded, the funds will be used to support:

1. Enhancing the knowledge of minority consumers regarding critical health care issues
2. Enhancing local health care delivery systems by raising awareness and skills of providers. In this effort, the Minority Health Program will work closely with the network of *Healthier Communities* Coalitions build over the past six years with SSDI funds.
3. Integration and strengthening of information/referral resources, i.e. accessing translation services

Finally, even though the program is still in development, other functions of the Minority Health Coordinator will likely include: 1) assisting with the organization of a cultural diversity conference; 2) representing minority populations in policy decisions made by health and social services program administrators; 3) training professionals in cultural competency; 4) educating minorities about the availability of services; and 5) attending and facilitating information exchange at health fairs.

Other Activities

Children's Trust Fund Board of Directors: MCH represents the Department of Health on this board. The lead agency is the Department of Family Services. Other members include a representative from the Department of Education, law enforcement and schools. The purpose of grants funded by the Children's Trust Fund is the reduction of the incidence of child abuse and neglect in Wyoming.

Comprehensive Social Services Planning Team: MCH is a member of this committee, which was revitalized in June 1998 by the Department of Family Services. Other members include the Department of Education, Child Welfare League, and the University of Wyoming. The goal of the committee is to develop a five-year family preservation plan to include: 1) child safety, 2) child well being, and 3) permanent foster home placements.

Head Start State Collaboration Project: Initiated in FY97, the Head Start State Collaboration Project fosters partnerships to build a comprehensive early childhood system to link Head Start services to the broader child care, health, and education services currently available. The University of Wyoming chairs and staffs the project, which brings Head Start leaders together with the Departments of Health, Education, and Family Services. The project focuses on building and promoting linkages, assessing the current delivery system, including information about system efficiency, redundancies and capacity.

During the reporting period, the Project established its management team and hired full-time staff. In FY01, the project will enhance collaboration between Head Start, child care programs, and policy makers by developing electronic linkages among Head Start programs and ensuring Head Start representation on the Wyoming Department of Health Early Intervention Council and the Governor's Early Childhood Development Council.

D.3 CSHCN

NPM#11: Percent of Children with Special Health Care Needs in the state CSHCN program with a source of insurance for primary and specialty care. (The objective for FY01 is 75%. The percentage with a source of insurance in FY99 was 71.2%.)

The following narrative discusses proposed activities relating to this performance measure.

In the spring of 1999, the Wyoming Legislature authorized a two-phase children's insurance program, and recently the Health Care Financing Administration (HCFA) approved a state plan for implementing the first phase. Called Kid Care 1 in Wyoming, the first phase will be a Medicaid look-alike program and cover children with family incomes from 100% to 133% of federal poverty level (FPL). Kid Care 2, a private insurance buy-in program, has not yet been approved by HCFA, but is intended to provide coverage for children in families with incomes from 134% to 150%. Referral of children between Kid Care 1 and CSHCN is already taking place and will continue.

Outreach and enrollment personnel for the Kid Care 1 Program have discovered that a substantial number of applicants for Kid Care are eligible for Medicaid. Some families apparently do not understand that their children may still be eligible for Medicaid even though the family is no longer eligible for the TANF program. CSHCN staff will continue to work with Caring for the Children, Kid Care staff, Medicaid staff and Department of Family service personnel to improve access to health care for Wyoming's children.

Periodically, CSHCN staff have queried (and will continue to query) the CSHCN database for families within various poverty levels. Letters have been and will be sent to these families outlining various health care coverage options such as Kid Care 1, Kid Care 2 and Medicaid depending on the family income level.

NPM# 13: Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program. (The objective for FY01 is 90%. In State FY99, the percent was 71%).

The following narrative discusses proposed activities relating to this performance measure.

The MCH Program will continue its Memorandum of Understanding with Medicaid to consolidate medical claims processing, utilizing the Medicaid fiscal intermediary, Consultec. The Consultec database enables CHS to identify which of its clients are Medicaid eligible and have received services paid for by the Medicaid program. At the same time, Consultec has successfully billed Medicaid for all transportation for which Medicaid is responsible, a savings to MCH block grant that previously covered these medical expenses through the CHS program and Newborn Intensive Care.

In addition, MCH will continue to coordinate with the Kid Care 1 Program. This Medicaid look-alike program provides health care benefits to children in families with incomes between 100% and 133% of poverty level. A Robert Wood Johnson grant received by the Kid Care Program provides for an aggressive outreach effort. Outreach activities to date are discovering that a considerable number of uninsured children are eligible for Medicaid.

NPM #14: The degree to which the State assures family participation in program and policy activities in the State CSHCN program. (The objective for FY01 is to achieve a component score of 15.)

The following narrative discusses proposed activities relating to this performance measure.

The CSHCN family consultant has recently retired. A new person is currently being sought for this position. Once hired, the position will serve the entire MCH population, rather than just families with CSHCN, as had been the case previously. It is felt that this shared function will better position MCH to serve our “at risk” populations. Taking more of an infrastructure building approach, the new position will work to build local support systems and redirect the amount of direct parent support back to the communities and local care coordinators who are more adept at identifying and accessing local resources to meet familial needs. The following activities will continue to be among the priorities of the new position:

- ◆ *Partnership building*
- ◆ *Policy development*
- ◆ *Committee representation*
- ◆ *Presentations to professional groups (training)*
- ◆ *Participation at clinics for children with special health care needs*
- ◆ *Participation at programs for children with special health care needs*
- ◆ *Annual MEGA Conference*
- ◆ *The Parent’s Guide For Baby And Child Wellness (“The Baby Book”)*
- ◆ *Build parent contacts in the communities*

The parent consultant and CSHCN staff will also work with the new minority health coordinator to improve service to minority populations, i.e. Translation services, forms in Spanish.

4.2 Other Program Activities

It should be emphasized that even though a number of FY00 performance measures have been dropped for FY01, MCH will continue activities in these areas. Dropped performance measures include: SPM #1 Number of specialty/subspecialty clinics offered in Wyoming tertiary centers; SPM #4 Percent of low birth weight babies; SPM #5 Rate of fetal deaths per 1,000 live births; SPM #6 Percent of preventable child death due to non-vehicle related causes; and SPM #10 Percent of licensed child care facilities that have accessed health and safety consultation and training. These performance measures were not dropped because they are unimportant. They were dropped due to other priorities developing from the needs assessment process and/or the difficulty of collecting performance data, or in addressing issues from a different perspective.

Also, the needs assessment process revealed several areas where Wyoming rates are worse than national averages, but a specific state performance measure was not in place. In that instance, a specific performance measure was not developed because: 1) the State is only allowed ten performance measures; and 2) in some cases the public input process identified other priorities. While a specific performance measure may not have been developed, all areas where state rates are worse than national rates will receive additional attention in FY01.

The MCH Program will continue to build its data and computer infrastructure in FY01. MCH received a SSDI grant for this purpose in 1999. The SSDI grant provides funds for two levels of activities: 1) database improvement within the MCH section; and 2) database improvement in the Wyoming Department of Health as a whole. Personnel have been selected to begin both levels of activities. The focus of each effort will be to: 1) insure that relevant databases contain data necessary for health planning; and 2) improve access to health related databases. Also, MCH is in the process of developing a new database system that will replace several existing types of software. The new unified system will provide improved access to MCH data.

4.3 Public Input

This application, including the annual report and needs assessment were open a full month (June, 2000) for public comment. These documents were also circulated to local health departments, child and family advocates, and primary stakeholders identified herein during the same period. All comments received during this period were duly reviewed and incorporated as appropriate. Both the Community and Family Health Division's webpage, as well as the Governor's Weekly Brief invited participants to request and review the documents. In September, 1999 the MCH Block Grant and budget request were submitted to the Health, Education and Welfare Committee of the State Legislature for a formal hearing.

4.4 Technical Assistance

The SSDI data improvement project will include interviews with key officials in other state health departments. The purpose will be to determine how others have improved access to data. Did they develop a web site? What data are included on the web site? How did they handle issues of confidentiality? Does the general public have access to the data or is access restricted to health professionals? These and other questions will be deliberated by the data improvement steering committee during the next several months. MCH requests travel funds for staff to make an on-site visit to one state health department, location yet to be determined. This visit will be made after an investigation has been conducted to identify a state health department that has a "good" data system that Wyoming may wish to emulate.

During the course of developing an issue brief for the needs assessment on the impact of welfare reform, it was noted that drawing conclusions about the impact of welfare reform on the MCH population is difficult at this point. The overwhelming consensus, however, by agencies and other stakeholders is that this issue needs more study. Two possible studies include: 1) a cost/benefit comparison of the real savings of moving families off AFDC but on to food stamp, Medicaid, and child care public assistance programs; and 2) a cost/benefit study of the provision of job training *in addition* to the more traditional interview/application skills training offered alone.

V. SUPPORTING DOCUMENTS

5.1 Glossary

Administration of Title V Funds - The amount of funds the State uses for the management of the Title V allocation. It is limited by statute to 10 percent of the Federal Title V allotment.

Assessment - (see “Needs Assessment”)

Capacity - Program capacity includes delivery systems, workforce, policies, and support systems (e.g., training, research, technical assistance, and information systems) and other infrastructure needed to maintain service delivery and policy-making activities. Program capacity results measure the strength of the human and material resources necessary to meet public health obligations. As program capacity sets the stage for other activities, program capacity results are closely related to the results for process, health outcome, and risk factors. Program capacity results should answer the question, “What does the State need to achieve the results we want?”

Capacity Objectives - Objectives that describe an improvement in the ability of the program to deliver services or affect the delivery of services.

Care Coordination Services for CSHCN - Those services that promote the effective and efficient organization and utilization of resources to assure access to necessary comprehensive services for children with special health care needs and their families. *[Title V Sec. 501(b)(3)]*

Carryover (as used in Forms 2 and 3) - The unobligated balance from the previous year’s MCH Block Grant Federal Allocation.

Case Management Services - For pregnant women - those services that assure access to quality prenatal, delivery and postpartum care. For infants up to age one - those services that assure access to quality preventive and primary care services. *[Title V Sec. 501(b)(4)]*

Children -A child from 1st birthday through the 21st year, who is not otherwise included in any other class of individuals.

Children With Special Health Care Needs (CSHCN) - (*For budgetary purposes*) Infants or children from birth through the 21st year with special health care needs who the State has elected to provide with services funded through Title V. CSHCN are children who have health problems requiring more than routine and basic care including children with or at risk of disabilities, chronic illnesses and conditions and health-

related education and behavioral problems. *(For planning and systems development)* Those children who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally.

Children With Special Health Care Needs (CSHCN) - Constructs of a Service System

1. State Program Collaboration with Other State Agencies and Private Organizations

States establish and maintain ongoing interagency collaborative processes for the assessment of needs with respect to the development of community-based systems of services for CSHCN. State programs collaborate with other agencies and organizations in the formulation of coordinated policies, standards, data collection and analysis, financing of services, and program monitoring to assure comprehensive, coordinated services for CSHCN and their families.

2. State Support for Communities

State programs emphasize the development of community-based programs by establishing and maintaining a process for facilitating community systems building through mechanisms such as technical assistance and consultation, education and training, common data protocols, and financial resources for communities engaged in systems development, to assure that the unique needs of CSHCN are met.

3. Coordination of Health Components of Community-Based Systems

A mechanism exists in communities across the State for coordination of health services with one another. This includes coordination among providers of primary care, habilitative and rehabilitative services, other specialty medical treatment services, mental health services, and home health care.

4. Coordination of Health Services with Other Services at the Community Level

A mechanism exists in communities across the State for coordination and service integration among programs serving CSHCN, including early intervention and special education, social services, and family support services.

Classes of Individuals - Authorized persons to be served with Title V funds. See individual definitions under “Pregnant Women,” “Infants,” “Children with Special Health Care Needs,” “Children,” and “Others.”

Community - A group of individuals living as a smaller social unit within the confines of a larger one due to common geographic boundaries, cultural identity, a common work environment, common interests, etc.

Community-based Care - Services provided within the context of a defined community.

Community-based Service System - An organized network of services that are grounded in a plan developed by a community and that is based upon needs assessments.

Coordination (see Care Coordination Services)

Culturally Sensitive - The recognition and understanding that different cultures may have different concepts and practices with regard to health care; the respect of those differences and the development of approaches to health care with those differences in mind.

Culturally Competent - The ability to provide services to clients that honor different cultural beliefs, interpersonal styles, attitudes and behaviors and the use of multicultural staff in the policy development, administration and provision of those services.

Deliveries – Pregnant women who received a medical care procedure associated with the delivery or expulsion of a live birth or fetal death (gestation of 20 weeks or greater).

Direct Health Services - Those services generally delivered one-on-one between a health professional and a patient in an office, home, clinic or emergency room which may include primary care physicians, registered dietitians, public health or visiting nurses, nurses certified for obstetric and pediatric primary care, medical social workers, nutritionists, dentists, sub-specialty physicians who serve children with special health care needs, audiologists, occupational therapists, physical therapists, speech and language therapists, specialty registered dietitians. Basic services include what most consider ordinary medical care: inpatient and outpatient medical services, allied health services, drugs, laboratory testing, x-ray services, dental care, and pharmaceutical products and services. State Title V programs support - by directly operating programs or by funding local providers - services such as prenatal care, child health, including immunizations and treatment or referrals, school health and family planning. For CSHCN, these services include specialty and subspecialty care for those with HIV/AIDS, hemophilia, birth defects, chronic illness, and other conditions requiring sophisticated technology, access to highly trained specialists, or an array of services not generally available in most communities.

Enabling Services - Services that allow or provide for access to and the derivation of benefits from, the array of basic health care services and include such things as transportation, translation services, outreach, respite care, health education, family support services, purchase of health insurance, case management, coordination with Medicaid, WIC and educations. These services are especially required for the low income, disadvantaged, geographically or culturally isolated and those with special and complicated health needs. For many of these

individuals, the enabling services are essential - for without them access is not possible. Enabling services most commonly provided by agencies for CSHCN include transportation, care coordination, translation services, home visiting, and family outreach. Family support activities include parent support groups, family training workshops, advocacy, nutrition and social work.

Family-centered Care - A system or philosophy of care that incorporates the family as an integral component of the health care system.

Federal (Allocation) (as it applies specifically to the Application Face Sheet [SF 424] and Forms 2 and 3) -The monies provided to the States under the Federal Title V Block Grant in any given year.

Government Performance and Results Act (GPRA) - Federal legislation enacted in 1993 that requires Federal agencies to develop strategic plans, prepare annual plans setting performance goals, and report annually on actual performance.

Health Care System - The entirety of the agencies, services, and providers involved or potentially involved in the health care of community members and the interactions among those agencies, services and providers.

Infants - Children under one year of age not included in any other class of individuals.

Infrastructure Building Services - The services that are the base of the MCH pyramid of health services and form its foundation are activities directed at improving and maintaining the health status of all women and children by providing support for development and maintenance of comprehensive health services systems including development and maintenance of health services standards/guidelines, training, data and planning systems. Examples include needs assessment, evaluation, planning, policy development, coordination, quality assurance, standards development, monitoring, training, applied research, information systems and systems of care. In the development of systems of care it should be assured that the systems are family centered, community based and culturally competent.

Local funding (as used in Forms 2 and 3) -Those monies deriving from local jurisdictions within the State that are used for MCH program activities.

Low Income - An individual or family with an income determined to be below the income official poverty line defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981. [*Title V, Sec. 501 (b)(2)*]

MCH Pyramid of Health Services - (see “Types of Services”)

Measures - (see “Performance Measures”)

Needs Assessment - A study undertaken to determine the service requirements within a jurisdiction. For maternal and child health purposes, the study is aimed at determining:

- 1) What is essential in terms of the provision of health services;
- 2) What is available, and
- 3) What is missing?

Objectives - The yardsticks by which an agency can measure its efforts to accomplish a goal. (See also “Performance Objectives”)

Other Federal Funds (Forms 2 and 3) - Federal funds other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program. These may include, but are not limited to: WIC, EMSC, Healthy Start, SPRANS, AIDS monies, CISS funds, and MCH targeted funds from CDC and MCH Education funds.

Others (as in Forms 4, 7, and 10) - Women of childbearing age, over age 21, and any others defined by the State and not otherwise included in any of the other listed classes of individuals.

Outcome Objectives - Objectives that describe the eventual result sought the target date, the target population, and the desired level of achievement for the result. Outcome objectives are related to health outcome and are usually expressed in terms of morbidity and mortality.

Outcome Measure - The ultimate focus and desired result of any set of public health program activities and interventions is an improved health outcome. Morbidity and mortality statistics are indicators of achievement of health outcome. Health outcome results are usually longer term and tied to the ultimate program goal. Outcome measures should answer the question, “Why does the State do our program?”

Performance Indicator - The statistical or quantitative value that expresses the result of a performance objective.

Performance Measure - A narrative statement that describes a specific maternal and child health need, or requirement, that, when successfully addressed, will lead to, or will assist in leading to, a specific health outcome within a community or jurisdiction and generally within a specified time frame. (Example: “The rate of women in [State] who receive early prenatal care in 19__.” This performance measure will assist in leading to [the health outcome measure of] reducing the rate of infant mortality in the State).

Performance Measurement - The collection of data on, recording of, or tabulation of results or achievements, usually for comparing with a benchmark.

Performance Objectives - A statement of intention with which actual achievement and results can be measured and compared. Performance objective statements clearly describe what is to be achieved, when it is to be achieved, the extent of the achievement, and target populations.

Population Based Services - Preventive interventions and personal health services, developed and available for the entire MCH population of the State rather than for individuals in a one-on-one situation. Disease prevention, health promotion, and statewide outreach are major components. Common among these services are newborn screening, lead screening, immunization, Sudden Infant Death Syndrome counseling, oral health, injury prevention, nutrition and outreach/public education. These services are generally available whether the mother or child receives care in the private or public system, in a rural clinic or an HMO, and whether insured or not.

Pregnant Woman - A female from the time that she conceives to 60 days after birth, delivery, or expulsion of fetus.

Preventive Services - Activities aimed at reducing the incidence of health problems or disease prevalence in the community, or the personal risk factors for such diseases or conditions.

Primary Care - The provision of comprehensive personal health services that include health maintenance and preventive services, initial assessment of health problems, treatment of uncomplicated and diagnosed chronic health problems, and the overall management of an individual's or family's health care services.

Process - Process results are indicators of activities, methods, and interventions that support the achievement of outcomes (e.g., improved health status or reduction in risk factors). A focus on process results can lead to an understanding of how practices and procedures can be improved to reach successful outcomes. Process results are a mechanism for review and accountability, and as such, tend to be shorter term than results focused on health outcomes or risk factors. The utility of process results often depends on the strength of the relationship between the process and the outcome. Process results should answer the question, "Why should this process be undertaken and measured (i.e., what is its relationship to achievement of a health outcome or risk factor result)?"

Process Objectives - The objectives for activities and interventions that drive the achievement of higher-level objectives.

Program Income (as used in the Application Face Sheet [SF 424] and Forms 2 and 3) - Funds collected by State MCH agencies from sources generated by the State's MCH program to include insurance payments, MEDICAID reimbursements, HMO payments, etc.

Risk Factor Objectives - Objectives that describe an improvement in risk factors (usually behavioral or physiological) that have been proven to cause morbidity and mortality.

Risk Factors - Public health activities and programs that focus on reduction of scientifically established direct causes of and contributors to, morbidity and mortality (i.e., risk factors) are essential steps toward achieving health outcomes. Changes in behavior or physiological conditions are the indicators of achievement of risk factor results. Results focused on risk factors tend to be intermediate term. Risk factor results should answer the question, "Why should the State address this risk factor (i.e., what health outcome will this result support)?"

State - As used in this guidance, includes the 50 States and the 9 jurisdictions of the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, the Republic of the Marshall Islands, the Federated States of Micronesia and the Republic of Belau.

State Funds (as used in Forms 2 and 3) - The State's required matching funds (including overmatch) in any given year.

Systems Development - Activities involving the creation or enhancement of organizational infrastructures at the community level for the delivery of health services and other needed ancillary services to individuals in the community by improving the service capacity of health care service providers.

Technical Assistance (TA) - The process of providing recipients with expert assistance of specific health related or administrative services that include; systems review planning, policy options analysis, coordination coalition building/training, data system development, needs assessment, performance indicators, health care reform wrap around services, CSHCN program development/evaluation, public health managed care quality standards development, public and private interagency integration, and identification of core public health issues.

Title XIX, number of infants entitled to - The unduplicated count of infants who were eligible for the State's Title XIX (MEDICAID) program at any time during the reporting period.

Title XIX, number of pregnant women entitled to - The number of pregnant women who delivered during the reporting period who were eligible for the State's Title XIX (MEDICAID) program

Title V, number of deliveries to pregnant women served under - Unduplicated number of deliveries to pregnant women who were provided prenatal, delivery, or post-partum services through the Title V program during the reporting period.

Title V, number of infants enrolled under - The unduplicated count of infants provided a direct service by the State's Title V program during the reporting period.

Total MCH Funding - All the MCH funds administered by a State MCH program which is made up of the sum of the *Federal* Title V Block Grant allocation, the *Applicant's* funds (carryover from the previous year's MCH Block Grant allocation - the unobligated balance), the *State* funds (the total matching funds for the Title V allocation - match and overmatch), *Local* funds (total of MCH dedicated funds from local jurisdictions within the State), *Other* Federal funds (monies other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program), and *Program Income* (those collected by State MCH agencies from insurance payments, MEDICAID, HMO's, etc.).

Types of Services - The major kinds or levels of health care services covered under Title V activities. See individual definitions under "Infrastructure Building," "Population Based Services," "Enabling Services," and "Direct Medical Services."

5.2 Assurances and Certifications

ASSURANCES -- NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have any questions, please contact the Awarding Agency. Further, certain Federal assistance awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or

documents related to the assistance; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.

3. Will establish safeguards to prohibit employees from using their position for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. Sects. 4728-2763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to non-discrimination. These include but are not limited to (a) Title VI of the Civil Rights Act of 1964 (P.L. 88 Sect. 352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. Sects. 1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. Sect. 794), which prohibits discrimination on the basis of handicaps; (d) The Age Discrimination Act of 1975, as amended (42 U.S.C. Sects 6101 6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office of Treatment Act of 1972 (P.L. 92-255), as amended, relating to non-discrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to non-discrimination on the basis of alcohol abuse or alcoholism; (g) Sects. 523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. Sect. 3601 et seq.), as amended, relating to non-discrimination in the sale, rental, or financing of housing; (i) any other non-discrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other non-discrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. Sects 1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. Sects. 276a to 276a-7), the Copeland Act (40 U.S.C. Sect 276c and 18 U.S.C. Sect. 874), the Contract Work Hours and Safety Standards Act (40 U.S.C. Sects. 327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in flood plains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. Sects. 1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. 7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. Sects 1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers systems
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. Sect. 470), EO 11593 (identification and preservation of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. Sects. 469a-1 et seq.)
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. Sect. 2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by the award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. Sects. 4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply will all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

By signing and submitting this proposal, the applicant, defined as the primary participant in accordance with 45 CFR Part 76, certifies to the best of its knowledge and belief that it and its principals:

- (a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
- (b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission or fraud or criminal judgment in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
- (c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission or any of the offenses enumerated in paragraph (b) of the certification; and
- (d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause, titled “Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion -- Lower Tier Covered Transactions” in all lower tier covered transactions (i.e. transactions with sub-grantees and/or contractors) in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

- (a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee’s workplace and specifying the actions that will be taken against employees for violation of such prohibition;
- (b) Establishing an ongoing drug-free awareness program to inform employee’s about-
 - (1) The dangers of drug abuse in the workplace;

- (2) The grantee's policy of maintaining a drug-free workplace,
 - (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
 - (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- (c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- (d) Notifying the employee in the statement required by paragraph (a) above, that, as a condition of employment under the grant, the employee will-
- (1) Abide by the terms of the statement; and
 - (2) Notify the employer in writing of his or her conviction for violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- (e) Notify the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
- (f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d)(2), with respect to any employee who is so convicted-
- (1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended, or
 - (2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- (g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Division of Grants Policy and Oversight
Office of Management and Acquisition
Department of Health and Human Services
Room 517-D
200 Independence Avenue, S.W.
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled “Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,” generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. The requirements apply to grants and cooperative agreements’ EXCEEDING \$100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief that:

- (1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
- (2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, “Disclosure of Lobbying Activities,” in accordance with its instructions. (If needed, Standard Form-LLL, “Disclosure of Lobbying Activities,” its instructions, and continuation sheet are included at the end of this application form.)
- (3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18 if the services are funded by Federal programs either directly or through State or local governments by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable Federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing this certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards, which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Service strongly encourages all grant recipients to provide a smoke free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of American people.

- 5.3 Other Supporting Documents**
- 5.4 Health Status Indicator Forms**
- 5.5 Core Health Status Indicator Detail Sheets**
- 5.6 Developmental Health Status Indicator Forms**
- 5.7 Developmental Health Status Indicator Detail Sheets**
- 5.8 All Other Forms**
- 5.9 National “Core” Performance Measure Detail Sheets**
- 5.10 State “Negotiated” Performance Measure Detail Sheets**
- 5.11 Outcome Measure Detail Sheets**