



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

**State Narrative for
Colorado**

**Application for 2013
Annual Report for 2011**



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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.

An attachment is included in this section. IA - Letter of Transmittal

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

The Appropriate Assurances and Certifications for non-construction programs, debarment and suspension, drug-free work place, lobbying, program fraud, and tobacco smoke, that are part of this grant, are maintained on file as required by the block grant guidance at the State's MCH administrative office on the fourth floor at the Colorado Department of Public Health and Environment, 4300 Cherry Creek Drive South, Denver, Colorado 80246.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

Colorado first placed online for review and public input its FY 2000 Maternal and Child Health Block Grant in 1999. Since that time, all narratives have been placed online. Users find online access to the grant very convenient, and comments throughout the year are solicited through a return email function on the Web site.

Much input was sought last year for the FY 2011 grant application through the intensive needs assessment process that was conducted. This process was described in detail in the needs assessment section (Section II).

A draft version of the FY 2011 grant application was placed on the state health department's Web site on July 1, 2010. The MCH Director sent a letter to key stakeholders informing them that comments were welcome. Appropriate changes were made in the final grant application before the July 15, 2010 submission.

After transmittal to the Maternal and Child Health Bureau, the final version of the Maternal and Child Health Application/Annual Report for FY 2011 will be available on the department Web site. Visitors to the Web site will be able to download the application and will be able to email the Division with their comments and questions throughout the year. Hard copies will also be available. A map of Colorado is attached to this section to assist the reader when county and place name references are used in the grant application.

/2012/ Multiple forums were held throughout 2010 and 2011 to gather input on Colorado's Block Grant application and the new MCH priorities. An effort was made to include multiple stakeholders, along with feedback from family leaders. Presentations/discussions included an MCH Stakeholder meeting in September 2010, a webinar in October 2010, an Early Childhood Stakeholders meeting in November 2010, a presentation to the Colorado Association of Local Public Health Officials (CALPHO) and the Colorado Association of Public Health Administrative

Directors (CoPHAD) in December 2010 and a review of the new priorities at the Health Integration Summit for Early Childhood Councils in January 2011. Health care professionals and interested staff were addressed at a presentation given at The Children's Hospital in May 2011.

In addition, the State Planning Team for the Family Leadership Training Institute (FLTl), which includes representation from six urban/rural counties (Adams, Arapahoe, Larimer, Montezuma, Dolores and Denver), discussed the Block Grant at team strategic planning meetings in October 2010 and April 2011. Input was also solicited from the Family Voices Executive Director during monthly "check in" calls. Discussion around the Block Grant and the new priorities was also featured at meetings with the Medical Home Advisory and Steering Committee members during the current grant year.

Overall, participants at the meetings provided positive feedback on the priorities. Discussions allowed all involved to share current activities occurring around the state, as well as brainstorm ideas and develop new partnerships for future activities. Specific feedback is summarized in the following sections focused on the National (NPM) and State Performance Measures (SPM). A full report from the September 2010 stakeholder meeting is available online (www.cdphe.state.co.us/ps/mch/mchresources/MCH_Stakeholder_Meeting_note_summary.docx)

In addition, input received at the early childhood stakeholder's meeting in November 2010 highlighted the importance of encouraging similar conversations about the MCH priorities between local public health and local early childhood councils, with state staff facilitation.

Stakeholder feedback has been shared with each MCH Implementation Teams for incorporation into the public health planning process.

The draft and final copy of the FY2012 application will again be posted online. //2012//

/2013/ The Colorado MCH Program engages stakeholders intentionally and routinely in both program planning, implementation and evaluation efforts. One primary focus of Colorado's MCH Program this year has been moving from the identification of the MCH priorities towards the implementation of evidence-based strategies, or data to action. For more detail on this process, please see the Needs Assessment update. Throughout the data to action process, the MCH Implementation Teams (MITs) engaged a variety of stakeholders in multiple ways to solicit feedback that would inform their state and local logic model and action plan development, including the selection of coordinated state and local public health strategies targeting Colorado's MCH priorities. Some MITs engaged stakeholders through ongoing participation on the implementation teams. Other MITs created advisory groups to guide their work and solicited input periodically through focus groups, summits, or material review. Internal and external stakeholders were involved throughout this process including representatives from the health care sector; insurance industry; Departments of Education, Transportation, and Human Services; other CDPHE programs such as STD/HIV prevention and chronic disease; community-based organizations; and families/youth. In addition, the MITs were required to engage local public health agency staff members in action plan development given local MCH staff are charged with implementing the local action plans in their communities.

Given the variation on stakeholder engagement efforts across the nine MITs, several examples are cited here in greater detail. In August 2011, the Maternal Wellness team hosted a summit bringing together 64 stakeholders from across the state to determine 1. Current efforts in place related to preconception health and pregnancy-related depression; 2. Ascertain successful population-based efforts; 3. Suggestions for what changes around preconception health and pregnancy-related depression are needed in Colorado; and 4. Identify Colorado strengths that support preconception health and pregnancy-related depression efforts. Summit attendees represented local public health agency staffs, academia, multi-disciplinary medical professionals, and state public health department

staffs.

Maternal Wellness Preconception health and pregnancy-related depression advisory committees were formed through an application process. Members were selected based on the need for diverse perspectives and multi-disciplinary knowledge and skill. Advisory committees consist of members from the state public health agency, local county public health agencies, academia, medical professionals, mental health professionals, social work professionals, health plan staffs, and non-profit organization staffs. Advisory Committees meet every quarter to discuss activity plan strategies and activities. In addition, committee members highlight their work related to preconception health and pregnancy-related depression.

The Youth Sexual Health MCH Implementation Team pulled together four state staff, including one MCH Generalist, and eight local public health champions from urban, rural and frontier communities to gather their input and feedback on both the state and local logic models and action plans. Participants were actively involved throughout the three hour meeting, breaking into small groups based on each strategy and discussing whether each one was population-based, feasible, a public health role, etc. The MIT Leads then incorporated the local feedback and finalized the state and local logic models and action plans.

The Colorado MCH Program revised its local funding model this past year, in part, to better align local funding to support work on the MCH priorities (see the Needs Assessment update for more information). Local public health stakeholder engagement was an integral component of this intensive, year-long initiative. To this end, 112 local public health agency staff members participated in two webinars conducted in October 2011. Twenty local staff responded to an on-line survey following the webinar with questions and comments. In November 2011, state MCH staff facilitated six regional meetings in Durango, Grand Junction, Eagle, Fort Morgan, Pueblo, and Metro Denver to discuss the proposed funding changes. Thirty-three out of the 55 LPHAs attended and provided feedback both on the proposed funding formula as well as on what would be reasonable contract expectations for different levels of funding. From December 2011 through March 2012, state staff facilitated two local health agency workgroups, with 8-12 members each, who informed decisions related to MCH program operations, as well as local funding expectations and guidance. Final local funding decisions were shared and discussed in two webinars held in late February/early March with 100 local health agency staff participating. A question and answer session was included. Finally, 150 local public health agency staff participated in a 2.5 day conference in March whereby priority strategies and funding expectations were highlighted in an interactive and engaging environment. A LPHA agency work group will continue to meet to assess the impact of local funding changes, as well as provide feedback for program operations.

Based on input from local communities, the Youth Sexual Health Team worked with Colorado Youth Matter to complete a statewide youth sexual health "call to action," called Youth Sexual Health in Colorado: A Call to Action. For more information, see NPM 8 and SPM 8.

For more information about input provided to MCH by Colorado families see NPMs 2 and 6.

The draft and final copy of the FY2013 application will be posted online on CoPrevent (<http://www.coprevent.org>), Colorado's prevention-related news and information site hosted by the Prevention Services Division (PSD) of CDPHE. The final version will also be posted on the MCH website (www.mchcolorado.org). //2013//

II. Needs Assessment

In application year 2013, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

Expanded State Infrastructure/Capacity for Addressing MCH Priorities

The MCH team in Colorado has developed and implemented a new infrastructure for addressing the state MCH priorities that promotes a coordinated approach between state and local MCH efforts; provides support and capacity-building opportunities among both state and local MCH staff; and provides oversight and accountability to state and local-level work. Elements include the MCH Steering Team; the MCH Implementation Teams (MITs); and the development and implementation of common expectations and a training plan for state and local MCH staff.

Accountability and Oversight

The MCH Steering Team, which includes the MCH Director, the MCH Program Manager, and the Directors of the Children and Youth Branch and the Women's Health Branch, was chartered to provide guidance, oversight and accountability for implementation of Colorado's MCH priorities. This team met twice a month throughout the year to oversee the direction of state MCH work, to identify and develop support for MITs, and to define expectations and guidance for MIT leads throughout the process. MITs were each required to attend the Steering Team meeting twice during the year to present on the team's progress and challenges, and to request any necessary support. Steering Team members also reviewed and approved the MITs' state and local logic models based on: alignment with Colorado's strategic direction (focus on population-based and infrastructure-level approaches, and primary prevention and early intervention public health strategies); quality assurance (evidence-based, realistic scope of work for available funding/capacity); and opportunities for integration across the priorities (those with mutual populations or common strategies). The Steering Team anticipates making an impact on intended outcomes given these oversight processes. The Steering Team will continue its work during the coming year as the MITs and local partners move from planning to the implementation and evaluation of strategies.

MCH Priorities: Data to Action

The MITs are work groups that were formed in December 2010 for the purpose of developing coordinated state and local MCH strategies to address the MCH priorities. Each team is led by state program staff who specialize in the priority area, with work groups consisting of both internal and external representation from a variety of settings. See the Public Input Section for more detail on stakeholder engagement in the MIT process. From December 2010 through March 2012, the MITs systematically applied Brownson's Evidenced-Based Public Health framework to ultimately develop state and local logic models and action plans that will guide state and local MCH work on Colorado's priorities for the next three years.

To support MITs in their work, the MCH Steering Team resourced 30 percent of a current MCH Generalist Consultant (a consultant to local health agency partners) to serve as the primary liaison and consultant to the MITs. In this role, the MIT Consultant provided ongoing communication with MITs about the Steering Team's expectations, and helped to identify and coordinate training and capacity-building opportunities. She also provided technical assistance to the MITs when needed and served as a coordinator with the MITs for the logic model and action plan review process as well as for the March MCH conference. Additionally, the MIT Consultant coordinated and facilitated quarterly meetings with all of the MIT leads, Steering Team members, and MCH Generalist Consultants.

The MCH Team developed multiple trainings and tools to support MITs in their work. Training

events were conducted on building partnerships and shaping health policy. State MCH staff worked with the Division's Epidemiology, Planning and Evaluation (EPE) Branch to develop logic model and action plan templates and training for MITs in order to provide useful tools as well as to assure consistency of the plans for state and local partners. To view all state and local logic models and action plans, see www.coprevent.org/label/mch.

Dissemination and Implementation of Priority-related Logic Models and Action Plans
MCH priority logic models and action plans were developed, reviewed and approved by late February 2012. State MCH staff began implementing their state-level activities once their work plans were approved. To disseminate these resources to local public health agencies, the MCH team designed and implemented a two and half day conference on March 7 - 9. See attached conference agenda (Attachment 1). 150 local public health agency staff attended. The MITs each presented their priority work multiple times during the conference. These presentations were re-recorded post-conference using webinar technology and will be made available with the logic models and action plans at www.mchcolorado.org and www.coprevent.org/label/mch. Local public health agencies will begin implementing work on the MCH priorities in October 2012, with the onset of the new contract year.

Participants provided valuable feedback on the conference as well as the priority resources. One question on the follow-up evaluation survey asked, what is one thing you learned at the conference that you are excited to apply on the job? Responses included: "Almost plug and play" action plans, logic models, and the stats; partnership building; and best practices for MCH work.

One local health agency partner and conference participant sent an email message following the event and shared, "I just wanted you to know how useful it has been over the last weeks to have the priority areas, each with work plans, logic models, etc. Although I could not articulate what it was I exactly needed when I took on this role, this body of tools fills multiple needs for Denver and I would like the staff who spent so many hours developing the information to know how useful it has been, even beyond its official purpose." --Denver Public Health MCH Program Manager

Importance of Population-based and Infrastructure Levels of the MCH Pyramid
Simultaneous to the state work on the MCH priorities, the MCH Team conducted a mixed methods, operational research project in an effort to increase local MCH staff capacity in understanding the definitions of the pyramid levels and the importance population-based approaches to health, as well as how to successfully transition efforts towards the bottom of the MCH pyramid. The results of the study informed the creation of a guiding document and presentation to share local public health agency staff experience with others (see attached - Attachment 2).

Revision of Local Funding Policy

Colorado launched an intensive effort in December 2010 to review and revise the current local MCH funding formula and contract expectations. Three primary factors precipitated these local funding changes including changes in the public health system in Colorado resulting from 2008 legislation; the introduction of the new MCH priorities; and the need to address some historical funding inequities at the local level. After six months of work by an internal MCH workgroup, local partners were engaged in six months of presentations and discussions about a revised funding model and commensurate contract expectations. See the Public Input section for details on the stakeholder engagement process. The results of this work included the following:

- The same local MCH funding formula (MCH population x poverty of MCH population) is being applied consistently to all 55 local public health agencies beginning in October 2012.
- 43 out of the 55 local agencies are receiving an increase in MCH funding.
- A three-year funding transition plan is being applied for all agencies.
- Agencies' contract expectations vary by funding level and include program requirements for children and youth with special health care needs (care coordination, specialty clinics and medical home systems building); work on the MCH priorities (10 percent in year 1, 20 percent in

year 2, and 30 percent by year 3); and an option for smaller agencies to work on their community health assessment required by the 2008 Public Health Act (see attached - Attachments 3 and 4).

Monitoring of State Priorities and Performance Measures

Colorado's state performance measures utilize secondary data sources, such as PRAMS, YRBS, BRFSS, and Vital Records. In 2010, baseline data were collected from these sources. Given that data collection occurs on a regular basis, SPM indicators will be collected regularly and monitored accordingly. No significant impact on the MCH priorities or state performance measures is yet anticipated, as state staff has only been implementing their action plans on the priorities for the past six months. Local partners will begin their work on the priorities in October 2012. See attached (Attachment 5) for a list of the state priority and performance measures.

An attachment is included in this section. IIC - Needs Assessment Summary

III. State Overview

A. Overview

Introduction

This section discusses the Colorado's health care delivery environment. It also provides an overview of the factors impacting health services delivery such as: poverty, racial and ethnic disparities and geography. More detailed analysis of these factors and others are found in the needs assessment section. The needs assessment section also delineates how these factors were analyzed within the process that led to the identification of the nine Colorado MCH priority areas.

For the Colorado needs assessment and planning process, the state used a conceptual framework that integrated a strengths-based approach with the goal of optimizing health and well-being among the MCH population across the life course. The approach took into account that a complex interplay of biological, behavioral, psychological, and social factors (e.g., both risk and protective) contribute to health outcomes (e.g., the Life Course Health Development Model). In alignment with this model, the influence of early life events (early programming) and critical periods across the life course were considered with attention given to the cumulative impact of experiences over time, which resulted in an emphasis on primary prevention and early intervention. The social determinants of health were also considered as factors that shape the health of individuals and communities.

For purposes of assessment and strategic planning, the MCH population was defined as women, children, adolescents, children with special health care needs, and families. The MCH population was further subdivided into women of reproductive age (ages 15-44), early childhood (ages birth-8), including children with special health care needs and child/adolescent (ages 9-21), including children and youth with special health care needs.

The needs assessment process focused on identifying a set of specific priorities that could be acted upon at some depth so that results, even preliminary ones, would be achievable and evident in five years. Strategies employed to achieve results were to be evidence-based/promising practices or interventions grounded in sound public health theory or research and consistent with the mission and scope of Colorado's MCH program. A clear MCH public health role needed to exist for an issue to be considered as a potential priority.

In the beginning stages of the Colorado's needs assessment, two strategies were used to solicit both qualitative and quantitative data to identify potential MCH priority areas. The first strategy involved convening groups of subject matter experts. The second Phase I strategy involved creating an updated version of the Colorado MCH Health Status Report, which served as a means for compiling and analyzing quantitative MCH population data.

Geography

The Rocky Mountain state of Colorado is bounded on the east by Kansas and Nebraska, on the north by Nebraska and Wyoming, on the west by Utah and on the south by New Mexico and Oklahoma. Colorado is the eighth largest state when measured in square miles and consists of different regions of mountains, plateaus, canyons and plains. Generally, the eastern half of the state has flat, high plains and rolling prairies that gradually rise westward to the Front Range foothills and the higher ranges of the Rocky Mountains. Colorado has the highest mean elevation of any state with more than a thousand mountain peaks over 10,000 feet high including 54 that are over 14,000. The Continental Divide runs from north to south through west central Colorado and bisects the state into the eastern and western slopes.

The state can be divided into five distinctive regions within its 64 counties: the Front Range, the Western Slope, the Eastern Plains, the Central Mountains, and the San Luis Valley. Each of these areas grew in population between 2000 and 2007, ranging from a 3 percent increase in the

Eastern Plains to an 18 percent increase on the Western Slope. Close to 85 percent of the population lives in urbanized areas and 82 percent of the population lives in the Front Range, which includes the metropolitan areas of Denver-Boulder, Ft. Collins, Greeley, Colorado Springs, and Pueblo. The San Luis Valley in the southern part of the state is the region with the smallest population, with about 48,000 residents. The rural vastness of much of the state is confirmed by 20 of Colorado's 64 counties which qualify as frontier counties containing fewer than 6 persons per square mile; of these 20, eleven have 2 or fewer persons per square mile.

Population

Colorado, ranking 22nd among states based on the size of its population, has had one of the fastest growth rates of all states. The overall population for Colorado in 2010 is projected to reach over 5 million--5,218,146; this projection is an increase of over 10 percent since 2005, when the estimated Colorado population was 4,731,787 residents. By 2015, the population is projected to increase by another 10 percent, reaching 5,737,307.

Population growth is determined by the number of resident births, deaths, and migration into the state. The ratio of births to deaths has consistently averaged over twice as many births as deaths in a given year. Between 2000 and 2008, the number of Colorado births increased by just 7 percent, reducing the very rapid growth in the total number of births that had been seen in the decade of the 1990s. In 2000 there were 65,000 births; the number of births has risen since then but remained at approximately 70,000 annually between 2006 and 2008. Preliminary estimates for 2009 actually suggest a decline to about 68,600. A drop this substantial can be attributed in large part to the downturn in the economy.

Women between the ages of 25 and 34 consistently contribute over 50 percent of births each year; in addition, women in this age group have not shown any decline in fertility rates in the past decade in contrast to the experience of younger women. Thus, the expected growth of women who are age 25 to 34 in the coming years will have a significant impact on the need for maternal and infant services and supports.

While the number of deaths annually has risen, both the crude and adjusted death rates have fallen since 2000. It is important to note as well that migration has been an important factor in the state's population growth in recent years. Between 2000 and 2008 net migration (the total number of people moving to the state minus the number leaving) exceeded 433,000 people. Between 2009 and 2012, net migration is expected to account for over 50 percent of the increase in total population, with an additional 143,000 residents arriving.

The two major racial and ethnic groups in Colorado are composed of White non-Hispanic persons and persons of any race who are of Hispanic origin or ethnicity. Estimates from the American Community Survey (2008) of the U.S. Census Bureau show that 70.9 percent of Coloradans identify themselves as White non-Hispanic and 20.2 percent identify themselves as of Hispanic origin. Non-Hispanic groups include African-American/Black (3.6 percent), Asian and Pacific Islander (2.6 percent), American Indian (0.6 percent) and people who report other races or more than one race (2.2 percent).

The Hispanic population has grown rapidly in recent years; from 735,601 in 2000 to an estimated 963,831 in 2006-2008 according to the most recent three-year estimates available from the American Community Survey. The vast majority of the Hispanic population is of Mexican descent, while virtually all the rest is from Central and South America. Over 71 percent of the Hispanic population in Colorado was born in the United States; 29 percent was not. Almost 16 percent of those born outside the U.S. are naturalized citizens.

Approximately 17 percent of Colorado residents age 5 and older speak a language other than English at home; over 70 percent of those speaking another language in the home speak Spanish. Four percent of households in Colorado are estimated to be linguistically isolated, i.e., all members 14 years and older have at least some difficulty with English.

Education

Colorado has an educated population. Over one-third (34.6 percent) of all Coloradans age 25 and older have a college degree or more and Colorado is ranked 4th among all states and the District of Columbia in the percentage of the population with a college degree. Educational attainment varies by race and ethnicity in Colorado; 46 percent of Asian/Pacific Islanders have a college degree or more as do 40 percent of White, non-Hispanics, 22 percent of African Americans/Blacks, and 11 percent of Hispanics. The high rate of college graduates in the state is reflected in the work force in Colorado; Colorado's economy has been based on employment in the service-based industries for more than six decades. The service-based industries cover a wide range of businesses that do not produce tangible goods and include professional, scientific, technical, managerial, administrative, educational, health care and social assistance, and accommodation and food services.

Income and education are highly correlated. Eighty-one percent of all low-income children come from families where parents had less than a high school education. The poverty rate for Coloradans age 25 and older who do not have a high school diploma is 23 percent compared to just over 3 percent for those with a college degree or higher.

While the prevalence of college graduates in Colorado is high, the percentage of high school students who graduate is relatively low. This state of affairs exists because many highly educated people migrate to Colorado after completing their education; they have completed at least high school elsewhere. High school graduation rates for Colorado for 2006, 2007, and 2008 show only three-fourths of Colorado's students who started 9th grade are known to have graduated from high school within four years. A Healthy People 2010 objective is to increase high school completion to 90 percent, and Colorado's students fall far short of the target.

Disparities in graduation rates also mimic the disparities in college graduation attainment among adult Coloradans, with Hispanics having the lowest high school graduation rate and Asian-Americans having the highest. Other groups that are consistently at risk of not graduating from high school include homeless children and children who are not proficient in English. From 2006 through 2008, graduation rates have increased slightly for Black students but have fallen for students with disabilities, those with limited English proficiency, homeless students, and those who are economically disadvantaged.

Students who do not graduate from high school are the most likely to experience low incomes and face the health-related consequences associated with lower incomes.

Economy

The downturn in the national economy since the end of 2007 has dramatically affected Colorado, resulting in the state's worst downturn in 50 years. As of July, 2009, unemployment stood at 7.8 percent, doubling since 2007 when the unemployment rate was at its lowest (3.8 percent). During the first half of 2009, there was a net loss of over 74,000 jobs in Colorado, bringing the total number of jobs in the state to the same number there were in 2001. Job losses have not been focused on one particular sector of the economy but have been broad-based. Only two sectors showed some job growth in 2009: government and educational and health services. All other sectors of the Colorado economy lost jobs. The Colorado Legislative Council suggests that the economy in Colorado will begin to recover in 2010 but predicts a "snail-paced recovery."

Even with the increase in unemployment rates, Colorado and other western states have some of the lowest unemployment rates in the country. Colorado was ranked 18th lowest among all 50 states; but all states bordering Colorado have even lower unemployment rates. With the economy in a downturn, state revenues have also been falling. Staff from the state legislature estimate that by fiscal year 2011-2012 the budget shortfall for the state will reach \$838 million dollars, putting pressures on all state-funded health programs.

The National Center for Children in Poverty estimated that in 2007, 32 percent of Colorado's children lived in low-income families whose income was less than 200 percent of the federal poverty level. Findings from the American Community Survey estimate that 15.3 percent of children lived in families whose income was at or below 100 percent of federal poverty level during this same time period. It is important to note that the rate of children living in low-income families is not evenly distributed throughout the population. Racial and ethnic minorities have much higher rates of children who live in low-income families than the majority population (White, 19 percent; African American/Black, 60 percent; and Hispanic/Latino, 56 percent). Rural (54 percent in 2006) and urban children (45 percent, 2007) are more likely to live in low-income families than suburban children (22 percent, 2007). The majority of children living in low-income families live in families where the parents are married (60 percent) and have at least one parent who has full-time year-round employment (65 percent) indicating that many of these families are having trouble meeting expenses because they are working in low-wage jobs.

The above data on income were reported for periods prior to the economic downturn. The Bureau of Economic Analysis found that personal income in Colorado declined by 1 percent in the 4th quarter of 2008 and another 0.7 percent in the first three months of 2009. Thus, it is important to remember that the data that are available on income most likely underestimate the number of women and children living in poverty and in low-income families in Colorado at this time.

Access to Health Care

Approximately 81 percent of Coloradans under the age of 65 have health insurance of some kind; over 86 percent of those under 19 have health insurance. These percentages are low, however, compared to other states. Colorado is ranked 36th among all states and the District of Columbia based on the percent of persons younger than 65 years old who have health insurance coverage, 43rd for those under age 19, and 49th for those under age 19 and below 200 percent of the federal poverty guideline.

The highest rate of coverage is for White non-Hispanics with over 87 percent reporting that they have health insurance. By contrast, less than half of all Hispanics younger than age of 65 with incomes below 200% of the federal poverty designation have health insurance. It is unknown how many of those who are insured are underinsured because deductibles and co-payments act as barriers to receiving care.

Several programs are available to reach low-income families and those without health insurance. Pregnant women and children living in households at or below 205 percent of the federal poverty level are eligible for health insurance coverage either through Child Health Plan Plus (CHP+) or Medicaid. Enrollments in these two programs have increased, and 543,000 Colorado children are now covered. A total of 7 percent of all Colorado children were enrolled in CHP+ at some time between July 2008 and June 2009, and 32 percent of all Colorado children were enrolled in Medicaid in the same period. Other health care services available to low-income and uninsured persons include 15 community health centers that operate 138 clinic sites in 35 counties. These are non-profit or public health centers where 90 percent of their patients have incomes below 200 percent of the federal poverty level and 40 percent are uninsured by either public or private programs.

/2012/

The overall population for Colorado was 5,160,189 in 2010, and is projected to grow to 5,622,019 by 2015. Births in 2009 were lower than the number in 2008, with 68,605 recorded. Preliminary estimates for 2010 also suggest a continuing decline to about 66,200 births. Deaths in 2009 totaled 31,132. Net migration was estimated at 48,200 in 2009.

In 2009, the Colorado high school graduation rate increased 0.7 percentage points to 74.6 percent. The Healthy People 2020 objective is to increase high school completion with a regular diploma within 4 years after starting 9th grade to 82.4 percent. Colorado's students continue to

fall far short of this new target.

Colorado's economy continued to recover slowly. As of March 2011, Colorado's unemployment rate stood at 9.2 percent. For the same time period, Colorado ranked 33rd in the nation, a level of unemployment that was higher than 32 other states plus the District of Columbia. Between January 2010 and January 2011, total non-farm employment increased by 13,100 jobs. The Colorado Legislative Council predicts slow job growth in 2011 along with an elevated unemployment rate. The FY 2011-12 state budget shortfall is estimated to be about \$600 million assuming the General Assembly maintains a 4 percent reserve. Budgets for MCH health-related programs will not be markedly changed.

Health insurance estimates for 2007 show that 82 percent of Coloradans under the age of 65 have health insurance of some kind and over 87 percent of those under age 19 have health insurance. These percentages are low, however, compared to other states. Colorado is ranked 35th among all states and the District of Columbia based on the percentage of persons younger than 65 years who have health insurance coverage, 42nd for those under age 19, and 47th for those under age 19 and below 200 percent of the federal poverty guideline.

In May 2010, the eligibility level for Child Health Plan Plus (CHP+) increased from 205 to 250 percent of the federal poverty level for pregnant women and children. Total enrollment of children in Medicaid and CHP+ is about 497,000, up from the previous year (450,000). The new total is driven by an increase of about 10 percent in the number of children enrolled in CHP+ and in the number of children enrolled in Medicaid. //2012//

/2013/

State Health Agency Priorities

In FY2011, CDPHE identified 10 key public health and environmental Winnable Battles where progress can be made over the next three years. They are: clean air, clean water, infectious disease prevention, injury prevention, mental health and substance abuse, obesity, oral health, safe food, tobacco and unintended pregnancy. The Winnable Battles were chosen with consideration of national and local goals (CDC's Winnable Battles, the Seven Priorities for EPA's Future and local public health and environmental priorities). The two Battles chosen as a focus this year for the Prevention Services Division, which houses the MCH programs, are obesity and unintended pregnancy. While many of the Winnable Battles overlap with the MCH priorities, obesity and unintended pregnancy are directly related to Priority 1: Promote preconception health among women and men of reproductive age with a focus on intended pregnancy and healthy weight and Priority 4: Prevent obesity among all children birth to 5.

Demographics

The total population of Colorado in 2012 is estimated at 5,196,200, a small increase from the previous year. Births in 2010 were 66,346, a decline of more than 2,000 from the 2009 total. Preliminary estimates for 2011 suggest another decline of at least 1,000 births from the 2010 level. The decline in births in recent years is thought to be attributable to the negative impact of the economic recession on household income, as couples wait to start or expand their families until their financial situations are more secure.

Deaths in 2010 were 31,435, and net migration was estimated at 38,100. Colorado is experiencing much slower growth compared to the period of time before the 2008 recession. Virtually no change has occurred in the distribution of the population by race/ethnicity reported in the full overview written two years ago, with about 70 percent of Coloradans identified as White/non-Hispanic, 20 percent as Hispanic, and 10 percent as other races.

Education

Colorado's education picture for high school graduation has not changed markedly since

last year, although a small improvement has been noted. According to the Colorado Department of Education, the graduation rate for the state's class of 2011 was 73.9 percent, strictly measured as the percentage of all ninth-graders graduating who had entered high school four years previously. The comparable figure for the class of 2010 was 72.4 percent. Since the definition changed beginning in 2010, graduation rates before that year are not comparable. Differences between major ethnic and racial groups are noticeable: the rate for White students was 81.1 percent; for black students, 64.6 percent; and for Hispanic students, 60.1 percent.

Economy

The state's economy has shown marked improvement since the report in last year's block grant. As of February 2012, the unemployment rate was 7.8 percent, a considerable drop from 9.2 percent in March 2011. Nonfarm payroll jobs increased by 48,000 between February 2011 and February 2012, compared to 13,100 reported for the previous year. The state's revenue picture has improved, and no new budget shortfall is predicted for FY 13; indeed, revenues estimated in March 2012 exceeded December 2011 estimates by \$165 million. The overall increase is mainly attributable to continued improvement in the job market and increased confidence among households and businesses, according to the Colorado Department of Labor.

Health Insurance

Health insurance for Coloradans continues to be problematic. The Colorado Health Access Survey in 2011 determined that 829,000 Coloradans do not have health insurance, a statistically significant increase from the last survey done two years previously. A total of 1.5 million people are also considered underinsured, so that more than 2.3 million people lack insurance or find what they do have is inadequate for their needs. One in six residents (16 percent) has no insurance and nearly two in six (29 percent) lack adequate insurance.

Total enrollment by children in Medicaid has increased from last year: over 429,000 received some service at some point during FY 11, as did 110,000 children enrolled in the Child Health Plan. These figures reveal a six percent increase over the combined total of 497,000 in the two programs in FY 10. //2013//

B. Agency Capacity

The following section describes each of the three primary units within the MCH Program that address pregnant women, mothers, infants, children and youth, including children and youth with special needs. Information about state support of communities, coordination with health components of community-based systems; and coordination of health services with other services at the community level is provided by unit. Responses to the questions about the CSHCN Unit's ability to provide and promote family-centered, community-based, coordinated care including care coordination services for CSHCN and facilitate the development of community based systems of services for such children and their families is integrated into the segment describing the CSHCN activities.

1. Services to pregnant women, mothers and infants

The Women's Health Unit (WHU) promotes health and wellness by promoting health and well-being, education and support for women and men of reproductive age in Colorado. The unit administers programs that promote lifestyles and behaviors that improve health status and emphasize the value of preconception health and family planning as public health priorities. The WHU provides funding, oversight, direction, consultation, training and technical assistance to state and local public and private entities serving women and families. The unit also participates in program development and systems building efforts at the state and local levels and in analysis of federal, state and local policies impacting these populations. The WHU administers the

Prenatal Plus, Nurse Home Visitor, Title X Family Planning Programs and the Colorado Family Planning Initiative. Under Maternal Child Health (MCH), the WHU oversees the Healthy Baby Campaign.

The WHU administers the Prenatal Plus Program on behalf of the Colorado Department of Health Care Policy and Financing (HCPF). Prenatal Plus is a Medicaid-funded program that provides care coordination, nutrition and mental health counseling to eligible pregnant women who are at a higher risk for delivering low birthweight infants. The program's multidisciplinary approach uses professionals to effectively address risk reduction for women enrolled in the program. Care coordinators address client needs throughout pregnancy and up to 60 days postpartum. Concerns addressed include housing, nutrition, employment, domestic violence, substance abuse, high life stress, and depression and/or other mental health problems that may increase the risk of delivering a low birthweight infant. The Prenatal Plus Program served approximately 1,900 women covering 21 counties through 34 sites comprised of local health agencies, community health centers, private non-profit organizations, and hospital-based clinics. This program will be administered by HCPF as of June 2011, given that administration of Medicaid benefits is the agency's primary mission. The MCH Program is focused on population-based and infrastructure-building activities.

The Nurse Home Visitor Program funds the Nurse-Family Partnership (NFP) model, which is an evidence-based, community health program that helps improve the lives of low-income mothers pregnant with their first child. An NFP mother is partnered with a registered nurse early in her pregnancy and receives ongoing nurse home visits (64 planned visits) that continue through her child's second birthday. Through ongoing home visits, mothers receive the care and support they need to have a healthy pregnancy, provide responsible and competent care for their children, and become more economically self-sufficient. The program disseminates nearly \$13 million in master tobacco settlement funds annually to 19 local public health and non-profits agencies for nurse home visitation services covering 53 of the states' 64 counties, approximately 2,590 mothers are served annually.

Nurse Home Visitor Program staff collaborate with HCPF to draw down federal Medicaid funding for Targeted Case Management (TCM) services provided to first-time, low-income (up to 200 percent of the Federal Poverty Level) mothers. The Nurse Home Visitor Program contributes the match for Medicaid reimbursements paid directly to the providers. Medicaid reimbursements support program expansion by generating additional program revenue, which is used to serve more families. Recent rate adjustments have resulted in a significant drop in reimbursement for NHVP TCM.

Title X Family Planning distributes about \$4.7 million to 29 local public health and non-profit agencies in 38 counties to provide family planning services to about 62,000 men and women. Title X Family Planning staff work closely with HCPF and the Centers for Medicare and Medicaid Services (CMS) in a long standing attempt to gain approval for a Reproductive Health 1115 Medicaid Waiver for family planning services. The waiver is intended to expand family planning services to men and women 19-50 years old with incomes up to 200 percent of the Federal Poverty Level. As a result of the federal health care reform, states now have the option to create a family planning-only benefit under a state plan amendment. The Title X Family Planning, Colorado Family Planning Initiative and Nurse Home Visitor Program funding is distributed among the network of local health departments, community health centers, hospitals and non-profit agencies to best support and build existing community infrastructure and to fund needed services in local communities. The Prenatal Plus program is administered throughout the state in coordination with this same local health network.

Per statute, the WHU staff cooperates with the University of Colorado Cord Blood Bank to transfer voluntary state income tax check-off funds from the state health department to the University for the Adult Stem Cells Cure Fund. The funds are used to increase public awareness and to encourage umbilical cord blood donations to public blood banks to aid in the cure of life-

threatening diseases.

WHU personnel serves on a number of teams, including private organizations and other public agencies, related to the unit's mission. These groups include the Adolescent Sexual Health Team, Advisory Council on Adolescent Health, Colorado Clinical Guidelines Collaborative, Colorado Nurse-Family Partnership Coordination Team, Perinatal Care Council, Folic Acid Task Force, Healthy Women/Healthy Babies, Infertility Prevention Project Regional Advisory Committee, March of Dimes State Programs Committee, Tobacco Cessation Workgroup for Pregnant Women and persons receiving Medicaid, Sexual Risk Prevention Group, Cessation Resource Alliance, Covering Kids and Families Workgroup, Maternal Mortality Review Committee, Prevention First NARAL Education Committee and the U.S. Department of Health and Human Services/ Office of Public Health and Science/ Women's Health/ Region VIII Partners.

The WHU supports local communities through a variety of means, including state, federal and private funding, training and technical assistance. The MCH generalists and specialists work with 15 local county public health agencies on their MCH plans, which include preconception and prenatal goals. The MCH generalist within the WHU provides consultation and assistance to local health departments with their needs assessment and preparation of their three-year MCH plans for all three core MCH populations.

The Healthy Baby Campaign provides support and resources to local communities related to low birth weight and inadequate weight gain through technical assistance, the campaign website and continued dissemination of campaign materials, including brochures, weight grids and BMI wheels.

The Colorado Family Planning Initiative, funded by an anonymous donor, distributes \$4.8 million to 29 local public health and non-profit agencies in 38 counties to help expand family planning services to men and women.

MCH staff worked with the Colorado Clinical Guidelines Collaborative and the HealthyWomen HealthyBabies Preconception Care Workgroup to develop a Preconception and Interconception Clinical Care Guideline. The guideline was completed in December 2009 and disseminated to nearly 4,500 health care providers around the state.

A Tobacco Cessation Workgroup for Pregnant Women and persons receiving Medicaid were developed with the State Tobacco Education and Prevention Partnership to address the high rates of tobacco use among these populations. The group's goal is to increase use of the Colorado QuitLine service and Medicaid's tobacco cessation benefit. The staff also worked with the QuitLine to enhance the protocol to more effectively target pregnant and postpartum women.

WHU personnel also participates in a number of groups related to community-based health systems, including Medical Policy Advisory Committee, Policy Advisory Committee and the Medicaid Waiver Advisory Committee for the Title X Family Planning program, Prenatal Plus Advisory Committee and the MCH Coordinating Team.

2. Preventive and Primary Care Services for Children

The Child, Adolescent, and School Health (CASH) Unit leads efforts to improve the health and well-being of all Colorado children and adolescents through health promotion, public health prevention programs and access to health care. The unit provides leadership in setting priorities; identifying and promoting best practices to address the priorities; and working with local public health agencies, early childhood councils, schools and other state and community partners to develop and implement comprehensive, coordinated strategies to improve the health of children and adolescents.

The organizational structure of the unit includes three teams: an early childhood team; an

adolescent and school health team; and the Tony Grampsas Youth Services team. Across these three teams, a variety of state- and federally-funded programs and initiatives to address the needs of children, youth and families are administered.

The Early Childhood Team is currently focused on the following programs/initiatives: the Early Childhood Comprehensive Systems Grant, the Early Childhood Health Integration Initiative, the Assuring Better Child Health and Development Project, and the Early Childhood Obesity Prevention Needs Assessment Project.

The Early Childhood Systems (ECCS) Grant supports a statewide alliance of early childhood partnerships working together to create a comprehensive system for young children birth to age eight and their families. The Early Childhood Colorado Framework and the Framework in Action State Plan were developed to guide the state's systems-building efforts. Colorado's Lieutenant Governor has identified early childhood issues as a top priority and the ECCS Director, a CDPHE employee, is now physically located within the Office of the Lieutenant Governor.

The CASH Unit receives funding from a local foundation to provide technical assistance to those local early childhood councils receiving Early Childhood Health Integration grants. The technical assistance supports the integration of health into local early childhood systems-building efforts. A staff person was hired to assist the local councils in the development and implementation of local health integration plans.

The CASH and Health Care Program for Children with Special Health Care Needs Units work together to implement the Assuring Better Child Health and Development Project that focuses on: promoting the use of standardized developmental screening tools in primary health care settings to help increase early identification of developmental concerns; and strengthening the referral and service-delivery processes for early intervention.

In partnership with the Nutrition Services Branch (WIC and CACFP) and the Colorado Physical Activity and Nutrition Program, the CASH Unit has coordinated an early childhood obesity prevention needs assessment project. The results of the needs assessment will be used to inform a statewide strategic plan to address early childhood obesity, with a focus on prenatal through age two.

The Adolescent and School Health Team within the Unit, is focused on the School-Based Health Center Program, the Coordinated School Health Program, school health technical assistance, and youth sexual health initiatives.

The School-Based Health Center Program, in collaboration with the Colorado Association for School-Based Health Care, convenes, facilitates, and provides technical assistance to schools and provider agencies that develop, implements, and supports approximately forty school-based health centers throughout the state. The School-Based Health Center Program, located within the CASH Unit, receives one million dollars in state general fund dollars to support school-based health centers throughout Colorado. In addition, the Colorado Department of Health Care Policy and Financing, in collaboration with CDPHE, has received a five-year evaluation grant for school-based health centers in Colorado funded through the Child Health Insurance Program Reauthorization Act. In order to meet the grant deliverables, the CASH Unit will be hiring one additional full-time staff person.

Colorado is in the second year of a five-year funding cycle for the Coordinated School Health Program from the Centers for Disease Control and Prevention. The funding supports a partnership between the Colorado Department of Education and CDPHE to build state and local infrastructure to support the coordinated school health model, with an emphasis on nutrition, physical activity and tobacco prevention. In addition to CDC funding, the Coordinated School Health Program receives funding from a local foundation to support school health teams throughout Colorado to address the program's priorities.

One of the three MCH Generalist Consultants is located within the CASH Unit, and has expertise in school nursing. As part of this role, the consultant collaborates with the Colorado Department of Education's statewide nurse consultant to provide technical assistance and training for school nurses.

The CASH Unit is providing leadership for a collaborative effort to address youth sexual health. The Unit is partnering with the Women's Health Unit, the STI/HIV Program, Colorado Youth Matter (formerly, the Colorado Organization on Adolescent Parenting, Pregnancy, and Prevention), Pregnancy, and Prevention, and the Department of Education to create a statewide youth sexual health strategic plan.

The third team within the CASH Unit implements is the Tony Grampsas Youth Services Program is focused on the prevention of youth crime and violence, as well as reducing child abuse and neglect. The Tony Grampsas Youth Services Program, funded with master settlement tobacco funds, supports over 90 contracts with local non-profit organizations throughout the state to prevent youth crime and violence, as well as child abuse and neglect. These funds support early childhood programs, student drop-out prevention programs, youth mentoring, restorative justice, after-school programs, as well as a variety of other programs targeting high-risk youth and families.

Advisory groups convened by the CASH Unit include the Early Childhood Partners, the Interagency School Health Team, the Advisory Council on Adolescent Health, the Colorado Youth Development Team, the Youth Partnership for Health and the Tony Grampsas Youth Services Board. The Early Childhood Partners is a multi-disciplinary group of public and private early childhood stakeholders who advised in the creation, and now implementation, of the Early Childhood Colorado Framework in Action State Plan. The Interagency School Health Team serves as the advisory group for the Coordinated School Health Program. The Advisory Council on Adolescent Health is an interdisciplinary group of adolescent health experts and community advocates, who advise the Colorado Department of Public Health and Environment, educate and inform the public, and advocate for policies and programs to improve the health and well-being of all Colorado adolescents. The Colorado Youth Development Team is a public-private partnership of youth and professionals that raises awareness, promotes, enhances and unites positive youth development efforts and strategies across the State of Colorado. The Youth Partnership for Health is composed of 25 diverse youth, recruited from all parts of the state. YPH advises the state health department on policies and programs that affect adolescents. The Tony Grampsas Youth Services Board is an 11-member that provides guidance and oversight for the TGYS Program. Appointments to the board are made by the Governor, the Speaker of the House of Representatives, the Senate President, and the Senate Minority Leader.

Collectively, these advisory groups include representatives from the Department of Human Services (Divisions of Behavioral Health Services, Child Care, Youth Services, Child Welfare, and the Office of Homeless Youth); the Department of Transportation; the Department of Education (Coordinated School Health Program, School Nursing Services, Special Education Services, Early Childhood Initiatives); the Department of Public Safety; the Colorado State University Cooperative Extension Program; higher education; Colorado-based foundations and other many other public and private partners.

3. Services for Children with Special Health Care Needs (CSHCN)

The Children with Special Health Care Needs Unit includes the Health Care Program for Children with Special Needs (HCP), the Newborn Screening Programs, the Family Leadership Initiative and The Colorado Medical Home Initiative (CMHI).

The unit's purpose is to build a sustainable system of care for CSHCN and their families in alignment with the six CSHCN national outcome measures. To champion a medical home approach for families, the HCP Program has chosen two core strategies; these are care coordination and local systems building. It is expected that successful implementation of these

strategies will decrease systems barriers to care and reduce unmet needs among families.

All programs/initiatives in the CSHCN Unit collaborate with other state agencies and private organizations for children with special health care needs.

A statewide clinic system exists for children with special health care needs resulting from the coordination of local and state resources. The HCP program provides gap filling care coordination services and strives to avoid duplication and to compliment other similar services in the state. The HCP state program contracts with 15 counties to serve as regional offices to provide administration and implementation of the program statewide. Program planning and reporting processes are implemented with state staff support and consultation. HCP-sponsored clinic programs provide access to specialty medical care, genetic, and diagnostic and evaluation services. These clinics are important in ensuring that families have access to specialized pediatric health services in rural and frontier areas of the state.

HCP has developed a care coordination definition describing three levels of coordination, service standards and an evaluation process. The care coordination definition and standards are used with Medicaid EPSDT outreach, Early Intervention Colorado, children receiving clinic services, the Colorado Responds to Children with Special Needs birth defects registry, and for infant hearing screening follow-up.

Public health nurses and HCP's regional office teams work together so that there is coordination at the local level among the services needed by families and children. All local HCP agencies provide resource and referral information. Each HCP agency provides care coordination services to targeted populations depending on community need, capacity, and reimbursement. Additionally, local systems building services are provided in every county. Most local HCP staff are also involved in other interagency work such as serving on child protection teams, working with school districts to support parents in special education staffing, and developing Individual Education Plans or Individual Family Service Plans.

HCP also provides access to specialty services and coordination of primary and specialty care by providing clinics in outlying and rural communities. Last year there were 2,428 community encounters by public health contractors with other providers, agencies and organizations to organize services for ease of use by families. Access to specialty medical providers was addressed through 99 Specialty Clinics (Orthopedic 8, Neurology 64, Cardiology 5, Rehabilitation 18, and Pediatric 4). There were 1,116 total completed patient visits offered through 14 specialty clinic sites in 13 counties.

Through the state health department's laboratory, the Newborn Screening Program provides screening at birth and again at eight to 14 days of age for a variety of metabolic and genetic diseases for all infants born in the state. The program provides data to ensure appropriate follow-up with contract sites. The Newborn Hearing Screening Program connects hospital birth certificate clerks and hospital audiologists with local HCP and early intervention personnel to ensure follow-up screening and referral into early intervention. The metabolic screening program connects families with The Children's Hospital and community-based services. The program contracts with The Children's Hospital for follow-up services and makes connections to community supports to develop a medical home approach for children with metabolic conditions.

The Colorado Infant Hearing Program tests the hearing of infants at birth to identify deaf and hearing impaired infants and makes appropriate referrals. The Newborn Hearing Screening Program provides support to local communities that have low follow-up rates, by developing Early Hearing Detection and Intervention (EHDI) teams to develop systems for follow-up and referral into early intervention. The Colorado Infant Hearing and Newborn Screening Advisories address standard practices, funding, and program development. The committee is comprised of parents, consumers, public health professionals, physicians, and other stakeholder state agencies.

The Colorado Infant Hearing Program has a CDC Early Hearing Detection and Intervention (EHDI) grant that is used to integrate several data systems: the newborn hearing; newborn metabolic screening; the Colorado Responds to Children with Special Needs birth defects registry data, metabolic clinics at The Children's Hospital, and the Traumatic Brain Injury Program.

Colorado Responds to Children with Special Needs (CRCSN) is the state's birth defects monitoring and prevention program. CRCSN and HCP share data so that HCP can link children and families, who have been identified with birth defects and related disabilities, with early intervention services and potentially care coordination.

The CSHCN Unit's Family Leadership Initiative partners with the Department of Education and the Department of Human Services, early childhood efforts, the state Prevention Leadership Council of six state departments, as well as non-profit organizations to advise the development of family engagement and leadership in the state. These partners promote the importance of family engagement and leadership and help to identify funding sources for local implementation of the Family Leadership Training Institute. The CSHCN Unit Family Leadership Initiative supports communities to implement the Family Leadership Training Institute (FLT), an eleven week course to teach civic leadership and to support community projects for families and children.

The Colorado Medical Home Initiative (CMHI) is a state systems building initiative to improve the quality of the pediatric health care system to ensure a comprehensive, coordinated medical home team approach for all families. The CMHI partners with the Medicaid agency to implement Colorado's Medical Home legislation and to build the infrastructure to support a medical home system. The initiative partners with a broad array of stakeholders to build a system to support a medical home approach for all children. The Department of Health Care Policy and Financing, the Medicaid and SCHIP agency, partners with the CMHI to provide the clinical practice and quality improvement to ensure a medical home approach. The CMHI convenes partners to address state systems development, including the role of public health and families/consumers.

The CMHI Advisory Board provides updates and networking for over 50 agencies, organizations and individuals on a bi-monthly basis. The CMHI also provides information about the state's medical home efforts that connect and build infrastructure for an improved system. CMHI provides tools such as a medical home website and collects information about local projects.

The Integrated Services for Children with Special Health Care Needs implementation grant supports a project that is taking action to overcoming local systems barriers to a medical home approach in four counties (Boulder, Summit, Larimer and Mesa).

The Colorado Department of Human Services contracts with the HCP Program to provide care coordination through local offices to families of children with traumatic brain injury. Local HCP staff work closely with early intervention coordinators to assure that health-related early intervention services are coordinated.

The HCP program also works closely with Early Intervention Colorado at the Department of Human Services, Division of Developmental Disabilities to implement HCP care coordination standards, and to define respective roles in serving infants and toddlers with special health care needs at the community level. An HCP staff member represents the program and the department on the Interagency Coordinating Council and the state level Memorandum of Understanding committee.

In Colorado, blind and disabled individuals under the age of 16 receive rehabilitation services under Title XVI (SSI). All SSI beneficiaries under 16 years of age are automatically eligible for Medicaid. Community-based EPSDT outreach workers call all newly enrolled SSI beneficiaries to assess whether each child's medical and support needs are being met. In the majority of cases, Medicaid is covering all of the medical needs. HCP personnel at the local community level provide care coordination when families have more complex medical or psychosocial needs.

Other Programs Supported by MCH funds

Child and maternal mortality reviews are done by a multi-disciplinary team working together to determine the underlying causes of maternal and child deaths. The reviews also promote preventive programs that may help reduce premature death. Multiple agencies and department programs are involved in both reviews.

The Family Healthline is the statewide MCH information and referral service. The Healthline resource specialist assists women, families, and individuals in locating free or low-cost health care services. Information is provided about other programs such as emergency shelters, food subsidies, or mental health. The Healthline specialists speak fluent Spanish and English.

Culturally competent care is provided to the State's MCH populations. The state health department has an Office of Health Disparities and a Citizen's Commission on Minority health. The office is dedicated to eliminating racial and ethnic health disparities in Colorado by fostering systems change and capacity building through multi-sector collaboration, so that all Coloradans will have equal opportunity to be healthy, regardless of race and ethnicity.

The Minority Health Advisory Commission was created in 2005 and established in statute in 2007. The commission provides a formal mechanism for community members to provide input on health programming at the level of the Colorado Department of Public Health and Environment Executive Director. It also helps the department determine culturally innovative data collection strategies and strengthens collaborations between the Colorado Department of Public Health and Environment and communities of color.

The Prevention Services Division, where the MCH Program is housed, has developed a Cultural Competence Plan based upon a division-wide assessment. Additionally, all staff received training this year on the Social Determinants of Health and will receive additional training on cultural competence in the coming year. All division personnel are required to participate in cultural competency training as part of their annual performance plan and all divisions units will implement activities that support the plan.

In 2009, the Child, Adolescent and School Health Unit coordinated a learning circle series, entitled, the Dimensions of Diversity. Part I included an overview of the social determinants of health framework, and a presentation of data that demonstrates how health disparities are a result of the social determinants of health. Part II focused on strategies for working in multi-cultural settings and was facilitated by the CDPHE Office of Health Disparities. The unit is continuing to participate in monthly learning circles. In December 2010, the unit will create a photo essay project that captures observations and insights.

Staff from both the CASH and Women's Health Units also viewed and discussed the Unnatural Causes six-segment documentary, produced by PBS, which illuminates the root causes of the socio-economic and racial inequities in health.

In 2009, the Women's Health Unit created the Health Equity Learning Community. The goal of this learning community is to address health equity and disparities through staff learning and practical application of data, information and experiences. The learning community objectives are all related to improving staffs knowledge of health disparities, health equity and cultural competency. In December 2010, the unit will create a photo essay project that captures community-based observations and insights related to the social determinants of health.

The CSHCN Unit held a conference about cultural competency in October 2008 that featured Wendy Jones from the National Center for Cultural Competence with follow-up meeting scheduled in 2009.

Data collected, analyzed and used through the MCH program is available by gender, race and

ethnicity so information about culture does inform program development and service delivery.

/2012/1. Services to pregnant women, mothers and infants

In 2010, the Women's Health Unit changed the name of the Prenatal Program to Maternal Wellness given that the work of the team encompasses the health of women and their families from preconception and pregnancy through postpartum and into early childhood.

Administration of the Medicaid-funded Prenatal Plus Program was transferred to the Department of Health Care Policy and Financing (HCPF) effective July 1, 2011, where it will continue as a Medicaid benefit under the direction of the state Medicaid agency. In 2010, the Prenatal Plus Program served approximately 2,000 women in 21 counties.

WHU completed the final application process for \$1,842,294 for a 27-month grant period to provide evidence-based home visiting programs for children and families in at-risk communities. Funding is expected to be distributed to local providers in Colorado by September 2011.

The Title X Family Planning Program, served 68,175 clients in 2010, a 12.2 percent increase. The number of Title X clients using a LARC method (intrauterine devices or contraceptive implants) rose by 48 percent compared to 2009, for a total of 8,005 LARC users.

2 & 3. Preventive and Primary Care Services for Children and Services for Children with Special Health Care Needs

Upon the retirement of the Children with Special Health Care Needs (CSHCN) Unit Director, a new Children and Youth Branch was formed in April 2011, integrating the CSHCN and the Child, Adolescent and School Health (CASH) Units. The branch is directed by Rachel Hutson, who previously served as the Director of the CASH Unit. The mission of the Children and Youth Branch is to: "Maximize the health and well-being of all Colorado children, youth and families by partnering with communities." The integrated focus and new organizational structure provide more opportunities to enhance population-based efforts on behalf of all children and youth, including those with special health care needs. The branch's organizational chart is attached.

As of June 2011, the Early Childhood Systems (ECCS) Director position will be transferred to the Lt. Governor's Office and CDPHE will contract with the Office for the ECCS grant deliverables.

The Children and Youth Branch continues to receive funding from a local foundation to provide technical assistance to local early childhood councils to promote the integration of health into local early childhood systems-building efforts. These local health integration efforts align with several of the state's MCH priorities, most specifically those related to improved developmental screening and referral rates; prevention of dental caries in all children birth to five; and reducing barriers to a medical home approach.

The Early Childhood Team also supports the Assuring Better Child Health and Development Project (ABCD) that focuses on: promoting the use of standardized developmental screening tools in primary health care settings to help increase early identification of developmental concern; and strengthen the referral and service-delivery processes for early intervention.

In partnership with the Nutrition Services Branch (WIC and the Child and Adult Care Food Program) and the Healthy Living Branch, members of the branch's Early Childhood Team coordinated an early childhood obesity prevention needs assessment project. The results of the needs assessment were presented to 40 key stakeholders who provided input to inform a CDPHE action plan to address early childhood obesity, with a focus on prenatal through age two.

The Local Implementation Team includes branch staff who works specifically with local public health agencies to implement the MCH contract components for the Health Care Program (HCP) for Children with Special Needs. The program's purpose is to build a sustainable system of care for CSHCN and their families in alignment with the six CSHCN national outcome measures. To champion a medical home approach for families, the HCP Program has chosen three core

strategies: care coordination, specialty clinics and local systems building.

Colorado Responds to Children with Special Needs (CRCSN) is the state's birth defects monitoring and prevention program. CRCSN and HCP share data so that HCP can link children and families, who have been identified with birth defects and related disabilities, with early intervention services and potentially care coordination. CRCSN and HCP are currently exploring a partnership with Family Voices to assist with the CRCSN follow-up through a pilot project with one of the local HCP programs.

CDPHE returned administration of the traumatic brain injury (TBI) program to The Colorado Department of Human Services (CDHS) as of June 30, 2011. Children and youth with TBI will continue to be served with HCP care coordination as needed.

With the development of the new branch, the Tony Grampass Youth Services Program, which is focused on the reduction of youth crime and violence, was moved to the Injury, Suicide and Violence Prevention (ISVP) Unit.

Within the past year, representatives from the Advisory Council on Adolescent Health and the Colorado Youth Development Team, developed a plan to integrate the two teams into one larger statewide public-private partnership that will focus on improving the health and well-being of Colorado youth. The purpose of the new group will be to finalize a common youth framework for professionals across the state; develop and implement strategies to improve youth health and well-being; build and enhance partnerships at the state and local levels; and provide networking and professional development opportunities for members.

Also in the past year, 180 employees from the Prevention Services Division participated in a six part cultural competency training for a total of 18 hours per person.//2012/

/2013/

The Women's Health Unit is now the Women's Health Branch (WHB). The WHB administers the Title X Family Planning Program, Colorado Family Planning Initiative, Nurse Home Visitor Program (NHVP) and Maternal, Infant and Early Childhood Home Visitation (MIECHV)]. The state's Breast and Cervical Cancer Screening program, Women's Wellness Connection, was transferred to the WHB in November of 2011 in order to house all Division direct service delivery programs within one Branch. The WHB is also responsible for two MCH priorities: preconception health and pregnancy-related depression.

The MIECHV program funds the following evidence-based home visitation models: NFP, Parents as Teachers (PAT), Home Instruction for Parents of Preschool Youngsters (HIPPO), Healthy Steps and the Early Head Start Home-Based Program. Initial MIECHV funding is allocated to the state's five highest risk communities based on a set of risk assessment criteria set forth in the grant application.

In 2011, the WHB received \$12.7 million in NHVP funds to provide the NFP model to 2,500 mothers. Under MIECHV, the branch also received \$1.8 million in Year 1 formula funding, \$2.3 million in Year 2 formula funding and \$3.7 million in Year 1 competitive funding for local planning and implementation of evidence-based home visitation programs.

The Title X Family Planning Program served 64,938 clients in 2011. The number of Title X clients using a LARC method (intrauterine devices or contraceptive implants) increased in 2011 to 9,257 users. For feasibility reasons and with the advent of health care reform, HCPF rescinded the Reproductive Health 1115 Medicaid Waiver application for family planning in December 2011 in anticipation of greater health care coverage for the nation, including reproductive health services.

The Tobacco Cessation Workgroup for Pregnant Women and Persons Receiving Medicaid

completed its work to increase use of the Quitline and disbanded.

The MCH Team formed in October 2011 and moved into the CYB in April 2012. The MCH Program Manager supervises the three MCH Generalist Consultants who support local public health agencies and the MITs, as well as the MCH Program Specialist who prepares Colorado's Block Grant application and SSDI. This structural move further supports the integration of the MCH and HCP local implementation efforts, in addition to fostering connections with the population-based efforts of the Early Childhood Unit and the Youth and Young Adult Units that were already housed within the branch. In addition, the Interagency Prevention Systems Initiative moved into the CYB. The initiative was created through legislation in 2000 and is charged with aligning state agency prevention efforts that target children and youth.

In November 2011, the Health Care Program for Children with Special Needs (HCP) launched a new care coordination model and CYSHCN data system. The care coordination model includes five core components: an intake interview; assessment of need; development of an action plan; a six-month review of action plan progress; and case closure. This standardized framework, and associated data collection process, is enabling the HCP program to collect more consistent and accurate data that reflects the volume and type of service provided by HCP care coordinators. HCP is still supporting specialty clinic services and has standardized the approach for clinic delivery within a regional system.

Cultural competency training and translation/interpretation services for state staff continue in accordance with the division's cultural competency strategic plan. //2013//

C. Organizational Structure

The Colorado Department of Public Health and Environment is one of sixteen Colorado state agencies that are all located in Denver. Martha Rudolph is the Executive Director, and reports to Governor Bill W. Ritter, Jr. A CDPHE organization chart is posted at <http://10.1.0.61/ic/orgchart.pdf>.

The MCH program is located within the Prevention Services Division (PSD) which has two centers: the Center for Healthy Families and Communities and the Center for Healthy Living and Chronic Disease Prevention, along with an Office of Policy, Fiscal Analysis and Operations. A cross-divisional Epidemiology, Planning and Evaluation Unit was developed about three years ago which provides all of the epidemiology and evaluation services for all programs within the PSD, including MCH. Jillian Jacobellis, PhD directs the division.

The Center for Healthy Families and Communities houses all MCH activities and is directed by Karen Trierweiler, MS, CNM who is also the state MCH Director. The Center for Healthy Families and Communities includes the Special Supplemental Nutrition Program for Women, Infants and Children (WIC); the Child and Adult Care Food Program housed with WIC; the Women's Health Unit (Family Planning, Prenatal, Prenatal Plus and Nurse Home Visitor Programs); the Child, Adolescent & School Health Unit (Early Childhood Initiatives, Adolescent Health Program, School-Based Health Centers, Coordinated School Health Program and the Tony Grampas Youth Services Program); the Children with Special Health Care Needs Unit; the Injury, Suicide and Violence Prevention Unit; and the Center's Fiscal and Administrative Services Unit.

The Center for Healthy Living and Chronic Disease Prevention includes the Chronic Disease Prevention Branch (Diabetes; Cardiovascular Disease; Comprehensive Cancer Program; Breast & Cervical Cancer Program; and the Oral Health Unit; the Healthy Living Branch that includes the Healthy Aging Unit, State Tobacco Education and Prevention Partnership, Colorado Obesity, Physical Activity and Nutrition Unit; and a Center-specific Fiscal and Administrative Services Unit. The Center has recently been reorganized according to function as opposed to program.

The Office of Policy, Fiscal Analysis and Operations includes the Interagency Prevention Systems for Children and Youth, which contains the Inter-Departmental Prevention Leadership Council; the Primary Care Office; and provides coordination of the Division's overall fiscal policy and human resources functions.

The Epidemiology, Planning, and Evaluation (EPE) Branch works collaboratively with programs in the Prevention Services Division and other partners to conduct systematic collection, analysis and interpretation of population-based and program specific health and related data in order to assess the distribution and determinants of the health status and needs of the population, for the purpose of planning and implementing effective interventions, promoting policy development, and evaluating the outcome of these activities.

MCH funds are distributed to local contractors (primarily local health agencies) via a formal planning process. Based on the state-defined MCH priorities, contractors are asked to assess and prioritize the local health status needs of the prenatal, child and adolescent, and children with special health care needs populations and to identify how their allocated MCH funds will be used. The services or activities they implement are expected to address the Colorado MCH priority areas. The state-level MCH program assists agencies by providing consultation and technical assistance in developing and carrying out plans and managing statewide initiatives and efforts. More information about the MCH planning process and forms are at www.mchcolorado.org.

/2012/ Dr. Christopher Urbina, MD, MPH is the new Executive Director of the CDPHE, reporting directly to Governor John Hickenlooper. A CDPHE organization chart is posted at <http://www.cdphe.state.co.us/ic/orgchart.pdf>.

Chris Lindley, MPH, PhD(c) now directs the PSD.

The Center for Healthy Families and Communities now includes the Special Supplemental Nutrition Program for Women, Infants and Children (WIC); the Child and Adult Care Food Program housed within WIC; the Women's Health Unit (Title X Family Planning, Colorado Family Planning Initiative, Maternal Wellness, Home Visitation Programs, Healthy Baby Campaign and Adult Stem Cells Cure Fund); the Children and Youth Branch (Early Childhood Initiatives, Adolescent Health Program, School-Based Health Centers, Coordinated School Health Program and Children with Special Health Care Needs); the Injury, Suicide and Violence Prevention Unit (includes the Tony Grampsas Youth Services Program); and the Center's Fiscal and Administrative Services Unit. An organizational chart for the center is attached.

After re-organization, The Center for Healthy Living and Chronic Disease Prevention now includes the Chronic Disease Prevention Branch (Self Management Services Unit, Oral Health Unit, Screening Services Unit and Health Systems Change Unit); the Healthy Living Branch (Policy Development Unit, Policy Implementation Unit, and Healthy Communities Unit); the Healthy Equity, Communications and Planning Branch (Health Communications Unit and Health Equity Unit) and a Center-specific Fiscal and Administrative Services Unit.

The Maternal, Infant and Early Childhood Home Visiting (MIECHV) program fits in closely with the overall MCH program at CDPHE. Several outcome measures established for the MIECHV program directly relate to MCH priorities, including the promotion of preconception health; screening and referral for pregnancy related depression; and developmental and social-emotional screening and referral of children birth to 5. Other outcome measures reflect an intention to impact the overall health of children, including oral health, and to improve collaboration between systems and with families. //2012//

/2013/ The former Center structure was dismantled in August 2011. The Title V MCH Director now also serves as the Section Chief for Programs and Services and Deputy Division Director for the Prevention Services Division. Programming under the purview of

the Title V Director include the Special Supplemental Nutrition Program for Women, Infants and Children (WIC); the Child and Adult Care Food Program housed within WIC; the Women's Health Branch (Family Planning, Maternal Wellness, Home Visitation Programs, Healthy Baby Campaign, Adult Stem Cells Cure Fund and Women's Wellness Connection); the Children and Youth Branch (Early Childhood Initiatives, Adolescent Health Program, School-Based Health Centers, Coordinated School Health Program and Children with Special Health Care Needs); the Injury, Suicide and Violence Prevention Branch (includes the Tony Grampas Youth Services Program); the Healthy Living and Chronic Disease Prevention Branch; and the Health Equity and Access Branches, which includes Oral Health. An organizational chart for the division is attached. The latest division re-organization has established separate Branches for Prevention Health Policy, Systems and Analytics, Health Communications and Fiscal and Administrative Operations, which includes the Epidemiology, Planning and Evaluation Branch.

Legislation was crafted during the FY13 session to establish an Office of Early Childhood within the Colorado Department of Human Services (DHS). The following programs would have been transferred to the new office: Colorado Children's Trust Fund and Family Resource Center programs, the Tony Grampas Youth Services Program and both the federal MIECHV and state nurse home visitor programs. The legislation did not pass, and the DHS plans to establish a similar office, aggregating internal human service programs related to early childhood. The programs mentioned earlier will continue to be housed at CDPHE. //2013//

An attachment is included in this section. IIIC - Organizational Structure

D. Other MCH Capacity

Title V funds and matching state funds support 31.50 FTE exclusively housed at the Colorado Department of Public Health and Environment in Denver.

The Maternal and Child Health Program is directed by Karen Trierweiler, MS, CNM. It is comprised of four units. A Fiscal and Contracts Management Section is led by Laurie Freedle. The Director of the Women's Health Unit is Esperanza Ybarra; Rachel Hutson RN, MS, serves as the Director of the Child, Adolescent, and School Health Unit; and Kathy Watters, MA, directs the Children with Special Health Care Needs Unit. The SSDI Coordinator is Helene Kent. Organizational charts for the Center for Health Families & Communities is attached.

There is one paid FTE family consultant within the Health Care Program for Children with Special Health Care Needs at the state health department in Denver. Each of the regional offices associated with the program has a family consultant.

Brief Biographical Information for Key MCH Management Staff

Karen Trierweiler, CNM, MS is the Director of the Center for Healthy Families and Communities and the state MCH Director. Ms. Trierweiler is a certified nurse midwife with over 30 years of experience in women's health as a clinician, educator, and public health professional. She received both her undergraduate and Master's degrees in Nursing from the University of Colorado. Ms. Trierweiler has worked at the Colorado Department of Public Health and Environment since 1990, originally as a nurse consultant, and formerly served as the Director of the Women's Health Section and Title X program director.

Laurie Freedle, BS has been the Director of the Fiscal Services Unit for the Center for Healthy Families and Communities since 2008. Her Unit administers all aspects of fiscal management for Maternal Child Health Block Grant, Women's Health Unit, Injury, Suicide and Violence Prevention Unit, Children with Special Health Care Needs Unit, and Child, Adolescent School Health Unit. Previously, Ms. Freedle was with the Colorado Department of Transportation for eleven years. She was the finance director and managed over \$1 billion in state, federal, and local government funding, as well as a \$1.3 billion bonding program.

Gina Febbraro, MPH is the Maternal and Child Health (MCH) Program Manager. Prior to joining MCH, Gina managed a variety of MCH-related programs including the Tony Grampsas Youth Services Program at the CDPHE and a sexuality education and teen pregnancy prevention program at Girls Incorporated of Metro Denver. Gina received her Master's in Public Health from the University of North Carolina, Chapel Hill and her Bachelor's degree from the Pennsylvania State University.

Kathy Watters, MA is the Director of the Children with Special Health Care Needs Unit. Kathy Watters came to the Colorado Department of Public Health in 1984 from the Colorado Department of Education's State School for the Deaf and Blind. She received her undergraduate degree in Communication Disorders from the University of Cincinnati and her Master's degree in Audiology from the University of Colorado-Boulder. Kathy began her career at the state health department as the Home Intervention Program Director. She subsequently became the Hearing and Speech Director, the Consultation Team Director, the HCP Assistant Director, and the HCP Director. She is now the Unit Director for Children with Special Health Care Needs.

Rachel Hutson RN, MS is the Director of the Child, Adolescent and School Health Unit. Ms. Hutson has been with the Colorado Department of Public Health and Environment since 2001, as the Director of Early Childhood Initiatives. She now provides supervision and oversight for Early childhood Systems Development, the Coordinated School Health Program, the School-Based Health Center Program, Adolescent Health Program, and the Tony Grampsas Youth Services Program. Prior to working for the department she was the Pediatric Health Services Coordinator at the Colorado Coalition for the Homeless, where she provided primary health care services as a Pediatric Nurse Practitioner at the Stout Street Clinic in Denver. Ms. Hutson received a BA from Franklin and Marshall College and a Masters in Nursing from Yale University.

Esperanza Ybarra, BSW, MAOM is the Director of the Women's Health Unit. Ms. Ybarra assumed the director position this year. She directed the Nurse Home Visitor Program for over six years and worked with the Women's Health Unit for three years. She has a variety of experiences in managing health and social services programs. Ms. Ybarra holds a masters degree in organizational management and is a licensed social worker.

Mandy Bakulski, RD is the Prenatal Program Director in the Women's Health Unit. Ms. Bakulski is a registered dietitian and has worked in the field of prenatal health for nearly 10 years. She received her bachelor's degree in Nutrition Science & Dietetics from Colorado State University. Ms. Bakulski has worked at the Colorado Department of Public Health and Environment since 2004, originally as the Director of the Prenatal Plus Program.

Gabriel Kaplan, PhD is the branch director of Epidemiology, Planning and Evaluation. Dr. Kaplan recently joined the Department of Public Health and Environment after spending the last 5 years as an assistant professor of public policy at the University of Colorado, Denver School of Public Affairs. Dr. Kaplan received his Ph.D. in public policy from Harvard University in 2002 and his Masters in Public Affairs from Princeton University in 1994. He has worked as an analyst for the US Senate, for government agencies overseas, and nonprofit clients.

Helene Kent RD, MPH is the SSDI Coordinator. She has over 20 years of experience with the Colorado Department of Public Health and Environment, including previous tenure as the Director of the Women's Health Section within the MCH Program. Ms. Kent was the Director of Assessment and Assurance for the Association of Maternal and Child Health in Washington DC.

/2012/ Laurie Freedle is no longer with the CDPHE. Karen Trierweiler serves as the interim Director of the Fiscal and Contracts Management Section. Plans are to consolidate all fiscal and administrative services at the Division versus Center level.

Kathy Watters retired from the CDPHE.

The new Child and Youth Branch Director is Rachel Hutson RN, MS, who previously served as the Director of the Child, Adolescent and School Health Unit. Ms. Hutson will also serve as the state's CSHCN Director.

Mandy Bakulski is now the Maternal Wellness Director.

The new SSDI Coordinator is Risa Friedman, MPH. Prior to the CDPHE, Risa worked as a Program Officer at the Colorado Health Foundation and as a Clinical Education Coordinator at the Mountain Plains AIDS Education and Training Center. She has contributed to health-related research projects in Denver; Quito, Ecuador; and New York City. Risa earned a Master's in Public Health from Columbia University and a Bachelor's degree from Wesleyan University.

Barbara Gabella, MSPH, is the director of the Epidemiology Unit. As director, Ms. Gabella created a new central unit to expand the capacity of epidemiology in the areas of MCH, injury and chronic diseases. Previously, she served as the state traumatic brain injury epidemiologist. Barbara has her Master of Science degree in Public Health, focusing on epidemiology, from the University of Colorado. //2012//

//2013// Karen Trierweiler now serves as both the Section Chief for Programs and Services and the Deputy Division Director for the Prevention Services Division. She continues to serve as the Colorado Title V MCH Director. All fiscal and operations staff (includes fiscal, contracts, and communications) are now consolidated at the Division versus Center or program level.

Mike Nugent is the new Prevention Services Division Deputy Director/Fiscal and Operations Director. From 2008-2011, Mike was the Colorado Department of Transportation's Director of Transportation Safety. In this position, he was responsible for the safety of Colorado's traveling public through leadership and oversight of the state's transportation safety and homeland security programs. Prior to joining state government in 2008, Mike was the Chief of Denver Emergency Medical Services and served as the Medical Branch Director for the 2008 Democratic National Convention. He holds a Bachelor of Arts Degree from the Metropolitan State College of Denver in Technical Communications and a Master of Science Degree in Management from Regis University.

Danielle Shoots now serves as the Chief Fiscal Officer for the PSD, with Betina Smith-Eisenussi maintaining oversight for the Title V Block Grant.

Gabriel Kaplan, PhD, now serves as the Director of the newly created Prevention Health Policy, Systems & Analytics Branch. Dana Erpelding has assumed management of the Epidemiology, Planning & Evaluation Branch. She has nine years of experience at CDPHE and has spent the past six years managing the Planning, Training, Exercise and Evaluation and Community Outreach units for the Office of Emergency Preparedness and Response. Prior to joining CDPHE, Dana worked as a consultant for Accenture. Dana has experience in leading efforts in project management, assessment and evaluation, and programmatic and fiscal oversight. //2013//

E. State Agency Coordination

This section describes the MCH Programs relationships with a number of key partners.

Relationships among the State Human Service Agencies

Much of the statewide work accomplished by MCH staff is done in collaboration with other state agency staff, particularly those who work with the Colorado Departments of Education; Health

Care Policy and Financing; and Human Services. MCH personnel work with other state agency staff on a daily basis through coalitions, task forces, advisory groups, committees, and through cooperative agreements. A number of examples of state agency coordination are provided in this section, but this list is not exhaustive. Examples are also provided in other sections, particularly agency capacity section (III, B) and in the performance measures sections (IV C and IV D).

The Colorado Department of Human Services, in particular the Division of Developmental Disabilities is an essential partner of the Children with Special Health Care Needs Unit within the MCH Program. Together the agencies offer services for children served by the Colorado Department of Human Services and the Health Care Program for Children with Special Needs. Programs include the Colorado Department of Human Services' Early Intervention Colorado; Family Support Services Program for families with a member who has developmental disabilities; Children's Extensive Support Waiver for Children Birth to 18 who are at high risk for out-of-home placement; and the Children's Medical Waiver for Children Age Birth to 18 with Developmental Disabilities that allows access to Medicaid state plan benefits regardless of parental income. The HCP program also works closely with Early Intervention Colorado to implement HCP care coordination standards, and to define respective roles in serving infants and toddlers with special health care needs at the community level. An HCP staff member represents the program and the department on the Interagency Coordinating Council and the state level Memorandum of Understanding committee.

The Women's Health Unit administers the Prenatal Plus Program on behalf of the Colorado Department of Health Care Policy and Financing (HCPF). This program will be administered by HCPF as of July 2011.

The Colorado Department of Education is an essential partner in activities relevant to early childhood state systems building efforts; coordinated school health model; work with school nurses; and school-based health center activities.

The Colorado Department of Human Services, Division of Behavioral Health leads efforts to reduce underage drinking through the Prevention of Alcohol Related Consequences (PARC) Committee (formerly called the Underage Drinking Prevention and Reduction Workgroup). The PARC Committee is responsible for prevention and reduction of underage drinking statewide while increasing intervention and treatment services to all youth, when needed.

Another important partners for work associated with efforts to address teen motor vehicle safety are the Colorado Departments of Transportation; Revenue, Motor Vehicle Division; and Public Safety, State Patrol.

Relationships with Local Public Health Agencies

In recent years there has been great progress in developing Colorado's public health infrastructure. In 2008, the Colorado Public Health Act was passed that requires each of the 64 counties to establish and maintain a public health agency. The state health department's Office of Planning and Partnerships is responsible for carrying out this work via the Colorado's Public Health Improvement Plan - From Act to Action, which is found at <http://www.cdphe.state.co.us/opp/cophip.html>. The Office works with state- and community-based public health systems to maintain and strengthen statewide infrastructure and capacity to provide comprehensive public health services in the state. The MCH program works through and with the department's Office of Planning & Partnerships to address statewide MCH issues.

The MCH Program uses a comprehensive planning process to support fifteen local public health agencies in developing an MCH operational plan to address community needs. This planning process, developed collaboratively with local public health partners, is a systematic way of planning, implementing and evaluating that ensures that MCH plans at the local level are in alignment with the state-level MCH performance measures and priority CSHCN national outcome measures. Each local public health agency engages in a three-year cycle, that includes one year

of intensive planning, followed by two years of implementation that is documented with annual updates to the state office. The three-year cycles are staggered so that five local public health agencies are completing the intensive planning each year.

The state MCH program provides MCH data to each local MCH agency annually to ensure planning is data driven. Counties use evidence-based and/or promising practice strategies with explicit goals, objectives, and activities to address the needs identified through their planning process. Agencies also evaluate their efforts using process and outcome evaluation measures. Go to www.mchcolorado.com for more information.

MCH Action Guides are available to assist local health agencies in developing their MCH operational plans. These action guides provide comprehensive resources for developing strong goals and SMART objectives and for identifying strategies and action steps to address priority health issues. Action Guides related to a variety of key MCH issues are available on the MCH Web site.

Relationships with Federally Qualified Health Centers and Primary Care

The Colorado Community Health Network (CCHN) is the state primary care association that represents Colorado's 15 Community Health Centers (CHC) that are the backbone of the primary health care safety-net in Colorado. CCHN has a Medical Home project that is coordinated with the CSHCN Unit's Colorado Medical Home Initiative to develop common messaging about medical home concepts and to infuse the consumer voice. CHCs operate 138 health care delivery sites in 35 Colorado counties. Colorado's community health centers provided over 1.7 million visits to over 419,000 low-income patients in 2008, many of them women and children. Thirteen CHCs operate 37 dental clinic sites in 21 Colorado counties and provided 175,000 visits. 90 percent of patients served by CHCs have family incomes below 200% of the Federal Poverty Level.

The state health department's Primary Care Office works with CCHN to improve accessibility and expand primary care services to targeted low-income and vulnerable populations. These efforts include information and data sharing; recruitment and retention of health professionals; policy development; and assisting communities with applying for health professional shortage area and medically underserved designations.

Relationships with Tertiary Care Facilities

The lead partner with tertiary care facilities is the state health department's Primary Care Office. Community health centers are responsible for much of the primary care provided within Colorado. As MCH focus is mainly on public health functions, the relationship with tertiary care facilities has changed. MCH-funded programs work to link families to care within the community, support reforms that increase access to health care, and participate in partnerships to assure adequate systems of care in communities to meet residents' needs.

The CSHCN program still has a strong relationship with specialty health care provision and has prioritized creating medical homes for children and building systems of care in communities, which requires the involvement of hospitals. The Newborn Metabolic Screening Program contracts with The Children's Hospital for follow-up services.

The Women's Health Unit participates on the Colorado Perinatal Care Council (CPCC) a volunteer, non-profit, advisory group whose members represent a variety of professions, hospitals and organizations with an expertise or interest in perinatal care that addresses the coordination and improvement of perinatal care services in Colorado

Available Technical Resources

Colorado is fortunate to have a number of training and technical assistance resources available. Resources include in-house training through the state health department and the new School of Public Health at the University of Colorado Denver. In addition, the CSHCN Unit works with the

University of Colorado JFK Partners, a MCH LEND grantee, and Colorado Win Partners, dedicated to workforce development for people with disabilities, to support their technical assistance needs.

Title V Program Coordination with Other Specific Programs

1. Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT) is located at the Colorado Department of Health Care Policy and Financing. The Medicaid Program contracts directly with local public health agencies. The Health Care Program for Children with Special Needs' local and regional care coordinators work closely with EPSDT staff. Typically, EPSDT coordinators work with public health service programs such as WIC, prenatal, immunization services, the Health Care Program for Children with Special Needs, and other child health initiatives. At the state level, Title V continues to work with EPSDT and to participate in the EPSDT State Advisory Board. EPSDT personnel also serve on the Health Care Program for Children with Special Needs Medical Home Advisory Committee.

2. Other Federal Grant Programs

The Nutrition Services Branch, that includes the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) and Child and Adult Care Food Program (CACFP), is in the same division as the MCH program. The programs have worked jointly for many years. Current efforts are focused on increasing breastfeeding rates and decreasing childhood overweight and obesity.

Title X Family Planning is housed within the Women's Health Unit. The MCH Block grant and Title X family planning activities are well-integrated. Efforts to address unintended pregnancy, preconception health and teen fertility are targeted to both family planning and MCH contractors. MCH funds are not used to fund direct family planning services, but rather to support population-based activities around unintended pregnancy prevention.

3. Providers of services to identify pregnant women and infants who are eligible for Title XIX and to assist them in applying for other services.

The majority of local MCH contractors for Prenatal Plus and the Nurse Home Visit Program also served as presumptive eligibility sites for Medicaid. The Baby Care/Kids Care Program (authorized under Colorado's Medicaid state plan) allowed Medicaid presumptive eligibility determinations to be made at public health sites. MCH contractors identified women and infants who were eligible for Medicaid at the local public health site (through WIC, family planning, EPSDT, etc.), and deemed them presumptively eligible for Medicaid if the income requirements were met. Women are referred to community resources for direct care, case management, and other services.

4. Title V Coordination with the Social Security Administration, State Disabilities Determination Services unit, Vocational Rehabilitation, and Family Leadership and Support Programs Social Security Administration (SSA)

Relationships with the State Determination Unit of the Social Security Administration are strong. Local level EPSDT outreach workers make calls to families of children receiving Title XVI (SSI) to assess whether service and support needs are being met. Referrals are made to the Health Care Program for Children with Special Needs when family needs are complex and the EPSDT outreach worker feels that care coordination by a Health Care Program for Children with Special Needs staff member is appropriate.

Developmental Disabilities

In Colorado, blind and disabled individuals under the age of 16 receive rehabilitation services under Title XVI (SSI). All SSI beneficiaries under 16 years of age are automatically eligible for Medicaid. Community-based EPSDT outreach workers call all newly enrolled SSI beneficiaries to assess whether each child's medical and support needs are being met. In the majority of cases, Medicaid is covering all of the medical needs. HCP personnel at the community level provide care coordination when families have more complex medical or psychosocial needs.

Vocational Rehabilitation

Relationships with Vocational Rehabilitation have been cultivated through the Colorado Interagency Transition Team that consists of ten stakeholder agencies that work together to address youth transition to adulthood. A representative from Vocational Rehabilitation sits on CSHCN's Unit's Colorado Health Transition Coalition. Both the Department of Education's Special Education Section and Vocational Rehabilitation are actively involved in the Brain Injury Steering Committee.

Family Leadership and Support

Title V has supported Family Voices Colorado financially and through membership on its board of directors since it became an official chapter in 2001. Family Voices works with the state-level CSHCN family position and local family consultants to implement the Family-to-Family Health Information Network provides state level family advocacy; and represents the parent perspective in developing systems of care. The CSHCN's Unit financially supports the Colorado Families for Hands & Voices to engage in family advocacy, outreach to underserved populations, and parent leadership activities.

Title V Program Coordination with other Specific Programs

The MCH Program works with many other programs. The following list is incomplete, but includes important programs within and external to the state health department. It also includes grant-funded programs associated with the MCH program.

The following programs are external to the health department:

The Healthier Beginnings for African-American/ Black Communities' Project is based at Tri-County Health Department with participation from the Women's Health Unit, Healthy Start, Aurora City Council, March of Dimes, and the community.

The Colorado Association for School-Based Health Care advocates for health care in schools for Colorado's children and adolescents. It is a membership organization that provides policy leadership, training and technical assistance, and quality assurance programs.

The Colorado Breastfeeding Coalition is a volunteer organization comprised of physicians, nurses, public health officials, nutritionists, dietitians, lactation consultants, counselors, and members of the business community. The coalition works to increase breastfeeding initiation and duration rates within the state.

Colorado Children's Healthcare Access Program is a non-profit organization devoted to ensuring that every child enrolled in Medicaid and Child Health Plan Plus (CHP+) receives comprehensive health care from a primary care provider, medical home team, and that all pregnant women covered by Medicaid or CHP+ receive comprehensive prenatal services.

The Colorado Perinatal Care Council is a volunteer, non-profit, advisory group whose members represent a variety of professions, hospitals and organizations with an expertise or interest in perinatal care. Its major focus is the coordination and improvement of perinatal care services in Colorado.

Covering Kids and Families is a coalition aimed at reducing the number of uninsured children. It has a membership of over 300 individuals from over 170 community-based organizations and agencies.

The Family-to-Family Health Information Center is located at Family Voices. It is a federally-funded, family-run center established to provide information and support to families of children and youth with special health care needs and the professionals who serve them.

Healthy Child Care Colorado provides consultation, technical assistance and training for

providers of child care in Colorado to enhance their response to the health and safety needs of young children.

HealthyWomen/HealthyBabies is a nonprofit coalition working to improve birth outcomes through advocacy, collaboration, research and education. The group has active workgroups addressing: access to prenatal care, family planning and enhancing preconception care.

Oral Health Awareness Colorado (OHAC!) is the statewide oral health coalition whose members are professionals representing a wide range of public, private and non-profit organizations interested in advancing oral health care in Colorado.

The following programs are associated with the state health department.

The "Own Your C" youth tobacco prevention and cessation media campaign is a campaign that seeks to help young people make the connection that their choices define who they are and who they will become.

The Teen Driving Alliance, formerly the Teen Motor Vehicle Leadership Alliance, is a multidisciplinary, statewide coalition that formed in November 2005 with the purpose of bringing together different state agencies, local agencies and private partners concerned about teen driving safety.

The Vaccine Advisory Committee for Colorado (VACC) is co-chaired by the Lieutenant Governor and members represent public health, school health, child advocacy, health care, philanthropy and academia. Together they work to increase childhood immunization coverage in Colorado.

The Colorado Advisory Council on Adolescent Health is an interdisciplinary group of adolescent health experts and community advocates who are dedicated to improving the health and well-being of all Colorado adolescents. The Council was commissioned in 1982 by the Department to provide guidance on priorities and use of resources to improve the health and well-being of Colorado's young people.

The Youth Partnership for Health (YPH) is a diverse group of 14-18 year olds from across Colorado, recruited from a variety of schools, local health agencies and community programs to provide feedback and recommendations for public health programs, practices and policies that effect youth.

The following are grant-funded projects within the health department grouped by subject area:

The Child, Adolescent and School Health (CASH) Unit

The Children, Adolescent and School Health (CASH) Unit uses private foundation funding to provide technical assistance to local early childhood councils related to efforts to integrate health into their local early childhood systems building efforts.

The CASH Unit and the department of Health Care Policy and Financing are implementing a five-year evaluation grant of school-based health centers in Colorado funded through the Child Health Insurance Program Reauthorization Act.

Colorado Connections for Healthy Schools is the state's CDC Coordinated School Health initiative. The departments of health and education work together work to build state infrastructure for coordinated school health. CDPHE provides health content expertise and resources for school representatives to integrate into the school environment.

The Early Childhood Systems (ECCS) Grant supports a statewide alliance of early childhood partnerships working together to create a comprehensive system for young children birth to age eight and their families. The Early Childhood Colorado Framework and the Framework in Action

State Plan were developed to guide the state's systems-building efforts.

Children with Special Health Care Needs Unit

Colorado's Medical Home Initiative is funded by several grant awards. The initiative is dedicated to systems development and links all the Medical Home projects in the state to assure coordination at many levels.

The HRSA State Implementation: Integrated Services for Children with Special Health Care Needs grant project provides \$300,000 per year for three years to allow the department to assist communities to overcome local systemic barriers through the use of medical home quality improvement teams. It also supports the goals of the Colorado Medical Home Initiative.

The MCH Early Hearing Detection and Intervention grant project has developed hearing screening follow-up coalitions in ten communities identified as needing to improve follow-up. Hospital birth certificate staff, early intervention and HCP staff were members of the teams. It also allows for the integration databases including the universal newborn metabolic screening and infant hearing screening data; the Birth Defects Monitoring Program; immunization registry; and asthma surveillance data.

Women's Health Unit

The Women's Health Unit was selected by a private donor to receive up to five years of funding as part of the Colorado Family Planning Initiative. Funding is used to expand family planning services and provide long acting reversible contraception to decrease unintended pregnancies

A Tobacco Cessation Workgroup for Pregnant Women and persons receiving Medicaid was developed with the State Tobacco Education and Prevention Partnership to address the high rates of tobacco use among these populations.

Injury and Suicide, Violence Prevention Unit

A Child Injury Prevention Policy Plan was developed by the Injury, Suicide, and Violence Prevention Program through a grant from CDC. The plan includes strategies to enhance Colorado's booster seat law to require that children be secured in booster seats through age eight, or until they are at least four feet nine inches tall. The law passed this year.

The Youth Violence Prevention Program funded by a Youth Violence Prevention Program CDC grant enhances Colorado's capacity to address child and adolescent health through violence prevention. A Violence Prevention Advisory Group consisting of violence prevention experts, state agency leaders, and members of private and nonprofit prevention groups, work with the state health department on the development of a state needs and resources assessment, followed by the construction of a state-wide strategic plan.

The Office of Suicide Prevention received another three years of funding from the Substance Abuse and Mental Health Services Administration to continue and expand Project Safety Net. This grant allows eight community agencies to serve twenty counties by training adults to recognize and intervene with suicidal youth, and to refer those youth to appropriate services. Project Safety Net also includes a youth suicide prevention awareness campaign entitled Start the Conversation.

Colorado Physical Activity and Nutrition

Funded by CDC, the Colorado Physical Activity and Nutrition Program (COPAN) is responsible for implementing the Colorado Physical Activity and Nutrition State Plan 2010. The plan promotes healthy eating and physical activity to successfully prevent and reduce overweight, obesity, and related chronic diseases. COPAN worked collaboratively with the MCH units and WIC on an assessment of evidenced-based practices to impact early childhood obesity.

/2012/ Relationships among the State Human Service Agencies
CDHS, in particular the Division of Developmental Disabilities, is an essential partner of the CSHCN programs within the Children and Youth (C&Y) Branch.

Available Technical Resources

Additional resources include the Regional Institute of Health and Environmental Leadership (RIHEL) and WONDERBabies.

Vocational Rehabilitation partnerships continue as outlined last year.

Family Leadership and Support

Family Voices works with the state-level Family Leader position, as well as local family consultants, to implement the Family-to-Family Health Information Network. The C&Y Branch also collaborates with other family-centered organizations, including Colorado Families for Hands & Voices, the Colorado Autism Society, Parent-to-Parent of Colorado, PEAK Parent Center and the Colorado Parent Information and Resource Center (C-PIRC).

Injury and Suicide, Violence Prevention (ISVP) Unit

The ISVP Unit received a grant from the CDC to focus on developing prevention strategies for teen dating violence in Denver, as well as a grant to improve child injury prevention policies. Additionally, the Unit piloted an Integrated Curriculum for Youth Violence Prevention in two third grade Denver Public School classrooms. The purpose of the curriculum is to reduce risk factors across several domains of youth violence by increasing protective factors. These domains include bullying, suicide, sexual assault, child abuse, and dating violence. In April 2011, the ISVP Unit was awarded four new grants through the CDC Core Violence and Injury Prevention Program. This funding will enable Colorado to implement strategies outlined in the Colorado Injury and Violence Prevention Strategic Plan and to focus specifically on strengthening Colorado's graduated driver license and seat belt laws.

Oral Health Awareness Colorado (OHAC) is now called Oral Health Colorado (OHCO).

COPAN is now the Healthy Living Branch. //2012//

/2013/

Relationships among the State Human Service Agencies

The Women's Health Branch (WHB) coordinates with the Colorado Department of Health Care Policy and Financing (HCPF) in their administration of the Prenatal Plus Program. The WHB administers complementary programs, such as the Nurse Home Visitor and MIECHV Programs, so the two departments share resources and information for the local agencies providing these programs. The WHB also collaborates with HCPF, the Department of Human Services (DHS), and the Department of Education (CDE) on the state's Unintended Pregnancy Winnable Battle.

The Title V Director represents the CDPHE on the Early Childhood Leadership Commission, which works to improve early childhood systems in the four domains of physical and mental health, early learning and parent and family education and support.

See SPM 10 for information about the Colorado 9to25 network that is working to achieve positive outcomes for all youth in Colorado.

MCH staff coordinates resources with CDE staff to facilitate trainings and opportunities for school nurses and public health staff, including those working with CSHCN to design improved school health care delivery models. Examples of professional development strategies include; annual school nurse orientation, quarterly leadership meetings and a three session leadership institute for 40 school nurses. In addition, state staff works with

CDE partners to develop infrastructure such as conducting youth surveillance, promoting policy change and evaluating school efforts to improve the health of students.

Relationships with LPHAs

The Health Care Program for Children with Special Needs (HCP) is working with LPHAs, the University of Colorado School of Medicine and Children's Hospital Colorado to strengthen the rural network of specialty clinics for CYSHCN. With the goal of maximizing statewide access to specialty care, the HCP program has formed a specialty clinic advisory committee to assist with implementation of consistent processes for coordinating clinics in rural communities.

Relationships with Federally Qualified Health Centers and Primary Care

Community health centers (CHCs) operate 131 health care delivery sites in 34 Colorado counties. Colorado's CHCs provided over 1.8 million visits to over 458,000 low-income patients in 2010. Fourteen CHCs operate 43 dental clinic sites in 23 Colorado counties and provided 192,000 visits to more than 79,000 patients. 94 percent of patients served by CHCs have family incomes below 200 percent of the Federal Poverty Level.

See NPM 3 for information about the Colorado Medical Home Initiative (CMHI).

Injury, Suicide, and Violence Prevention Branch

Project Safety Net funding will end on September 30, 2012 and the Substance Abuse and Mental Health Service Administration has not released a new funding announcement under the Garrett Lee Smith Memorial Act. Therefore, the Office of Suicide Prevention will explore new federal funding opportunities to support youth suicide prevention and intervention efforts in Colorado. //2013//

F. Health Systems Capacity Indicators

The data for a variety of Health Systems Capacity Indicators for Colorado are shown below, along with a brief narrative for each topic. The years referenced are reporting years, which refer to data from the previous year.

Health Systems Capacity Indicator 01

Health Systems Capacity Indicator 01 shows a variable rate of hospitalization for asthma among children, ranging between 46.4 and 65.9 per 10,000 children under the age of five. Data for 2011 show 2,019 hospitalizations, a rate of 58.7 per 10,000, the highest rate since 2005 (65.9 per 10,000).

The Colorado Child Health Survey, carried out annually, provides a wealth of data on asthma that contributes to an understanding of asthma beyond what hospitalization data can provide. According to the calendar year 2010 survey, 11.7 percent of children ages 1 through 14 were diagnosed with asthma. Among this group, 80.6 percent still had asthma. Only a little over half (55.4 percent) had received an asthma management plan.

The Child Health Survey has been in place since 2004. With seven years of data now available (calendar 2004 through calendar 2010), trends can be analyzed, with substantial data available for some large counties. Statewide, the percentage of children ages 1 through 14 diagnosed with asthma was 12.5 in 2006, 11.9 in 2007, 10.0 in 2008, 12.4 in 2009 and 11.7 in 2010. The year to year changes are not statistically significant and the rate is essentially unchanging.

One of the MCH Generalist Consultants partners with school nurses who are working to improve asthma management in Colorado public schools. Many schools have preschools who serve three to five year olds. The staff in preschools is provided the additional support of Regional

Nurse Consultants that have expertise in asthma management. They work with school nurses and staff to help design health care plans and asthma management plans to be used in the school setting. Staff works with families and providers to improve and manage this chronic disease while children are in the school setting.

Health Systems Capacity Indicator 02

This measure does not inform future planning efforts.

Health Systems Capacity Indicator 03

This measure does not inform future planning efforts.

Health Systems Capacity Indicator 04

This measure does not inform future planning efforts.

Health Systems Capacity Indicator 05

Medicaid women are at an increased risk of having a low birth weight infant compared to non-Medicaid women (9.4 percent versus 8.3 percent, respectively). The Medicaid rate is a full percentage point higher than the non-Medicaid rate.

Infant death data by Medicaid and non-Medicaid status at delivery became available for the first time following the revision in 2007 of the Colorado birth certificate (which collects Medicaid status) and the end of calendar year 2008 (the earliest time at which one-year infant mortality rates could be calculated). Not unexpectedly, the Medicaid population is at increased risk of infant death. Infants born to women on Medicaid were 34.5 percent more likely to die within the first year of life compared to infants born to women not on Medicaid (down from 41.5 percent in 2010). The Medicaid infant mortality rate was almost two points higher than non-Medicaid infant mortality (7.4 deaths versus 5.5 per 1,000 births, respectively).

Medicaid patients enter prenatal care at much later dates than non-Medicaid patients; two out of three (68.0 percent) begin care in the first trimester compared to 85.6 percent of non-Medicaid patients who begin care early. The proportion of Medicaid patients entering prenatal care in the first trimester in 2011 is almost three percentage points higher than the 2010 percentage (65.1 percent). However, changes in prenatal care alone will not significantly close this gap in outcomes.

This measure also reveals that just over two-thirds of all Colorado women receive appropriate care according to the Kotelchuck Index. While there is a one-and-a-half-point difference between Medicaid and non-Medicaid women (68.1 versus 69.7), suggesting somewhat greater difficulty among Medicaid women to meet the Kotelchuck standard, this difference is small.

The PSD is creating a Health Systems Unit to address issues related to direct health care services, the ACA and Medicaid. MCH- related issues will be included in this effort, so further analysis of Medicaid vs non-Medicaid systems outcomes will be possible.

Health Systems Capacity Indicator 06

This measure does not inform future planning efforts.

Health Systems Capacity Indicator 07A

This measure does not inform future planning efforts.

Health Systems Capacity Indicator 07B

The percentage of EPSDT eligible children age 6 through 9 who have received any dental services during the year has been steadily increasing. There have been changes in how the Centers for Medicare and Medicaid calculate this statistic, but the value of 49.9 percent in 2006 is considered to be a more accurate representation of the percent of EPSDT children receiving services than figures before 2004. Since 2006, the percentage of children receiving dental

services appears to have increased moderately, reaching a high of 60.5 percent in 2011.

Health Systems Capacity Indicator 08

This measure does not inform future planning efforts.

Health Systems Capacity Indicator 09A

The Prevention Services Division is able to obtain data from most of the data sources listed, and has access to the electronic databases. The Health Statistics Section at the state health department provides much of the data and some of the analysis in addition to the analytical work completed by the staff of the Epidemiology, Planning and Evaluation Branch in the Prevention Services Division.

Birth certificates are linked monthly to Medicaid files for the purpose of obtaining contact information for births sampled for the PRAMS survey.

Colorado has the capacity to link the birth certificates and the WIC eligibility files, but no strong intervention-related need exists to create this linkage. PRAMS data, however, are used to produce estimates of many characteristics and outcomes of the WIC population. Use of the hospital discharge survey data, other than for injury analysis, is limited. More staff resources are needed to make use of the information that is available.

Health Systems Capacity Indicator 09B

The Colorado Youth Risk Behavior Survey provides data on adolescent tobacco use every other year. The number of surveys from the most recent year, 2011, was sufficient to yield valid statewide estimates of a number of behaviors. There was an adequate number of surveys in 2005 and 2009, although the 2007 survey fell short. It is hoped that efforts to yield an adequate sample size will continue to be successful in the future.

Child Health Survey data are collected by the Health Statistics Section at the state health department and provided annually. Results are tabulated in the spring of the year following the survey, which is conducted on an on-going monthly basis. Data for 2009 were available in May 2010; data for 2010 were made available in June 2011. Because the Child Health Survey is administered at the Colorado Department of Public Health and Environment, the results are available quickly, which greatly enhances program planning.

The Colorado Healthy Kids Survey on Tobacco (CHKS-T) was first conducted in the fall of 2001 and was repeated in the fall of 2006 and 2008. With a reinstatement of funding, tobacco questions from the CHKS-T will be included in a more comprehensive youth survey that will go into the field again in the fall of 2013.

Since December 2011, representatives from the Colorado Department of Education, the Colorado Department of Human Services, and the Colorado Department of Public Health and Environment have been meeting to explore how three separate school-based youth survey instruments and administration systems could be melded into a single, unified approach. They have crafted a charter which is guiding their work and on July 1, 2012 signed a Memorandum of Understanding describing expectations, the resources and amounts to be shared and transferred across the departments, and the new survey administration process. This is expected to result in a statewide youth survey system that dramatically reduces the amount of dollars spent on such data collection while at the same time increasing from 2,000 to 40,000 the number of students surveyed whose results feed into a state survey system.

IV. Priorities, Performance and Program Activities

A. Background and Overview

This section of the grant provides detailed information on Colorado's priorities in maternal and child health. The priorities are addressed through both national and state performance measures. There are a total of 18 national measures and 10 state measures. Each of these is discussed in detail under each measure's heading (Sections IV C and D).

B. State Priorities

This section addresses Colorado's State Performance Measures and the attachment lists the state priority needs along with the corresponding State and/or National Performance/Outcome Measures that will be used to evaluate progress. Each of the priorities is linked with at least one and sometimes multiple state and national measures. The state measures were chosen since, in all but one case, current population data sets (e.g., vital statistics, PRAMS, the Colorado Child Health Survey, BRFSS and/or YRBS) included data that aligned with the state performance measure. Wording used in a number of the state performance measures mirrors that used in the data source.

2011 - 2015 Colorado's Nine Priorities and Ten Accompanying State Performance Measures

Priority 1: Promote preconception health among women and men of reproductive age with a focus on intended pregnancy and healthy weight.

- SPM 1: Percentage of sexually active women and men ages 18-44 using an effective method of birth control to prevent pregnancy. (BRFSS)

- SPM 2: Percentage of live births to mothers who were overweight or obese based on BMI before pregnancy. (Birth certificate)

Priority 2: Improve screening, referral and support for perinatal depression.

- SPM 3: Percent of mothers reporting that a doctor, nurse, or other health care worker talked with them about what to do if they felt depressed during pregnancy or after delivery. (PRAMS)

Priority 3: Improve developmental and social emotional screening and referral rates for all children ages birth to 5.

- SPM 4: Percent of parents asked by a health care provider to fill out a questionnaire about development, communication, or social behavior of their child ages 1 through 5. (Child Health Survey - CH169)

- SPM 5: Percentage of Early Intervention Colorado referrals coming from targeted screening sources. (Early Intervention Colorado)

Priority 4: Prevent obesity among all children ages birth to 5.

- SPM 6: Percentage of live births where mothers gained an appropriate amount of weight during pregnancy according to pre-pregnancy BMI. (Birth certificate)

Priority 5: Prevent development of dental caries in all children ages birth to 5.

- SPM 7: Percent of parents reporting that their child (age 1 through 5) first went to the dentist by 12 months of age. (Child Health Survey - CH63a)

Priority 6: Reduce barriers to a medical home approach by facilitating collaboration between systems and families.

- There is no state performance measures associated with this priority. However, this priority is measured by National Performance Measure 3 -- The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (National CSHCN Survey) and National Outcome 2 -- All Children will receive comprehensive, coordinated care within a medical home.

Priority 7: Improve sexual health among all youth ages 15 -19.

•SPM 8: Percentage of sexually active high school students using an effective method of birth control to prevent pregnancy. (YRBS)

Priority 8: Improve motor vehicle safety among all youth ages 15 -- 19.

•SPM 9: Motor vehicle death rate for teens ages 15-19 yrs old.

Priority 9: Build a system of coordinated and integrated services, opportunities and supports for all youth ages 9-24.

•SPM 10: The percentage of group members that invest the right amount of time in the collaborative effort to build a youth system of services & supports. (Wilder Collaborative Factor Inventory)

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	54	63	60	74	73
Denominator	54	63	60	74	73
Data Source		CDPHE Newborn Screening Laboratory	CDPHE Newborn Screening Laboratory	CDPHE Newborn Screening Laboratory	CDPHE Newborn Screening Laboratory
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	100	100	100	100	100

Notes - 2011

Data for reporting year 2011 represent calendar year 2010 births.

Notes - 2010

Data for reporting year 2010 represent calendar year 2009 births.

Notes - 2009

Data shown for reporting year 2009 are based on calendar year 2008 births.

a. Last Year's Accomplishments

The indicator for reporting year 2011 showed that 100 percent of screen positive newborns received timely follow up to definitive diagnosis and clinical management for conditions mandated by the newborn screening program. The target for reporting year 2011 was 100.0 percent, and the target was met.

The newborn screening laboratory piloted a web access feature to allow certain entities, such as laboratories and contracted subspecialists, to view newborn screening results online.

The CDPHE Laboratory, the Immunization Registry, and the Newborn Metabolic and Newborn Hearing Screening Follow-up programs continued efforts to integrate newborn metabolic and newborn hearing results with immunization records in the online immunization registry, thereby allowing physicians access to newborn screening results online.

In October 2010, The Advisory Committee on Heritable Disorders in Newborns and Children recommended the addition of newborn screening for critical congenital heart disease (CCHD) by pulse oximetry. That recommendation, as well as the American Academy of Pediatrics' endorsement of that recommendation cautioned that special protocols must be developed for screening at high altitude. The newborn screening advisory committee began studying this recommendation in light of the special circumstances created by high altitude. While screening cut-offs for CCHD were formulated at sea level, normal infants born at high altitude have pulse oximetry levels that would fall into the category of "abnormal" using the established sea-level cut-offs, necessitating expensive, stressful, and unnecessary diagnostic testing. Certain large hospitals began screening infants in their nurseries for CCHD, as a way to collect data for establishing altitude-specific cut-offs for CCHD screening. Colorado applied for a HRSA grant to do in-depth research of CCHD screening at high altitude.

The Newborn Screening Follow-up program designed a parent brochure specifically for midwife-attended home births, because infants delivered at home are among the least likely to receive newborn screening. The brochure was well-received by midwives and parents and is in widespread use.

Colorado participated in a multi-state study of the efficacy of "second-tier" testing for congenital adrenal hyperplasia (CAH) as a means of reducing false-positive and false-negative results.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continued efforts to integrate newborn metabolic and newborn hearing results with immunization records in the online Immunization Registry				X
2. Studied implementation of recommended screening for CCHD				X
3. Designed newborn screening parent brochure for midwife attended home births			X	
4.				
5.				

6.				
7.				
8.				
9.				
10.				

b. Current Activities

The target for reporting year 2012 is 100.0 percent.

Colorado's newborn screening program added newborn screening for Severe Combined Immunodeficiency (SCID) in February 2012. At the same time, a change was made to the protocol for newborn screening for hemoglobinopathies. Positive results for Hemoglobin (Hb) Bart's, now receive additional testing to confirm the accuracy of positive results.

The newborn screening advisory committee continues to do research on creating altitude-specific screening protocols for screening and follow-up of critical congenital heart disease at high altitude.

The newborn screening program is considering a proposal from Utah to participate in a multi-state pilot project to screen newborns for Spinal Muscular Atrophy.

The newborn screening laboratory is changing its submission criteria to reduce the possibility of delayed testing and reporting.

Heated controversy over the retention and research use of residual newborn screening specimens continues. The newborn screening program and advisory committee monitors activity nationally and internationally with regard to this topic.

The program participates in activities related to the implementation of telehealth for genetics and emergency preparedness for newborn screening through participation on the Mountain States Genetics Regional Collaborative Center.

c. Plan for the Coming Year

The target for reporting year 2013 is 100.0 percent.

Activities will continue from the previous year.

The Colorado School of Public Health, University of Colorado (in cooperation with the Association of Public Health Laboratories) will develop and manage the Newborn Screening Technical Assistance and Evaluation Program (NewSTEPS) under a five-year cooperative agreement from the Genetics Services Branch of the HRSA. The award of up to \$4 million will create a national data repository and provide quality improvement initiatives and technical and educational resources for U.S. newborn screening programs.

The Colorado Newborn Screening Program will advise the NewSTEPS team on the data repository and provide feedback on new features of the website and repository as they evolve. Working with the NewSTEPS team, the Colorado newborn screening program will identify steps to improve the quality of Colorado's newborn screening system and will interact with other states in quality improvement initiatives developed by NewSTEPS.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	66821					
Reporting Year:	2011					
Type of Screening Tests:	(A) Receiving at least one Screen (1)		(B) No. of Presumptive Positive Screens	(C) No. Confirmed Cases (2)	(D) Needing Treatment that Received Treatment (3)	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	65778	98.4	8	4	4	100.0
Congenital Hypothyroidism (Classical)	65778	98.4	51	33	33	100.0
Galactosemia (Classical)	65778	98.4	7	3	3	100.0
Sickle Cell Disease	65778	98.4	7	6	6	100.0
Biotinidase Deficiency	65778	98.4	5	5	5	100.0
Cystic Fibrosis	65778	98.4	18	16	16	100.0
21-Hydroxylase Deficient Congenital Adrenal Hyperplasia	65778	98.4	20	6	6	100.0

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	57.4	60	60	60	61
Annual Indicator	59.1	59.1	59.1	59.1	66.5
Numerator					
Denominator					
Data Source		National Survey of CSHCN			
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events					

over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	68	68	68	68	68

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The 2009-2010 results are not available until late 2011, so reporting year 2010 repeats the data shown for reporting year 2007, 2008, and 2009.

Notes - 2009

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The next survey went out in the field in early 2009, so reporting year 2009 data repeats the data shown for reporting year 2007 and 2008.

a. Last Year's Accomplishments

The indicator for reporting year 2011 showed that 66.5 percent of families with children with special health care needs partnered in decision making at all levels and were satisfied with the services they received. The target for reporting year 2011 was 61.0 percent, and it was met. The 2011 indicator cannot be directly compared to the 2011 target that was set based on indicators derived from a different, earlier, set of questions.

The Title V State Family Leader directs the Colorado Family Leadership Training Institute (FLTI), which was offered in four pilot sites statewide. This 20-week course is designed to give parents/families the tools they need in order to blend civic engagement with effective leadership on behalf of children and families. This newly acquired set of skills increases partnership by participants within the service systems they navigate in their local communities. In October 2010, the CSHCN Unit sponsored four additional emerging family leaders to attend the national train-the-trainer event to increase the number of credentialed facilitators for the FLTI. These newly trained facilitators increased the Colorado cadre of trained facilitators to include more women of color, bilingual skills and a rural perspective. As of May 2012, 77 FLTI facilitators have been trained.

Nearly 100 students with varying levels of education, socioeconomic status, and previous civic engagement experience completed the 20-week FLTI course which is anchored by a curriculum designed for all families to become agents of change on behalf of children. Each graduate also completed a community project specific to their topic of advocacy/interest, which span multiple MCH-related topics such as teen pregnancy, depression, support to families with CYSHCN, substance abuse and suicide prevention. A thorough evaluation process has been developed to track outcomes such as skills development and satisfaction with the FLTI course itself, as well as participant's confidence in being an authentic partner in decision making.

In December 2010, in collaboration with the Colorado Department of Human Services, through an MCHB-funded Traumatic Brain Injury (TBI) project, two FLTI graduates were contracted to work with the TBI community. The two parents, who each self-identify as women of color, are serving as brokers in the community for meaningful outreach to diverse cultures to support the growth of FLTI across the state with a targeted focus to the TBI community.

A solid evaluation plan for the FLTI was developed in collaboration with CDPHE evaluation staff. Evaluation components will measure growth in civic knowledge and skills as well as personal leadership skills.

With the Early Childhood State Framework in Action and the Prevention Leadership Council (PLC) State Plan, state departments are now required to include families/youth in all levels of program development, implementation and evaluation. New policies will be in place, such as language in RFA/RFPs that mandate family involvement, as well as budgeting for family leaders. As a result, the Colorado Family Leadership Coalition (the Coalition), a cross-agency, multi-interest group of stakeholders who have expressed a commitment to embed the voice of families in their work, was formed and convened by the Title V State Family Leader (SFL). The goal of the Coalition is to implement the components of the PLC State Plan respective to family engagement and family leadership development.

Collaborative partnerships were developed with other statewide initiatives, including Strengthening Families, HeadStart, F2F, P2P, and several local Medical Home projects. These partnerships have increased referrals to FLTI and have raised awareness regarding the value of including family leaders in the planning and implementation of their respective initiatives and projects.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Maintained the Family Leadership Training Institute (FLTI) across Colorado		X	X	
2. Sponsored four additional family leaders to be credentialed as FLTI Facilitators through the national training to increase number of diverse facilitators for the FLTI		X	X	X
3. Solidified a HRSA/MCHB traumatic brain injury grant to support FLTI expansion		X	X	X
4. Shared the outcomes of FLTI and respective community projects of the graduates with various stakeholders			X	X
5. Solidified strong evaluation plan for FLTI				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The target for reporting year 2012 is 68.0 percent.

A pilot FLTI class in Spanish was conducted in a largely Hispanic community.

Referencing the PLC State Plan, the Coalition created nine recommendations as activities that would lead to family engagement across multiple state systems. This will serve as a detailed action plan for implementation.

The Title V SFL convened the FLTI State Civic Design Team, a statewide steering committee designed to address the sustainability and expansion of FLTI. The team produced an Action Plan that will guide FLTI for the next three years.

A grant proposal was submitted to the Colorado Health Foundation (TCHF) to sustain and expand the FLTI. Five additional communities statewide were identified and are undergoing "readiness" training. TCHF will announce awards in June 2012.

Outcome data was aggregated for the graduates of FLTI. Data supports the goals set forth by the Title V SFL, including diversity in socio-economic status (20 percent household income of less than \$20,000 a year, 20 percent more than \$85,000 a year) as well as growth in leadership skills (89 percent active in community organizing, 82 percent participate on community boards/advisories and 100 percent feel they can have a part in improving their community).

The two MCHB-funded contractors make it possible for families living with TBI to access the FLTI. The SFL worked closely with HRSA/MCHB Region 8 staff to increase awareness of the value of family engagement.

c. Plan for the Coming Year

The target for reporting year 2013 is 68.0 percent.

Activities from the previous year will continue.

With a strong and growing cadre of trained family leaders, the Title V State Family Leader (SFL) will involve family leaders in providing feedback and input on work related to the MCH priorities. This will promote family involvement in population-based service efforts. These family leaders will receive mentoring by the SFL, as well as continuing leadership development.

Sustaining the four FLTI sites will be a focus, as funding at the local level is uncertain. The Early Childhood network continues to be a strong conduit for family leadership development due to aligned goals as a statewide approach. Early Childhood Councils (ECCs) are seeking technical assistance on how to include family leadership and FLTI into their annual strategic plans. The ECCs who currently support the FLTI course in their community are mentoring other ECCs interested in implementing FLTI. In addition, the Early Childhood private funders are exploring funding strategies, such as funding the statewide Leadership Registry, convening a Family Leadership Summit, and/or supporting state staff infrastructure. In January 2013, an additional FLTI site will launch in the Denver metro area through collaboration with Children's Hospital Colorado. This partnership will serve families who have CYSHCN, as well as the community more broadly. Children's Hospital Colorado will do outreach and recruitment for participants in the Denver/Aurora area outside of the walls of the hospital. They will serve as a community lead on this topic, and will convene a group of stakeholders such as local parks and recreation, local schools, and family resource centers. Children's Hospital Colorado is also receiving technical assistance from the Title V Family Leader to implement a more comprehensive approach to integrating FLTI graduates and noted family leaders into leadership opportunities within the hospital. This will also align with the work of the family centered medical home workgroup currently in place at the hospital.

The FLTI State Civic Design Team will continue to implement the activities noted in the Action Plan developed in November 2011. Activities include curriculum refinement, developing partnerships and identifying additional communities for expansion.

With the guidance of the FLTI State Civic Design Team, the SFL will implement a strong messaging and marketing effort to highlight the successes of family leadership and the impact at the local, state and national level to encourage broader adoption of family leaders in MCH

programming. This work will include showcasing the community projects and increased levels of civic engagement, as well as revising the FLTI website. The messaging will be evaluated by EPE branch staff.

The FLTI evaluation will continue, with a focus on measuring long term community impact and civic engagement.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	51.7	51.7	51.7	51.7	52
Annual Indicator	48.2	48.2	48.2	48.2	43.7
Numerator					
Denominator					
Data Source		National Survey of CSHCN			
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	45	45	45	45	45

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The 2009-2010 results are not available until late 2011, so reporting year 2010 repeats the data shown for reporting year 2007, 2008, and 2009.

Notes - 2009

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The next survey went out in the field in early 2009, so reporting year 2009 data repeats the data shown for reporting years 2007 and 2008.

a. Last Year's Accomplishments

The indicator for reporting year 2011 showed that 43.7 percent of children with special health care needs received coordinated, ongoing, comprehensive care within a medical home. The target for reporting year 2011 was 52 percent, and the target was not met.

Through the MCHB Integrated Services grant, four pilot sites implemented action plans to support community-based medical home systems in Larimer, Summit, Boulder and Mesa counties. Although the grant ended in May 2011, all four communities established plans for sustainability with community partners.

The Children and Youth Branch (CYB) continued to lead the work of the Colorado Medical Home Initiative (CMHI) in collaboration with the Colorado Department of Health Care Policy and Financing (HCPF). CMHI objectives include working to build and implement sustainable systems that support quality health care for all children and youth in Colorado; reinforcing the medical home approach as a core concept of quality health care; promoting care coordination partnerships between families and providers; and encouraging a team approach among all health care providers. The CMHI provides support for two key working groups. The first is the Colorado Medical Home Coalition, which is a group of Colorado leaders focused on strategically aligning existing statewide medical home projects, grants and initiatives. The coalition consists of representatives from the following organizations: The Children's Hospital Colorado, HealthTeamWorks (formerly known as the Colorado Clinical Guidelines Collaborative), the Colorado Medical Society, the Colorado Children's Healthcare Access Program, Family Voices Colorado, ClinicNET, and the Colorado Community Health Network.

The second CMHI-supported group is the Colorado Medical Home Community Forum, a bimonthly meeting of Colorado stakeholders representing various state and local agencies, families, health care providers and policymakers from all over Colorado. On average, approximately 50 stakeholders participate in the meeting to discuss and provide input on issues related to supporting the medical home approach in Colorado.

CYB staff will continue to work in partnership with Family Voices Colorado to address emerging needs of families with children and youth with special needs. Family Voices Colorado directs the Colorado Family-to-Family Health Information grant and works closely with the Colorado Medical Home Initiative, as active participants in both the Medical Home Coalition and the Medical Home Community Forum.

The Children and Youth Branch Director provided leadership for the MCH Implementation Team (MIT) for the medical home priority. The implementation team members include staff from the Health Care Program for Children with Special Needs, the Early Childhood Unit, the Youth and Young Adult Unit, the Interagency Prevention Initiatives, the Health Systems Unit, the Office of Primary Care, the principal investigator from the MCHB Integrated Services grant, as well as representatives from two of the four medical home pilot communities for that grant.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Co-lead the Colorado Medical Home Initiative, in partnership with the Department of Health Care Policy and Financing				X
2. Coordinated the MCH Implementation Team for the MCH Medical Home Priority				X

3.				
4.				
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b. Current Activities

The target for reporting year 2012 is 45.0 percent.

In April 2012, the Colorado Medical Home Initiative launched a new medical home website, www.medicalhomecolorado.org. The website integrates content from the CDPHE medical home website and the HCPF medical home website, in order to centralize Colorado medical home resources and information.

The Medical Home MIT developed state and local logic models and action plans for this priority. The action plans were informed by the experiences of several key groups who have been working on medical home issues at the community level: local HCP systems building efforts that were required in previous MCH/HCP plans; local Early Childhood Health Integration grantees; and the local pilot communities from the MCHB Integrated Services grant.

For FY2013, local public health agencies who are participating in the MCH/HCP planning process are required to submit a medical home action plan. In addition, agencies are asked to include at least one objective with an early childhood focus. This is based on 1) the importance of early identification of and support related to children with special needs and 2) the opportunity to align and leverage resources with existing early childhood systems building efforts in Colorado.

Both the state and local medical home action plans include a focus on four strategies for systems building: mobilizing partnerships; policy analysis and action; supporting consumer voice; and facilitating provider support.

c. Plan for the Coming Year

The target for reporting year 2013 is for 45.0 percent.

CYB staff will continue to provide leadership for the Colorado Medical Home Initiative, in partnership with the Department of Health Care Policy and Financing.

The Medical Home MCH Implementation Team will implement the state action plan and support local public health agencies in the implementation of their local action plans.

The MCH Program has been exploring the implementation of a Help Me Grow state plan to provide a statewide call-in resource number for children and youth, including those with special needs, that is more comprehensive in scope than the current Family Healthline. This plan will involve multiple state partners and agencies who work with children and youth. The goal is to complete an implementation plan for Help Me Grow during the next grant year.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	58.2	60	60	60	61
Annual Indicator	59.1	59.1	59.1	59.1	49.9
Numerator					
Denominator					
Data Source		National Survey of CSHCN			
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	51	51	51	51	51

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The 2009-2010 results are not available until late 2011, so reporting year 2010 repeats the data shown for reporting year 2007, 2008, and 2009.

Notes - 2009

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The next survey went out in the field in early 2009, so reporting year 2009 data repeats the data shown for reporting years 2007 and 2008.

a. Last Year's Accomplishments

The annual indicator for reporting year 2011 showed that 49.9 percent of families with children with special health care needs had adequate private and/or public insurance to pay for the services they need. The rate dropped from 59.1 percent in reporting year 2010. Since the new data is based on the 2009-2010 National Survey of CSHCN, however, it does not take into account the 2010 CHP+ expansion and therefore may not be accurate. The target for reporting year 2011 was 61.0 percent and it was not met.

Health Care Program for Children with Special Needs (HCP) staff continued to participate with the Medicaid and Kids and the Covering Kids and Families Coalitions to share information, simplify the public insurance application process and identify concerns for families using public insurance.

Colorado Children's Healthcare Access Program and Family Voices Colorado continued using the Provider Resource Helpline for health care providers in Colorado. The helpline provided information about insurance and resources for families and providers. During fiscal year 2011 there were 156 phone contacts with providers and 18 individual families.

When local county public health agency staff provides HCP Care Coordination, they assist families with insurance coverage and/or local payer sources for services. Insurance data was recorded for 2,340 children receiving care coordination.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Participated in Medicaid and Kids and the Covering Kids and Families Coalitions				X
2. Continued using the Provider Resource Helpline		X	X	
3. Collected insurance data for children and youth with special needs receiving HCP Care Coordination				X
4.				
5.				
6.				
7.				
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b. Current Activities

The target for the reporting year 2012 is 51.0 percent (adjusted from 61.0 percent) based on the 2011 annual indicator of 49.9 percent.

The new Children CYSHCN data system was launched on November 1st and includes the collection of insurance data for the population receiving HCP Care Coordination. This data will inform future programmatic decisions in order to most effectively support CYSCHN with care coordination services.

HCP staff participates with the Medicaid Kids and the Covering Kids and Families Coalitions to share information to simplify the public insurance application process and identify concerns for families using public insurance.

The Colorado Health Care Affordability Act allows families who make too much to qualify for Medicaid or Child Health Plan Plus (CHP+) to "buy into" Medicaid coverage for their children with a disability by paying a monthly premium based on their family's income. Qualifying children are those under age 19, who have a qualifying disability using the Social Security Administration listings, and whose family income is below 300% of the federal poverty level. Children enrolled in the Medicaid Buy-In Program will receive Regular Medicaid benefits with monthly premiums ranging from \$0 to \$120. The program began July 1, 2012.

c. Plan for the Coming Year

The target for reporting year 2013 is 51.0 percent.

Activities will continue for the upcoming year.

The Colorado Department of Health Care Policy and Financing (HCPF) contracted with Regional Care Collaborative Organizations (RCCOs) as part of Medicaid reform for provider support, medical management and care coordination, and accountability for the Medicaid population. MCH state and local public health staff are meeting with HCPF and the RCCOs to discuss how to collaborate and leverage services for the birth to 21 Medicaid population. The RCCO network is still in a pilot phase with 38 percent of the state's children on Medicaid enrolled in a RCCO. This discussion will continue with the planned expansion of the RCCOs in 2012-13 and HCP will continue to provide care coordination for children on Medicaid during this transition period.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	77.4	87.8	87.8	88	89
Annual Indicator	87.8	87.8	87.8	87.8	60.1
Numerator					
Denominator					
Data Source		National Survey of CSHCN			
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	61	61	61	61	61

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The 2009-2010 results are not available until late 2011, so reporting year 2010 repeats the data shown for reporting year 2007, 2008, and 2009.

Notes - 2009

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The next survey went out in the field in early 2009, so reporting year 2009 data repeats the data shown for reporting years 2007 and 2008.

a. Last Year's Accomplishments

The annual indicator for reporting year 2011 showed that 60.1 percent of families with children with special health care needs reported the community-based service systems are organized so they can use them easily. The target for reporting year 2011 was 89.0 percent; it was not met. The 2011 indicator cannot be directly compared to the 2011 target that was set based on indicators derived from a different, earlier, set of questions.

Local agencies presented "lessons learned" from their experiences with the MCHB Integrated Services Grant at the Medical Home Community Forum in April 2011.

The Family Leadership Training Institute (FLTI) was offered in four communities. Sixty participants graduated and 42 percent of the participants had children with special needs. See NPM 2 for more information about the FLTI last year, in the current year and the coming year.

An assessment of local systems development for ease of use was included as part of local MCH/Health Care Program for Children with Special Needs (HCP) planning and reporting process.

The HCP returned administration of the Traumatic Brain Injury Program to the Colorado Department of Human Services (CDHS) in June 2011. Children with traumatic brain injury will still be referred for HCP Care Coordination in local communities. CDHS and the Colorado Department of Education developed an infrastructure for local TBI liaisons from school districts and the community. Community TBI liaisons are often from local HCP offices and have experience providing care coordination for Children and Youth with Special Health Care Needs (CYSHCN).

HCP provided support for over 100 local specialty clinics in rural areas of the state through a contract with the University of Colorado School of Medicine and Children's Hospital Colorado. Specialty clinics include neurology, orthopedic, rehabilitation, and diagnostic and evaluation clinics. The specialist clinicians are provided by the University of Colorado School of Medicine, with local coordination provided by local public health agency staff.

The new HCP Care Coordination model was developed and finalized based on a review of the literature and best practices in care coordination. The new model provides a standardized approach to care coordination that will be utilized by HCP offices throughout the state. HCP Care Coordination staff from local public health agencies was trained on the new model and the new CYSHCN data system in the fall of 2011.

The HCP Care Coordination Nurse Consultant participated in the Colorado Care Coordination Community of Practice workgroup. The workgroup developed a standard definition, functions and outcomes for care coordination to be utilized as a resource by organizations providing care coordination services.

The Children and Youth Branch was developed in April 2011, and integrates the Child and Adolescent School Health Unit with the Children with Special Health Care Needs Unit. This has increased opportunities for integration across MCH programs and initiatives. Examples included health integration work with Early Childhood Councils; medical home efforts for all MCH populations; family participation/leadership for youth initiatives; and inclusion of children with special needs in all child and youth initiatives.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Finalized MCHB Integrated Services Grant and local communities presented "lessons learned"				X
2. Family Leadership Training Institute coordinated in four communities				X
3. Local systems development included as part of local MCH Operational Plans with an emphasis on early childhood				X
4. Transition of TBI Program to DHS with development of infrastructure for local liaisons from community and school districts				X
5. Continued support for HCP specialty clinics				X
6. Continued support for HCP Care Coordination				X
7.				
8.				
9.				
10.				

b. Current Activities

The target for reporting year 2012 is 61.0 percent (adjusted from 89.0 percent). The 89.0 was based on the 2005/06 National Survey of CSHCN rate of 87.8 percent. However, the 2009-2010 National Survey of CSHCN rate was only 60.1 percent and, therefore, the target was reduced.

All local public health agencies (LPHAs) participating in the MCH/HCP planning process are required to submit a medical home local action plan. The Medical Home MIT developed the local action plan template based on previous experiences of the MCHB Systems Integration pilot communities, the Colorado-based Early Childhood Health Integration grantees, and HCP local systems building efforts. The template includes the identification of barriers to a medical home approach experienced by children, youth and families. LPHAs are encouraged to examine the experiences of CYSHCN to help illuminate and prioritize the systemic barriers that need to be addressed in their community.

HCP maintains a contract with University Physicians, Inc., the University of Colorado School of Medicine and the Children's Hospital Colorado for HCP specialty clinics. A LEAN event was held with LPHA clinic coordinators to identify efficiencies in administration and opportunities to standardize procedures.

State staff participates in the Colorado Respite Coalition to identify strategies to increase support of respite for families with CYSHCN.

c. Plan for the Coming Year

The target for reporting year 2013 is 61.0 percent.

Activities will continue for the upcoming year.

The plan to regionalize specialty clinic host sites and support the use of telemedicine will be implemented. An evaluation of the new regional structure for specialty clinics will be completed in FY 2013. This will include a review of clinic usage data and survey data from families, local public health staff, providers and the University of Colorado School of Medicine and Children's

Hospital Colorado.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	14	47	48	48	49
Annual Indicator	47	47	47	47	42.1
Numerator					
Denominator					
Data Source		National Survey of CSHCN			
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	44	44	44	44	44

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The 2009-2010 results are not available until late 2011, so reporting year 2010 repeats the data shown for reporting year 2007, 2008, and 2009.

Notes - 2009

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The next survey went out in the field in early 2009, so reporting year 2009 data repeats the data shown for reporting years 2007 and 2008.

a. Last Year's Accomplishments

The annual indicator for reporting year 2011 showed that 42.1 percent of youth with special health care needs received the services necessary to make transitions to all aspects of adult life. The decrease from 2010 was not statistically significant. The target for reporting year 2011 was 49.0 percent and it was not met.

The Medical Home Youth Leadership Council continued to provide trainings, especially on how the medical home approach relates to transition. Members completed documents addressing issues including:

- FAQ's about disabilities that most "typical" kids want to know
- Checklist for providers on how to have a successful clinic visit with a YSHCN
- Youth endorsing the Medical Home Model

In addition, they provided feedback on marketing materials from state staff and local communities. They also designed and populated a page on www.ColoradoMedicalHome.com specifically designed for young adults. The group also produced a video promoting the Medical Home model, featuring the perspective of youth from this Council as well as other youth leaders. This professionally produced video serves as an orientation to the medical home model, featuring perspectives from a physician, community leader and youth. These three distinct but integrated perspectives give compelling reasons why the medical home model is the "new old way of delivering health care" for youth in a community setting.

The activities of the Council ended in May 2011. Sustainability of the work is maintained through continued collaboration with the Youth Partnership for Health, CDPHE's youth advisory group, coordinated by the Youth and Young Adult Unit. These two groups met jointly to share experiences, insights and resources. Members of these two groups expressed that this was a powerful learning opportunity due to the open dialogue within a fully inclusive setting.

Contract requirements with local public health agencies include objectives to address transition within care coordination activities. The Colorado Department of Education (CDE), due to IDEA regulations, is a key partner and made progress in including health issues as part of their resource dissemination. Further collaboration with CDE involved care coordination and support for families who have a youth with Traumatic Brain Injury to assure that transition services and strategies are discussed with these families/youth.

Family Voices Colorado, supported by Title V, convened a stakeholder group at The Children's Hospital Colorado to address transition from the pediatric to the adult health system.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Medical Home Youth Leadership Council provided trainings			X	X
2. The Council also created a website and a video			X	
3. Collaboration with CDE continued		X	X	
4. Family Voices convened a stakeholder group				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The target for reporting year 2012 is 44.0 percent.

The Colorado Medical Home Initiative promotes health care transition planning as an essential element of a Medical Home Team Approach. The Initiative heavily encourages partners to consider transition a priority at the clinical and community level.

The Title V State Family Leader will continue to serve as a Title V and parent representative on the National Cabinet for the National Center for Transition -- Got Transition? Working closely with the youth leader on the Cabinet, the Family Leader is proactive in sharing the family perspective through the transition process. Colorado was chosen by the National Center on Transition to implement a learning collaborative related to transitioning youth from the pediatric health system to the adult system. The Title V State Family Leader participates on the planning and implementation team, a collaboration with a provider from Children's Hospital Colorado. This learning collaborative features a large pediatric practice working in partnership with adult health providers to assure a smooth transition for YSHCN. New policies, forms, checklists and patient welcome kits have all been developed as a result of this project. At the conclusion of the learning collaborative in June 2013, lessons learned and replication strategies will be shared with the entire Title V network.

c. Plan for the Coming Year

The target for reporting year 2013 is 44.0 percent.

Activities from the previous year will continue.

Collaboration with the National Center on Healthcare Transition will continue. Best practices will be identified as a result of the Got Transition Learning Collaborative project, of which Colorado was selected as a research site. Joining Boston and Washington DC, Denver's project features a PDSA cycle of change theory related to successfully transitioning youth from the pediatric system to the adult health care system.

The Title V Family Leader will work closely with the MCH Implementation Team dedicated to developing a comprehensive Youth System, (similar to the work and framework of the Early Childhood System) to assure YSHCN are represented.

The Title V Family Leader will continue to participate on a national workgroup convened by AMCHP to address a comprehensive approach to developing effective youth leaders, including YSHCN, within projects and activities supported by AMCHP. Lessons learned and any subsequent promising practices gained from this work will be integrated into the work of the Youth and Young Adult Unit.

The care coordination process in the local Title V agencies will feature questions for youth and families regarding transition.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011

Annual Performance Objective	90	85	80	80	80
Annual Indicator	80	78.6	79.4	67.1	75.6
Numerator					
Denominator					
Data Source		2007 National Immunization Survey	2008 National Immunization Survey	2009 National Immunization Survey	2010 National Immunization Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	80	80	80	80	80

Notes - 2011

Data shown for reporting year 2011 are for the 4:3:1:3:3 series for calendar year 2010. This indicator represents the 4:3:1:3:3 series as defined originally, and can only be compared with the reporting year 2010 indicator. It is not recommended for comparison to years prior to reporting year 2010 because of the changes made in the way the Hib vaccine is now measured and the vaccine shortage that affected a large percent of children that were included in the 2009 and 2010 samples.

Notes - 2010

Data shown for reporting year 2010 are for the 4:3:1:3:3 series for calendar year 2009 from the National Immunization Survey. Note that there was a shortage of the Hib vaccine which could be partly responsible for the drop in immunization rates between 2008 and 2009. Targets for future years are all set at 80 percent.

The Colorado 2009 rate for the 4:3:1:3:3:1 series was 65.2.

Notes - 2009

Data shown for 2009 are for the 4:3:1:3:3:1 series for calendar year 2008 from the National Immunization Survey. See http://www2a.cdc.gov/nip/coverage/nis/nis_iap2.asp?fmt=r&rpt=tab29_43133_race_iap&qtr=Q1/2008-Q4/2008. Targets for future years are all set at 80 percent.

The Colorado 2008 rate for the 4:3:1:3:3 series was 80.7.

a. Last Year's Accomplishments

The annual indicator for reporting year 2011 showed that 75.6 percent of the 19--35 month olds received the full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilis Influenza, and Hepatitis B. The target for

reporting year 2011 was 80.0 percent and the target was not met. It should be noted that there were modifications to the vaccine series during this time. Although the availability of newer vaccines results in increased immunity in children, these additions pose challenges for the achievement of total updated rates as provider and public consumer education takes time. The Immunization Program suggests that the most beneficial data to reflect the status of Colorado's 19-35 month old children would be to report the status of each of the 12 antigens separately (See attached table).

MCH supported the largest public health agency to monitor vaccine records in licensed childcare centers in three highly populated counties in the Denver metropolitan. Staff reviewed vaccine records, educated childcare directors and conducted follow up reviews with 80 percent "up-to-date" record results.

The Colorado Immunization Information System (CIIS), an internet program within the Colorado Immunization Section at CDPHE, is a confidential, population-based, computerized system that collects and consolidates vaccination data for Coloradans of all ages from a variety of sources. This CIIS system was physically replaced with a web based system with a more robust, stable and modern immunization registry application. During this past year, more users and viewers have been added to the CIIS system. Most school districts are able to view student immunization records and some actually add new information for students, including preschool students, who present accurate immunization records. It is hoped that this access will improve the accuracy of student level immunization rates for schools. As of March 2012, 100 percent of public health departments, 100 percent of community health clinics, 87 percent of rural health clinics, 87 percent of pediatric clinics and 64 percent of family practice clinics in Colorado are linked with the CIIS. Additionally, 86 percent of school districts and 38 percent of Head Start programs access CIIS. CIIS has just started outreach and implementation to Colorado's more than 4,000 licensed child care centers.

The Colorado Immunization Program created a new and improved de-identified data collection methodology for the school immunization survey developed to comply with the provisions of Family Education Rights and Privacy Act (FERPA) and Colorado Revised Statute 25-4-906(3) of ensuring the required immunization of school aged children is achieved. The new system eliminated the need for CDPHE staff or their authorized representatives to visit schools to review student immunization records; rather it empowered school nurses to independently provide records of the immunization data should their school be selected in the annual random sample.

A new media campaign has been introduced in Colorado, "Immunize for Good". This is a Vaccine Advisory Committee of Colorado (VACC) project that was a joint venture of the Colorado Children's Immunization Coalition and Colorado Department of Public Health and Environment. These organizations work to further childhood immunization coverage in Colorado through education, vaccine provider resources and parental support. It is comprised of parent-focused online resources, strategically placed Billboards, media spots and educational handouts for parents and the public to get the facts about vaccine safety, how vaccines work, the vaccine schedule and vaccine preventable diseases.

An attachment is included in this section. IVC_NPM07_Last Year's Accomplishments

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Partnered with schools for required vaccine rates surveillance			X	X
2. Funds provided to local public health agencies to increase vaccine coverage	X	X	X	X
3. Implemented of new web based CIIS (registry)				X
4. Focused media campaign for parents and providers			X	X

5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The target for this reporting year 2012 remains at 80.0 percent with the recommendations that Colorado children have vaccinations for 12 diseases by the time they reach the age of 35 months, including Hepatitis A, Pneumococcal disease and Varicella. The data for this reporting year will be available in September 2012. (See separate antigen reporting recommendations above).

The Colorado Immunization Program implemented a new school surveillance survey to assess immunization rates of kindergartners. This surveillance reviewed the vaccine status of 350 students selected from 297 randomly selected schools throughout the State. For the 2010/2011 school year 69.1 percent - 78.55 percent of kindergartners in Colorado were up-to-date. The data for the 2011-2012 school year is not available at this time.

Beginning in April of 2012, the Colorado Immunization Program (CIP) initiated a campaign to highlight the harms associated with delayed and so-called "alternative" immunization schedules that have gained popularity in recent years. CIP is reaching out to parents and providers to discuss these schedules and the parental fears and misconceptions that have contributed to their popularity. Using the Immune for Good campaign, media outreach, and public speaking opportunities, CIP is focusing on the importance of vaccinating children on time and the strong safety profile of childhood immunizations.

c. Plan for the Coming Year

The target for reporting year 2013 will be 80.0 percent for each individual antigen that is recommended for 19--35 month old children.

Activities will continue from the previous year including enhancing local partnerships between local public health, schools and child care facilities to monitor completed immunization certificates for required immunizations, provision of offsite vaccine clinics and provision of educational information related to the efficacy of childhood vaccine.

Both state and local public health agencies will continue to provide the latest immunization information to providers, staff and parents. In collaboration with the Colorado Immunization Information System (CIIS) staff, public health will continue to engage providers to utilize the updated CIIS registry system. The goal for Colorado is 100% of all vaccine providers.

The Vaccine Advisory Committee for Colorado (VACC) will continue with their work plan activities related to: Provider Education and Public Awareness and Education. Using the Immune for Good campaign, media outreach, and public speaking opportunities, the Colorado Immunization Program will continue focusing on the importance of vaccinating children on time and the strong safety profile of childhood immunizations.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	23	22	21.5	21	19.5
Annual Indicator	23.7	22.1	21.4	19.9	17.4
Numerator	2312	2200	2142	1971	1688
Denominator	97617	99489	100252	98871	97252
Data Source		Birth Certificates	Birth Certificates	Birth Certificates	Birth Certificates
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	17	17	16.5	16.5	16

Notes - 2011

Data shown for reporting year 2011 are calendar year 2010 births. These data are available from the Colorado Health Information Dataset (CoHID) at <http://www.chd.dphe.state.co.us/cohid/Default.aspx>.

Notes - 2010

Data shown for reporting year 2010 are calendar year 2009 births. This data is provided in the Colorado Births and Deaths document available at <http://www.cdphe.state.co.us/hs/mchdata/mchdata.html>.

Notes - 2009

Data shown for reporting year 2009 are calendar year 2008 births. This data is provided in the Colorado Births and Deaths document available at <http://www.cdphe.state.co.us/hs/mchdata/mchdata.html>.

a. Last Year's Accomplishments

The annual indicator for reporting year 2011 was 17.4 per 1,000. The target for reporting year 2011 was 19.5 per 1,000 and the target was met.

The decline in the teen birth rate continued from the previous year, but the 13 percent drop in the rate was the largest change in over a decade. The Colorado Family Planning Initiative funded a large expansion in clients and use of long-acting contraceptives (LARCs) through Title X beginning in 2009. A preliminary analysis of the impact of the Initiative suggests greatly increased use of LARCs among teens contributed to the decline in teen births as early as 2010 (reporting year 2011).

The Youth Sexual Health Team (YSHT), previously known as the Adolescent Sexual Health workgroup, began work with Colorado Youth Matter and its subcontractor, the Healthy Colorado Youth Alliance, to develop a statewide youth sexual health plan.

The Children and Youth Branch collaborated with the STI/HIV Section to develop a web-automated human interaction (WAHI) website about youth sexual health (www.mylifecolorado.com).

The Colorado Department of Human Services received Personal Responsibility Education Program (PREP) funding and worked with CDPHE and the Colorado Department of Education on the project. In addition, team members presented a session on positive youth development during the Women's Health and Family Planning Conference in June 2011. The goal of the conference was to provide educational and collaborative opportunities for professionals working to prevent unintended pregnancy and promote women's health across Colorado.

YSHT members partnered with Colorado Youth Matter (then the Colorado Organization on Adolescent Pregnancy, Parenting, & Prevention) to create its annual report, the "State of Adolescent Sexual Health in Colorado," which provides a brief summary of relevant state and national data, along with providing a picture of how Colorado has progressed over time.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Developed a youth sexual health plan				X
2. CDPHE STI/HIV Branch and Children and Youth Branch released mylifecolorado.com			X	
3. Received PREP and abstinence funding				X
4. Colorado Youth Matter released reports relevant to youth sexual health				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The target for reporting year 2012 is 17.0 per 1,000.

Colorado Youth Matter and its subcontractor, the Healthy Colorado Youth Alliance, under the direction of the YSHT, completed a statewide youth sexual health "call to action," called Youth Sexual Health in Colorado: A Call to Action. This plan is based on input from communities across the state and outlines strategies and actions for communities to effectively affect youth sexual health (see attached).

CDPHE developed a statewide youth sexual health network, which will connect youth-serving professionals who are working on the topic. CDPHE also researched parent/child communication curriculums and is planning to implement trainings regionally over the next year.

The YSHT continues to partner with The Colorado Initiative to Reduce Unintended Pregnancies and Vermilion Inc. on the public awareness campaign, Beforeplay, which launched in February 2012. Campaign materials are placed in various media across the state. The website (www.beforeplay.org) provides a clinic locator and interactive reproductive health information for teens, parents, men, women and health care professionals.

In January 2012, Colorado announced Unintended Pregnancy as one of 10 Winnable Battles. Prevention of Teen Pregnancy is included in this Winnable Battle. The Unintended Pregnancy Winnable Battle has a Google Group listserv for sharing information. Local agencies have also identified preventing unintended pregnancy as a priority.

An attachment is included in this section. IVC_NPM08_Current Activities

c. Plan for the Coming Year

The target for reporting year 2013 is 17.0 per 1,000.

Activities will continue from the previous year.

CDPHE will continue work related to the youth sexual health logic models and action plans, which were developed with input from the Youth Sexual Health Team (also serving as the MCH Implementation Team) and finalized in the spring of 2012. Representatives from local public health agencies also contributed to the creation of these materials, as they will serve as the work plans for collaborative youth sexual health work both at the state and local level. The logic models and action plans have been shared with local public health agencies across the state and have been adapted locally by those agencies that are working on youth sexual health. The five main domains of the action plan include implementing the Call to Action (Youth Sexual Health Plan), increasing youth access to accurate information and services, creating a youth sexual health network, providing parent/child communication programs and promoting policy recommendations.

Team members will work with a contractor to provide evidence-based, parent-child connectedness trainings across Colorado.

CDPHE will continue partnering with The Colorado Initiative to Reduce Unintended Pregnancies and Vermilion Inc. on the public awareness campaign, Beforeplay.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	36	36	38	38	40
Annual Indicator	35	35	37.1	37.1	37.1
Numerator					
Denominator					
Data Source		2006-2007 CO Basic Screening Survey	2006-2007 CO Basic Screening Survey	2006-2007 CO Basic Screening Survey	2006-2007 CO Basic Screening Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or				Final	Final

Final?					
	2012	2013	2014	2015	2016
Annual Performance Objective	40	42	42	42	42

Notes - 2011

Data for reporting year 2011 are final Basic Screening Survey data from the 2006-2007 school year for a representative sample of third graders. The indicator repeats data previously reported since the survey is conducted every three to four years.

The 2011-2012 survey results were not available by the time of application submission. Since new results were not available for reporting year 2011, the annual performance objectives were kept the same.

Notes - 2010

Data for reporting year 2010 are final Basic Screening Survey data from the 2006-2007 school year for a representative sample of 3rd graders. The data repeat the data reported for 2007 since the survey is conducted every three to four years. The 2010-2011 survey results will be available for reporting year 2011. Since new results were not available for reporting year 2010, the annual performance objectives were kept the same.

Notes - 2009

Data reported for 2009 are final Basic Screening Survey data from the 2006-2007 school year for a representative sample of 3rd graders. The data repeat the data reported for 2007 since the survey is conducted every three years. That next survey will start in fall 2010.

The reporting year 2008 indicator was incorrect. The correct indicator is reported here.

a. Last Year's Accomplishments

The indicator for reporting year 2011 showed that 37.1 percent of third grade children in Colorado have dental sealants on at least one permanent molar tooth. The target for reporting year 2011 was 40.0 percent, and the target was not met.

Considerable progress was made in expanding the Be Smart and Seal Them school sealant program. In the 2008-2009 school year, 28 percent of eligible schools (those with 50 percent or more of the student population qualifying for the Free and/or Reduced Lunch Program) received these preventive services. In the 2010-2011 school year, Colorado's school sealant program reached 230 schools, serving 46 percent of all eligible schools in Colorado. Ten contractors screened 5,382 children and placed protective sealants on 3,726 children. One hundred percent of all eligible schools in the Denver Metro area, the most densely populated area of the state, are now being served by school sealant programs.

In addition to supporting ten school sealant programs in 2010-2011, the Oral Health Unit (OHU) provided funding to two local public health agencies through planning grants. The funds supported staff necessary to ascertain the feasibility of implementing a school sealant program in the respective rural communities.

The OHU regularly loans mobile dental units, operator chairs and over-head dental lights to brand new school sealant programs to help defray start-up costs. In 2010-2011, equipment was loaned to the Aspen to Parachute Dental Coalition.

In 2010, the OHU contracted with researchers at the University of Colorado Denver, Colorado School of Public Health to estimate cost savings associated with and the cost-effectiveness of dental sealant programs provided in elementary schools for second-grade school children in Colorado. The purpose of the project was to:

1. Describe school dental sealant program (SDSP) utilization and related costs

2. Analyze dental service utilization data for caries in first molars and estimate the cost of treating first molar caries using the data
3. Estimate cost savings and the cost effectiveness of Colorado school sealant programs from the societal perspective using the data provided by SEALS and interviews with individual providers

The key findings were:

1. The ten Colorado SDSPs conducted oral health screenings for nearly 5,000 and provided dental sealant services for nearly 70 percent (n=3,389) of the children screened. The average number of teeth sealed per child who had sealants placed was 3.1.
2. The average SDSP participation rate was 50 percent (i.e., number of children screened divided by the number of program consent forms distributed in the second grade classes).
3. Twenty-five percent of children screened had existing decay. On average, they had 2.0 first molars with existing decay. Approximately two-thirds of these children had sealants placed; the average number of teeth sealed among these children was 2.3.
4. The SDSP average cost per child provided dental sealants was \$113. The average cost per sealant placed was \$37.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Used planning grants to increase reach of the school sealant program				X
2. Loaned dental equipment to defray start-up costs				X
3. Conducted a Cost Analysis of School Sealant Program				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The target for reporting year 2012 is 40.0 percent.

CDPHE has named oral health as one of the ten "Winnable Battles" for the state. As a result, a Tri-Agency Collaborative has been formed with representation from the Colorado Department of Human services, Health Care Policy and Finance, and CDPHE with additional representation from a diverse group of state and local stakeholders. Out of the Collaborative, four workgroups have formed. The workgroup charged with developing strategies to improve the oral health of school aged children is in the process of conducting key informant interviews and an in-depth literature review to identify best and promising practices.

The OHU, in partnership with the Epidemiology, Planning and Evaluation Branch, is working to finalize the 2011-2012 BSS data. The findings will be published and communicated to stakeholders and used to track progress against performance measures to inform future program direction.

The OHU is creating a series of podcasts to assist contractors in becoming successful, independent providers, able to bill Medicaid and SCHIP for oral health services delivered in a school setting, leading to sustainable school sealant and school varnish programs.

Two new sealant programs began delivering services in rural areas of Colorado in the 2011-2012 school year, a direct result of planning grants awarded the previous year.

The Cost Study Analysis is complete and is being prepared for publication.

c. Plan for the Coming Year

The target for reporting year 2013 is 42.0 percent.

Activities described above will continue.

School-based Health Centers (SBHCs) can be instrumental in diminishing the burden of oral disease. The OHU actively participates in the Colorado Coalition for Healthy Schools that supports coordinated school health programs.

The OHU continues to market the school sealant program at the Colorado Dental Hygiene Annual Session, the Rocky Mountain Dental Convention and other venues, such as the Colorado Association of School Nurses and the Colorado Association of School Based Health Centers.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	3	3	2.5	2.4	2.2
Annual Indicator	3.2	2.7	2.6	2.3	2.0
Numerator	32	28	27	24	20
Denominator	1002764	1019648	1036835	1040402	1025217
Data Source		Death certificates	Death certificates	Death certificates	Death certificates
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	1.9	1.8	1.7	1.6	1.5

Notes - 2011

Data shown for reporting year 2011 are calendar year 2010 deaths. The data were retrieved from the Colorado Health Information Dataset (CoHID) at <http://www.chd.dphe.state.co.us/cohid/Default.aspx>.

Notes - 2010

Data shown for reporting year 2010 are calendar year 2009 data representing deaths from all motor vehicle injuries for children from birth through age 14. The data were retrieved from the Colorado Health Information Dataset (CoHID) at <http://www.cdphe.state.co.us/cohid/>.

Notes - 2009

Data shown for reporting year 2009 are calendar year 2008 data representing deaths from all motor vehicle injuries for children from birth through age 14. The data were retrieved from the Colorado Health Information Dataset (CoHID) at <http://www.cdphe.state.co.us/cohid/>.

a. Last Year's Accomplishments

The indicator for reporting year 2011 was 2.0 deaths per 100,000 children ages 14 years and younger caused by motor vehicle crashes. The target rate for reporting year 2011 was 2.2 per 100,000 children and the target was met.

The Injury, Suicide and Violence Prevention (ISVP) Branch completed a two-year child injury prevention policy grant project that included strategies to enhance Colorado's booster seat law to require children to be secured in booster seats until at least age eight. The ISVP Branch convened a Child Injury Policy Subgroup (CIPS) of the Injury Community Planning Group (ICPG) to oversee the implementation and evaluation of the Policy Plan developed in June 2010.

The CIPS partnered with the Colorado Department of Transportation to develop materials to educate the public about Colorado's new booster seat law that went into effect in August 2010.

During the 2011 legislative session, the ISVP Branch and the CIPS provided input to successfully close a loophole in the child restraint law, passed in 2010 (SB10-110), which put Colorado's child passenger safety law out of compliance with federal regulations.

To begin to measure the impact of the enhanced booster seat law, the ISVP Branch added a question to the 2010 Colorado Child Health Survey about booster seat use. This data will serve as a baseline to evaluate the impact of the 2010 booster seat law. ISVP Branch staff completed a baseline report using this data and distributed it to injury prevention partners statewide.

ISVP staff continued to serve as a board member on the state Child Passenger Safety Advisory Board.

The Colorado Child Fatality Prevention System (CFPS) State Review Team conducted reviews of motor vehicle death cases that involve children ages 0-14 from 2008. The team aggregated the findings, identified strategies to prevent child motor vehicle deaths and issued recommendations to the Colorado General Assembly in their Annual Legislative Report. Motor-vehicle related recommendations included: 1) establishing a statutory requirement that allows for primary enforcement of the seat belt law, making it possible for a driver to be stopped and issued a citation if anyone in the vehicle is not properly restrained; and 2) strengthening Colorado's graduated drivers license law by increasing the driving age to 17 and expanding the curfew hours to 10 p.m. to 5 a.m.

Colorado was one of ten states to receive a Motor Vehicle Policy grant from the Centers for Disease Control and Prevention. The ISVP Branch will receive \$750,000 over five years to 1) strengthen Colorado's graduated driver's license (GDL) law by increasing the minimum driving age and expanding the restricted driving hours for teens; and 2) establish a statutory requirement that allows for primary enforcement of Colorado's seat belt law. This project began on August 1, 2011 and will continue through July 2016.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Implemented and evaluated a Policy Plan				X
2. Participated in the creation and dissemination of social marketing materials to educate parents and law enforcement about Colorado's new booster seat law			X	
3. Prepared bill analyses for decision makers that lead to the removal of a loophole in the booster seat law				X
4. Collected baseline data to evaluate the effectiveness of the booster seat law				X
5. Served on the state Child Passenger Safety Advisory Board				X
6. Conducted reviews of motor vehicle death cases that involve children ages 0-14				X
7. Obtained grant funding to promote seat belt use for all occupants of motor vehicles				X
8.				
9.				
10.				

b. Current Activities

The target for reporting year 2012 is 1.9 deaths per 100,000 children age 0-14.

The ISVP Branch expanded CIPS to include additional policy partners and renamed the group the Injury and Violence Policy Committee (IVPC). The ISVP Branch worked with the IVPC to expand the Policy Action Plan to include strategies related to establishing primary seat belt legislation. Additionally, the ISVP Branch worked with the EPE Branch to develop an associated evaluation plan. The ISVP Branch held a Motor Vehicle Policy Symposium in July 2012 for local MCH agencies and their community-based partners.

The ISVP Branch and the Violence and Injury Prevention (VIP) Network (formally ICPG) continued to promote seat belt use for all occupants of motor vehicles and monitored motor vehicle-related legislation during the 2012 legislative session.

The ISVP Branch and the VIP Network developed a collaborative website to house injury information and resources (www.VIPreventionnetworkco.com).

ISVP staff continues to serve as a board member on the State CPS Advisory Board.

The CFPS State Review Team conducted comprehensive reviews of motor vehicle death cases that involved children ages 0-14 from 2009 and 2010. The team identified strategies to prevent child motor vehicle deaths and made recommendations to the Colorado General Assembly to enhance the primary seat belt and GDL laws. Prevention recommendations for other stakeholder groups were compiled in a Community and Systems recommendation report.

c. Plan for the Coming Year

The target for reporting year 2013 is 1.8 deaths per 100,000 children age 0-14.

The ISVP Branch will implement the Year Two activities outlined in Colorado's Motor Vehicle Policy grant and the Motor Vehicle Policy Plan. Activities will include: 1) building state-level partnerships; 2) educating about existing child passenger safety laws; 3) maintaining monitoring data systems related to child passenger safety; and 4) providing technical assistance to local partners.

The ISVP Branch and the VIP Network will continue to promote seat belt use for all occupants of motor vehicles and monitored motor vehicle-related legislation during the 2012 legislative session.

The ISVP Branch will include questions on the 2013 Child Health Survey to determine how many parents properly restrained their children in booster seats. This percentage will be compared to the baseline data from 2010 to evaluate Colorado's new booster seat law.

The ISVP Branch and the VIP Network will develop a motor vehicle section of the VIP Network website.

ISVP staff will continue to serve as a board member on the State CPS Advisory Board.

The Colorado Child Fatality Prevention State Review Team will conduct comprehensive reviews of motor vehicle death cases that involve children ages 0-14 from 2011. The team will identify strategies to prevent child motor vehicle deaths and will make recommendations to the Colorado General Assembly, state agencies, and community organizations.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	47	43	50	60	60
Annual Indicator	42	48.2	59.5	57.7	55.6
Numerator					
Denominator					
Data Source		2007 National Immunization Survey	2008 National Immunization Survey	2009 National Immunization Survey	2010 National Immunization Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	60	60	60	60	60

Notes - 2011

Data shown for reporting year 2011 are breastfeeding data collected by the National Immunization Survey for infants born in 2008 (see <http://www.cdc.gov/breastfeeding/data/reportcard.htm>). These data represent all breastfeeding (not just exclusive breastfeeding) at six months of age. The annual indicator is provisional.

Notes - 2010

Data shown for reporting year 2010 are breastfeeding data collected by the National Immunization Survey for infants born in 2007 (see http://www.cdc.gov/breastfeeding/data/NIS_data/index.htm). These data represent all breastfeeding (not just exclusive breastfeeding) at six months of age. The percentage is provisional.

Notes - 2009

Data shown for reporting year 2009 are breastfeeding data collected by the National Immunization Survey for infants born in 2006 (see http://www.cdc.gov/breastfeeding/data/NIS_data/index.htm). These data represent all breastfeeding (not just exclusive breastfeeding) at six months of age. The percentage is provisional.

a. Last Year's Accomplishments

The indicator for reporting year 2011 showed that provisionally 55.6 percent of mothers breastfed their infants at six months of age. The target for reporting year 2011 was 60.0 percent and the target was not met.

Six month breastfeeding duration rates for mothers participating on the WIC Program currently are not available for 2011 due to a statewide change in its computer system.

Women who begin their breastfeeding experience successfully in the hospital are more likely to breastfeed longer. The CDPHE set out to understand the presence and level of implementation of breastfeeding policies in Colorado's hospitals with maternity services. The survey asked questions addressing the Colorado Can Do 5! (CCD5) practices as well as other components of the Baby-Friendly Hospital Initiative. There is room to improve. For example, among the 49 (94 percent) hospitals responding, 88 percent of hospitals report having a policy to practice rooming-in while only 56 percent of hospitals had policies regarding pacifier use. In addition to the survey, hospitals were invited to apply for a Colorado Can Do 5! B.E.S.T. (Breastfeeding Excellence Starts Today) award by submitting copies of their breastfeeding policies for review. The policies had to be inclusive of the CCD5 practices to be considered. Thirteen of the 18 hospitals that applied received an award and public recognition as CCD5 hospitals.

CDPHE participated in three national efforts to improve breastfeeding rates: One, as part of a national breastfeeding awareness campaign led by Milk for Thought (MFT) (www.milkforthought.com), MFT staff taped interviews with several Colorado breastfeeding champions on the CCD5 for videos eventually to be posted on the web as a resource for hospitals to encourage taking steps toward the Baby-Friendly Hospital Initiative. Two, CDPHE staff also participated in an interstate collaborative to increase widespread implementation of the Ten Steps to Successful Breastfeeding which resulted in evidence-based recommendations for advanced adherence to the Ten Steps and a beginning draft for a research agenda to fill the gaps in the evidence base. Three, CDPHE, Denver Health, and the Colorado Breastfeeding Coalition collaborated with Every Mother, Inc. to produce video vignettes for the updated USDA Loving Support Through Peer Counseling: A Journey Together peer counseling curriculum.

Data comparisons between 2008 and 2010 (the years CDPHE promoted the CCD5 practices to all hospitals) show continuing improvement in the practices of the initiative. For all breastfed infants, Baby roomed in with mother increased from 89.4 percent in 2008 to 91.2 percent in 2010, Staff gave mother a telephone number to call increased from 85.7 percent in 2008 to 89.3 percent

in 2010, Baby was fed only breast milk in the hospital increased significantly from 54.6 percent in 2008 to 61.7 percent in 2010, Baby was breastfed in the first hour increased significantly from 67.0 percent in 2008 to 75.6 percent in 2010, and Baby did not use pacifier in hospital increased from 34.4 percent in 2008 to 38.6 percent in 2010.

The WIC and MCH Programs increased the lactation expertise of 112 public health staff representing WIC dietitians, nurses, educators and breastfeeding peer counselors and public health nurses through Lactation Management Specialist training.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Awarded hospitals implementing five specific breastfeeding supportive practices				X
2. Developed resources (videos, recommendations) to enable communities to improve breastfeeding support		X	X	
3. Provide Lactation Management Specialist (LMS) training		X	X	X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The target for reporting year 2012 is 60.0 percent.

To improve evidence-based practice in hospital maternity services specific to infant nutrition, the department is co-sponsoring with several organizations, Colorado's first Hospital Breastfeeding Summit targeted to hospital staff in leadership roles. The goals are to bring peers together to share experiences, best practices and challenges in embedding the components of the 10 Steps to Successful Breastfeeding; and to encourage attendees to create an action plan to close gaps in maternity practices identified in their CDC Maternity Practices in Infant Nutrition and Care biennial reports. This year's recipients of the CCD5 B.E.S.T. award will be recognized at the summit.

The CDPHE and the state Medicaid staffs collaborated on several activities as a means to improve breastfeeding promotion and support for mothers. CDPHE prepared a fact sheet describing the role of breastfeeding with reducing childhood risk of obesity and provided documentation and references for how hospitals that provide optimal breastfeeding support can reduce health care expenditures.

The Colorado Breastfeeding Coalition used a small grant to identify and work with over 10 employers in various sectors across the state to showcase, in a national database, their efforts to accommodate nursing mothers.

c. Plan for the Coming Year

The target for reporting year 2013 is 60.0 percent.

Drawing on momentum gained during the September hospital summit, Colorado Breastfeeding

Summit: Using Evidence-Based Practices in Our Hospitals, a report of next steps to provide continued technical assistance to hospitals will be drafted.

As hospitals discharge more exclusively breastfeeding infants to the community, the WIC Program will revitalize efforts to ensure staff follow program policies regarding the provision of breastfeeding support and referrals; and the limited provision of formula to breastfeeding infants.

To improve the experiences of breastfeeding mothers and infants using child care, CDPHE will establish standards and best practices for breastfeeding support in Colorado child care settings.

The WIC and MCH Programs will offer a Lactation Management Specialist (LMS) training to local public health agencies to increase the lactation expertise Colorado. LMS staffs are vital to assisting new mothers to overcome barriers to breastfeeding. Over 100 public health staff are expected to attend the three day spring training.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	98	98	98	98	98
Annual Indicator	97.6	97.2	97.8	97.3	97.3
Numerator	68282	68088	67905	66460	64265
Denominator	69939	70082	69432	68310	66066
Data Source		Newborn Hearing Screening Program			
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	98	98	98	98.2	98.2

Notes - 2011

Data shown for reporting year 2011 are calendar year 2010 births.

The numerator is the number of newborns, born to Colorado residents who delivered in Colorado, that underwent newborn hearing screening at birth. The denominator is the number of live births

to Colorado residents who gave birth in Colorado. (The denominator is smaller than the total number of births to Colorado residents by the number of residents who gave birth out of state.)

Notes - 2010

Data shown for reporting year 2010 are calendar year 2009 data.

The numerator is the number of newborns, born to Colorado residents who delivered in Colorado, that underwent newborn hearing screening at birth. The denominator is the number of live births to Colorado residents who gave birth in Colorado. (The denominator is smaller than the total number of births to Colorado residents by the number of residents who gave birth out of state.)

Notes - 2009

Data shown for reporting year 2009 are calendar year 2008 data.

The numerator is the number of newborns, born to Colorado residents who delivered in Colorado, that underwent newborn hearing screening at birth. The denominator is the number of live births to Colorado residents who gave birth in Colorado. (The denominator is smaller than the total number of births to Colorado residents by the number of residents who gave birth out of state.)

a. Last Year's Accomplishments

The indicator for reporting year 2011 showed that 97.3 percent of newborns were screened for hearing before hospital discharge. The target for reporting year 2011 was 98.0 percent and the target was not met.

Colorado continues to work collaboratively with other state agencies and partners to develop comprehensive systems from screening through early intervention at both the state and local level. The local Early Hearing Detection and Intervention (EHDI) teams are comprised of hospital coordinators, local Audiology Regional Coordinators, Hands & Voices Parent Guides, Colorado Hearing Resource Coordinators, Part C Coordinators, Health Care Program for Children with Special Health Care Needs nurses and other stakeholders (physicians, audiologists). The local EHDI teams continue to meet to address barriers in the EHDI system such as follow-up, travel to pediatric specialists and costs of services. The local EHDI teams, building on the previous work from the National Initiative in Child Health Quality (e.g. schedule the outpatient rescreen appointment prior to hospital discharge), continues to improve the percent of infants who receive follow-up. In 2009, the percent of infants who received timely follow-up and diagnosis increased from 80 percent to 87 percent. 2010 statistics are in the process of being analyzed.

Funding provided by the Association of University Centers on Disabilities (AUCD) Leadership in Neurodevelopment and Related Disabilities (LEND), has increased the number of pediatric audiology sites from 12 to 15. The EHDI program has partnered with the Marion Downs Hearing Center (MDHC) to provide intensive training to fourth-year audiology doctoral students and rural audiologists who have the desire and equipment to test young infants. Training for rural audiologists is provided in a variety of ways. Pediatric audiologists from the MDHC travel to the audiologists' rural sites, the audiologists travel to Denver, and telehealth technology is used for ongoing monitoring of evaluation and counseling. Funding from the Mountain States Regional Genetic Collaborative Center is being used to provide genetic counseling to families outside of the Denver metropolitan area.

The state Part C program has determined that children with unilateral and mild hearing loss are not eligible for services unless the child exhibits a delay. As a result, the Colorado Hearing Resource Coordinators (CO-Hears) do not have funding to serve these children. MCHB EHDI funding supports a CO-Hear Coordinator to provide information to the family and also encourage them to participate in the FAMILY assessment at the University of Colorado to monitor any potential developmental delays.

Through CDC EHDI funds, all hospital coordinators have been trained to enter any missed or

follow-up rescreen results directly into the EHDI Integrated Data System (IDS). This electronic conversion has decreased 500 sheets of paper per month being sent out to hospitals. Audiologists will be trained this year on how to enter diagnostic information into the EHDI IDS.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provided training to audiology doctoral students and rural audiologists to test young infants			X	X
2. Funding supported a CO-Hear Coordinator		X	X	X
3. Trained hospital coordinators to enter data into IDS				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The target for reporting year 2012 is 98.0 percent.

The Colorado EHDI Program will continue to work with local teams to improve follow-up from screening through early intervention. The local teams will reconvene this summer to review statistics and identify barriers and gaps in the system, especially for underserved populations. The EHDI staff and partners will continue to investigate how to increase hearing screening for infants born at home through education and access to free or low cost screens. In addition, the state EHDI staff is working with Early Head Start, Parents as Teachers, and Home Visiting Programs to increase education to providers and access to otoacoustic emissions screening.

The Colorado Infant Hearing Advisory Committee chaired by Dr. Albert Mehl, will continue to identify opportunities to educate primary care providers on their role in the follow-up of infants who miss or fail a newborn screen. Also, the newborn hearing screening results will be added to the Colorado Immunization Information System to give providers access to screening results and eventually diagnostic and early intervention results.

Colorado will continue to promote parent support through Colorado Hands & Voices. Hands & Voices has been a key partner to increase the screening follow-up through customized Roadmap for Families provided to every birthing hospital. The Loss & Found DVD has been distributed to every birthing hospital to encourage families to follow-up after a failed screen.

c. Plan for the Coming Year

The target for reporting year 2013 is 98.0 percent.

Now that the electronic birth certificate has added the NICU as a field, the EHDI program will separate infants in well baby vs. NICU nurseries for the Monthly Hospital Summary Report. This will allow the EHDI staff to monitor the NICU outcomes and develop strategies to improve the screening rate with those hospitals who do not meet the newborn screening benchmark of 100 percent.

In order to increase the percent of infants born at home who receive a screen, midwives who

currently screen will be given training and permission to enter results directly into the EHDI IDS. Education materials will be disseminated to all midwives that include the Loss & Found DVD, a letter from a midwife and a parent whose child born at home was late identified and resource information on where to obtain a screen. In addition parents who home birth will be given additional information in the letter that receive automatically from the EHDI IDS.

A survey will be conducted to identify how screening results and follow-up recommendations were given to all families to evaluate whether families are given the screening results in their native language, in a culturally sensitive fashion.

Efforts will continue to improve the follow-up rate from screening to diagnosis by adding another audiology rural site (from the AUCD LEND grant) and by education to primary care physicians (PCP) on following the Roadmap for Families for referrals to pediatric audiologists listed on the Roadmaps.

The audiologists will be trained in this next calendar year to enter diagnostic information directly into the EHDI IDS. This will improve the referral process by triggering an automatic referral to the Colorado Hearing Resource Coordinator to begin the Part C early intervention regulations within 48 hours.

A parent survey will be developed to determine if families are satisfied with the services they receive from screening through early intervention. This information will be used to help drive improvements for following years.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	9	10	8	8	5
Annual Indicator	10.3	8.2	8.7	5.1	5.1
Numerator					
Denominator					
Data Source		Colorado Child Health Survey			
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	5	4	4	4	4

Notes - 2011

Data shown for reporting year 2011 are calendar year 2010 Colorado Child Health Survey results. The percentage includes children ages 1-14 uninsured at the time of the survey.

The 2011 Child Health Survey results were not available by the time of application submission. Since new results were not available for reporting year 2011, the annual performance objectives were kept the same.

Notes - 2010

Data shown for reporting year 2010 are calendar year 2010 Colorado Child Health Survey results. The percentage includes children ages 1-14 uninsured at the time of the survey.

Notes - 2009

Data shown for reporting year 2009 are calendar year 2009 Colorado Child Health Survey results. The percentage includes children ages 1-14 uninsured at the time of the survey.

a. Last Year's Accomplishments

The indicator for reporting year 2011 showed that 5.1 percent of children had no health insurance. The target for reporting year 2011 was 5.0 percent, and the target was not met.

CYB's Early Childhood Team continued to provide technical assistance to the local early childhood councils, supported through the privately-funded Early Childhood Health Integration Initiative, to support local efforts to increase access to care. This has consisted of both individualized technical assistance as well as group training at the Health Integration Summit in January 2011, where councils participated in a session on Health Care Reform relative to Medicaid and CHP+.

An implementation team (MIT) was established for the MCH priority of reducing barriers to a medical home approach. The MIT began the development of state and local logic models and action plans to serve as a guide for impacting the priority statewide.

The Prevention Services Division formed the Health Systems Unit to serve as a centralized mechanism for addressing issues related to health care within the division, as well as to function as the primary liaison with the Department of Health Care Policy and Financing (HCPF) and other benefit plans for the division. A representative from the Health Systems Unit actively participates on the MIT for the medical home priority.

The Colorado Governor's Office designated a staff person to serve in a coordination role for health care reform efforts across state agencies.

Staff within the CYB continued to coordinate and lead the Colorado Medical Home Initiative, in partnership with HCPF. In this role, staff from CDPHE coordinated and facilitated the Colorado Medical Home Community Forum and the Medical Home Coalition. The bi-monthly community forum consists of state and local stakeholders and the coalition, which meets monthly, consists of representatives who are responsible for statewide medical home projects or initiatives. The purpose of the community forum is to provide an opportunity for state and local medical home stakeholders to discuss and provide input on medical home current events in Colorado. The purpose of the coalition is to strategically align the myriad of statewide medical home projects and initiatives for maximum impact.

During the 2010-2011 session, the Colorado legislature passed Senate Bill 200 to create a nonprofit unincorporated public entity known as the Health Benefit Exchange. The bill also established a "Legislative Health Benefit Exchange Implementation Review Committee" to provide oversight of the exchange. While CDPHE has not been designated as one of the non-voting state agency participants on the Health Benefit Exchange, it is important for MCH to be aware of the decisions made by the board as it relates to the state's MCH priority to "reduce barriers to a medical home approach by facilitating collaboration between systems and families."

Other legislative action related to access to care included House Bill 11-1242, which required HCPF to report on barriers to the delivery of integrated physical and behavioral health care services. A report was required to be drafted by HCPF and submitted to the General Assembly by April 1, 2012 and a subsequent report was due by June 30, 2012 to address:

1. The state and federal statutes and regulations affecting the integrated delivery of physical and behavioral health, including but not limited to statutes and regulations related to provider reimbursement, and the time and place of delivery of health care services;
2. Barriers or obstacles to the delivery of integrated physical and behavioral health care services; and
3. Incentives for health care providers that may increase the number of providers delivering integrated health services.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provided technical assistance to Early Childhood Councils through the Early Childhood Health Integration Initiative in partnership with CCHAP				X
2. Co-lead the Colorado Medical Home Initiative, in partnership with the Department of Health Care Policy and Financing				X
3. Coordinated the MCH Implementation Team for the MCH Medical Home Priority				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The target for reporting year 2012 is 5.0 percent.

CDPHE continues to provide leadership for the Colorado Medical Home Initiative, in partnership with HCPF.

The Medical Home MCH Implementation Team created state and local logic models and action plans to identify systems building strategies to reduce barriers to a medical home approach for all children and youth, including those with special health care needs. The following four strategies for systems building serve as foundations for the state and local logic models and action plans and reflect the public health role in reducing barriers to a medical home approach:

1. Mobilize partnerships to support the coordination of medical home projects and initiatives
2. Develop and implement a medical home policy agenda
3. Develop and implement a plan for a community-based network of consumer voices
4. Facilitate support for providers to implement a medical home approach within their practices

All local public health agencies who are participating in the MCH planning process are required to develop and implement a medical home local action plan.

As required by House Bill 11-1242, HCPF released reports in April 2012 and June 2012 that provides a summary of barriers to the delivery of integrated physical and behavioral health care

services. The conclusions and next steps identified in the report are focused on five specific areas that were identified through key informant interviews (see attached).

An attachment is included in this section. IVC_NPM13_Current Activities

c. Plan for the Coming Year

The target for reporting year 2013 is 4.0 percent.

Activities will continue for the upcoming year, with the Health Systems Unit staff becoming more involved in monitoring this performance measure and interacting with Medicaid and other benefit plans with a focus on the MCH population.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	24	24	23	23	23
Annual Indicator	24.3	24.3	23.5	23.2	23.2
Numerator	9018	9825	12139	12132	12132
Denominator	37111	40432	51659	52292	52292
Data Source		2007 Pediatric Nutrition Surveillance	2009 Pediatric Nutrition Surveillance	2010 Pediatric Nutrition Surveillance	2010 Pediatric Nutrition Surveillance
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	23	23	23	23	23

Notes - 2011

Data shown for reporting year 2011 are from the 2010 Pediatric Nutrition Survey. 2011 results for Colorado were not available at time of grant application submission. The WIC program changed computer systems in the middle of the year, thus complicating data extracts for CDC analysis of 2011 data.

Notes - 2010

Data shown for reporting year 2010 are from the 2010 Pediatric Nutrition Survey.

Notes - 2009

Data shown for 2009 are from the 2009 Pediatric Nutrition Survey. This can be accessed on the WIC website at: <http://www.cdphe.co.us/ps/wic/nutrition-surveillance/nutrition-surveillance.html>.

a. Last Year's Accomplishments

The indicator for reporting year 2011 showed that 23.2 percent of children ages 2 to 5 years receiving WIC services had a BMI at or above the 85th percentile. The target for reporting year 2011 was 23.0 percent which was not met.

CDPHE's Prevention Services Division created and filled a specialist position that is jointly funded by WIC, MCH, and CDC. This position is also the obesity prevention specialist for WIC and is responsible for managing a division-wide integrated approach to early childhood obesity prevention, including implementation of evidence-based and targeted strategies at the state and local level.

The Prevention Services Division released a report on Early Childhood Obesity Prevention, in September 2011, intended for use by state and local partners and stakeholders (<http://www.cdphe.state.co.us/ps/mch/mchresources/2011EarlyChildhoodObesityReport.pdf>). The report summarizes a three-phased project, including a literature review of risk and protective factors associated with early childhood obesity, a scan of prevention efforts in Colorado, and a stakeholder meeting (held January 2011) to identify Colorado priorities for obesity prevention. This project informed prioritization of early childhood obesity prevention focus areas in the 2012 reporting year.

The 2010 Colorado WIC Program State Meeting focused primarily on the importance of healthy weight among pregnant women and families with young children, and the role of WIC in this critical public health issue. More than 525 WIC staff members and other partners attended.

The Colorado WIC Program also convened a local WIC agency pediatric overweight advisory group to provide recommendations to the State WIC staff regarding what support local agencies need in addressing weight and obesity in their clinics. These recommendations informed the Colorado WIC 3-year plans for healthy weight promotion, which include, but are not limited to consistent messaging, improving participant and staff resources, enhancing staff competencies, and staff wellness.

The Colorado WIC Program fully implemented its new computer system, Compass, for use in the State WIC office and local WIC clinics. This system has standardized and improved the effectiveness of nutrition assessment, healthy lifestyle counseling, and WIC service delivery throughout Colorado, and provides a strong basis upon which additional healthy weight activities can be built.

Several local WIC agencies throughout Colorado implemented nutrition education plans related to healthy weight promotion. The State WIC office created a process for local WIC agencies to share these strategies among themselves as an opportunity for learning and collaboration.

The CDPHE Child and Adult Care Food Program (CACFP) identified four future policies for CACFP meal standards for participating childcare facilities, as part of the Healthier CACFP Meals Initiative. These standards will improve the quality of childcare meals in the CACFP and meet updated nutrition guidelines to prevent obesity in early childhood. The CACFP completed a six-month planning grant to identify implementation activities to support childcare providers in achieving these future higher meal standards.

A representative of the CDPHE Child and Adult Care Food Program served on the Colorado

Division of Childcare licensing rules revision committee for childcare centers and childcare quality initiatives committees. This representative successfully advocated for model childcare standards for obesity prevention to be incorporated into draft licensing rules revisions and Colorado's quality rating system for child care.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Created joint-funded early childhood obesity prevention specialist position			X	X
2. Released the September 2011 Early Childhood Obesity Prevention Report				X
3. Held the 2010 WIC State Meeting			X	X
4. Convened a Local WIC Pediatric Advisory Group				X
5. Implemented WIC computer system				X
6. Implemented WIC early childhood obesity prevention nutrition education plans				X
7. Identified new meal standards and activities for implementing these standards as part of the Healthier CACFP Meals Initiative			X	X
8. Participated in Colorado child care centers licensing rules revision and quality improvement initiatives committees				X
9.				
10.				

b. Current Activities

The target for reporting year 2012 is 23.0 percent.

The implementation team developed a logic model and action plan for both the state and local public health agencies for activities pertinent to the childcare, health care systems, and public health sectors. A health care systems and public health collaborative formed to collectively explore systems change to support healthy weight among women and families with young children. A collaborative project to identify key messages for pregnant women and parents/caregivers, relating to Colorado's focus areas, is currently underway.

The Colorado WIC Program completed a three-year healthy weight promotion plan, which reflects recommendations from the local agency advisory group. Local agency nutrition education plan processes are revised to align with local MCH activities and timelines. WIC will begin activities to strengthen State staff competencies in supporting local WIC agencies in healthy weight activities and the development of local referral systems and community collaboration. WIC also completed a Farm to Family pilot, testing processes for WIC families to cash value vouchers for fruits and vegetables at farmers' markets.

The Healthier CACFP Meals Initiative and representation in childcare rules and quality initiatives committees continues.

The CDPHE completed a literature review of obesity prevention strategies in childcare settings, later used to prioritize agency-wide obesity prevention efforts.

c. Plan for the Coming Year

The target for reporting year 2013 is 23.0 percent.

The early childhood obesity prevention implementation teams will continue to strengthen collaborative efforts within the teams and with other partners to carry out activities described in the State action plans. The health care systems and public health collaborative will begin implementation of systems changes to support early childhood obesity prevention within their respective organizations, and utilize the collaborative as an opportunity for learning and sharing best practices. Effective messages identified through the message testing project will be disseminated for use in the field, and the health care systems and public health collaborative will pursue preliminary steps to identify professional development needs for health care providers and public health professionals in their organizations.

The CDPHE Prevention Services staff representing multiple units (MCH, Women's Health, WIC, CDC-funded initiatives, and others) will provide partnership, technical assistance, and support for MCH local public health agencies in strengthening their local partnerships, implementing the early childhood obesity prevention plans, and evaluating these local efforts.

The Colorado WIC Program will continue to carry out activities described in the WIC three-year plan. A regional WIC training will be held, with a specific focus on healthy weight promotion for WIC families. Each local WIC agency throughout Colorado will identify a Healthy Weight Champion, to serve as a point of contact for obesity prevention communication, and the coordinator of activities related to this priority. Together with local WIC agencies, the Colorado WIC will determine the roles and responsibilities for the Healthy Weight Champion. Colorado WIC State office will identify a plan for improving participant education materials and methods, utilizing innovative delivery modes that are appropriate for and desired by today's WIC population. Colorado WIC will upgrade the growth charts with the WHO charts in the Compass computer system for WIC, and implement policy related to this change. The CDPHE and the State WIC staff will provide support for local WIC agencies' healthy weight promotion activities and development of effective referral systems and community collaboration, as well as adoption of worksite wellness policies and practices within their agencies.

The Colorado CACFP will implement four new policies for higher meal standards in participating child care facilities, which will require the following: 1) One percent or fat-free milk, 2) At least one whole grain product per day, 3) A limit of no more than one processed meat or meat alternative per week and 4) A limit of no more than two servings of 100% fruit juice per week. The Healthier CACFP Meals Initiative will continue to support childcare providers in meeting these standards. The CDPHE will also begin the development of breastfeeding standards for childcare settings.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	9	10	10	8	8.5
Annual Indicator	10.4	10.8	8.1	9	6.5
Numerator					
Denominator					
Data Source		Pregnancy Risk Assessment Monitoring System	Pregnancy Risk Assessment Monitoring System	Pregnancy Risk Assessment Monitoring System	Birth certificates
Check this box if you					

cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	6.5	6	6	5.5	5.5

Notes - 2011

Data for reporting year 2011 are from 2010 births. Because of the question change in PRAMS, the birth certificate question is used for reporting on this performance measure. Colorado started using the revised birth certificate in 2007. The smoking question on the birth certificate asks for the number of cigarettes smoked per day during the three months before pregnancy, first three months, second three months, and the last three months of pregnancy.

Notes - 2010

Data for reporting year 2010 are from 2009 Pregnancy Risk Assessment Monitoring System (PRAMS) data. In 2008 and earlier questionnaires, the smoking questions were only asked of women who smoked 100 or more cigarettes. In the 2009 questionnaire, the smoking questions were asked of women who smoked any amount of cigarettes.

Notes - 2009

Data for reporting year 2009 are from 2008 Pregnancy Risk Assessment Monitoring System (PRAMS) data.

a. Last Year's Accomplishments

The indicator for reporting year 2011 showed that 6.5 percent of women smoked during the last three months of pregnancy. The target for reporting year 2011 was 8.5 percent; the target was met. Because of a change in data sources (from PRAMS to birth certificates), the 2011 indicator cannot be directly compared to the 2011 target that was based on PRAMS data.

A statewide outreach/media campaign was launched in October 2010 to direct pregnant smokers enrolled in Medicaid to the Colorado QuitLine, increase the number of successful quits, sustain those quits among pregnant women, and increase the number of Medicaid participants using the expanded Medicaid pharmacotherapy benefit. American Recovery and Reinvestment Act (ARRA) funds were used to expand the Fax-to-Quit program targeting Medicaid providers, OB/GYN providers and community health centers serving the uninsured. ARRA funds were also used to develop and implement a specialized QuitLine protocol for pregnant women that included a consistent coach across telephone sessions for each participant and to expand the number of postpartum follow-up coaching calls from five to nine.

Staff members from the Women's Health Branch and Epidemiology, Planning and Evaluation Branch completed a population attributable risk (PAR) analysis of factors contributing to Colorado's low birth weight among singletons using Colorado birth certificate data. Using data from 2007-2009 births, the analysis found that one in 14 low weight births can be attributed to smoking during pregnancy. A decade ago, one in eight low weight births could be attributed to smoking during pregnancy. Results indicated that lower rates of smoking during pregnancy

impacted smoking's contribution to low weight births.
 (<http://www.cdphe.state.co.us/pp/womens/pdf/makingprogressontippingthescales.pdf>).

The Baby and Me Tobacco Free program (a statewide community diaper-incentive program), Planned Parenthood, WIC and other community resources changed their protocol to incorporate QuitLine referrals for all clients in the program(s).

The Tobacco Prevention and Cessation program websites and social marketing activities continued. The "Dear Me" smoking cessation TV advertising campaign ran in collaboration with the launch of the campaigns for pregnant women and Medicaid recipients. Outreach efforts to targeted populations continued through earned media and tobacco cessation advisory group efforts.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Launched statewide outreach/media campaign			X	
2. Expanded the fax-to-quit program				X
3. Completed PAR Analysis of factors contributing to LBW				X
4. Expanded QuitLine protocol for pregnant and postpartum women				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The target for reporting year 2012 is 6.5 percent.

Current activities include efforts to work with Health Care Policy and Financing (HCPF) to implement and track the new Medicaid tobacco cessation counseling benefit during pregnancy and postpartum; implement a 50 percent administrative match for QuitLine services to Medicaid recipients; distribute and follow up on the tobacco tool kit for Medicaid providers, including updates and provider feedback; implement the SB117 Over the Counter (OTC) benefit, including Nicotine Replacement Therapy (NRT); and promote QuitLine services with care coordinators in seven Regional Care Collaborative Organizations (RCCOs), which were established by HCPF to implement the Accountable Care Collaborative (ACC). The ACC is a new Medicaid program to improve clients' health and reduce costs. The ACC changes the incentives and health care delivery processes for providers from one that rewards a high volume of services to one that holds them accountable for health outcomes.

The QuitLine pregnancy protocol continues to be offered beyond the ARRA grant period with money from Colorado's voter-approved amendment 35 tobacco excise tax. The specialized protocol includes a consistent coach across sessions; up to four more postpartum calls than the standard five-call protocol; an incentive gift-card with funds added for each completed call; postpartum availability of NRT, even if NRT was used prenatally; and cessation-related text messaging support.

c. Plan for the Coming Year

The target for reporting year 2013 is 6.0 percent.

Upcoming activities include efforts to continue working with HCPF to implement and track the Medicaid tobacco cessation counseling benefit during pregnancy and postpartum; distribute and follow up on the tobacco tool kit for Medicaid providers (updates and provider feedback); promote QuitLine services with care coordinators in the RCCOs; and continue coordination of tobacco cessation activities with statewide partners.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	11	10.5	9.5	9.5	11
Annual Indicator	10.8	9.5	12.4	13.5	11.5
Numerator	38	34	45	49	39
Denominator	352852	358249	363012	362423	339475
Data Source		Death certificates	Death certificates	Death certificates	Death certificates
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	9	8.5	8	7.5	7

Notes - 2011

Data shown for reporting year 2011 are calendar year 2010 deaths. The data were retrieved from the Colorado Health Information Dataset (CoHID) at <http://www.chd.dphe.state.co.us/cohid/Default.aspx>. The objectives were increased slightly to accommodate fluctuation in this rate.

Notes - 2010

Data shown for reporting year 2010 are calendar year 2009 data representing suicide deaths for youth ages 15 through 19. The data were retrieved from the Colorado Health Information Dataset (CoHID) at <http://www.cdphe.state.co.us/cohid/>. Since the suicide rate fluctuates annually, only the annual performance objective for 2011 was changed.

Notes - 2009

Data shown for reporting year 2009 are calendar year 2008 data representing suicide deaths for youth ages 15 through 19. The data were retrieved from the Colorado Health Information Dataset (CoHID) at <http://www.cdphe.state.co.us/cohid/>. Since the suicide rate fluctuates annually, the annual performance objectives for 2010, 2011, 2012, and 2013 were not modified based on the annual indicator for reporting year 2009 (in response to the data alert). It is anticipated that the rate will decrease next year.

a. Last Year's Accomplishments

The indicator for reporting year 2011 showed that there were 11.5 suicide deaths per 100,000 youth aged 15 to 19. The target for reporting year 2011 was 11.0 per 100,000 and the target was not met.

Suicide remained the second leading cause of death among youth ages 10 through 24 in Colorado. Based on death certificate data from 2001-2010, the ten-year annual average suicide rate for young adults ages 15-19 in Colorado was 12.2 per 100,000, significantly higher than the Healthy People 2020 goal of 10.2 per 100,000 for all ages.

State funding of \$297,000 was allocated for suicide prevention programs statewide. In October 2009, the Office of Suicide Prevention was awarded three additional years of funding from the Substance Abuse and Mental Health Services Administration to continue and expand Project Safety Net. Eight community agencies that serve twenty counties are training adults to recognize and intervene with suicidal youth, and to refer those youth to appropriate services. Project Safety Net is targeting adults who work with Latino youth, lesbian, gay, bisexual, transgender and questioning youth, and youth in the juvenile justice and child welfare systems, all of which are at an elevated risk for suicide. Project Safety Net also includes a youth suicide prevention awareness campaign entitled Start the Conversation. Posters, stickers, informational brochures, and a thirty second radio spot were disseminated statewide in English and Spanish.

Other activities accomplished include ensuring that the suicide hotline (1.800.273.TALK) was operational 24 hours per day, every day; providing more than 15,000 pieces of public awareness materials statewide; disseminating community grants dedicated to suicide prevention across the state; working with the Suicide Prevention Coalition of Colorado; and participating on key advisory boards like the Colorado School Safety Resource Center and Safe2Tell. The Office of Suicide Prevention also sponsors and partners on the planning of the annual Bridging the Divide: Suicide Awareness and Prevention Summit, which is attended by an average of 200 individuals from Colorado and surrounding states.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Trained adults to recognize and intervene with suicidal youth and refer those youth to appropriate services		X		
2. Youth suicide prevention awareness materials including posters, stickers, informational brochures and a thirty second radio spot were disseminated statewide in English and Spanish		X	X	
3. Continued other activities within work plan to reduce suicide	X	X	X	X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The target for reporting year 2012 is 9.0 deaths per 100,000.

Proposed state funding of \$379,000 was allocated for suicide prevention programs statewide in April 2012. Activities included planning and sponsoring the fifth annual Bridging the Divide:

Suicide Awareness and Prevention Summit at Colorado State University in May 2012.

The Office of Suicide Prevention is partnering with the Colorado Department of Public Safety and the Colorado Department of Education to plan and host a suicide prevention symposia for school personnel throughout Colorado in November 2012. More than 250 school personnel are expected to attend the event in Aurora, which will focus on suicide risk assessment, prevention programs in schools, and post-intervention (managing the school and community after a suicide death).

The Office of Suicide Prevention continues Project Safety Net, a youth suicide prevention grant from the Substance Abuse and Mental Health Services Administration. Other activities include ensuring that the suicide prevention Lifeline is operational 24 hours per day; disseminating community grants dedicated to suicide prevention across the state; working with the Suicide Prevention Coalition of Colorado; and participating on key advisory boards.

c. Plan for the Coming Year

The target for reporting year 2013 is 8.5 deaths per 100,000.

Activities will continue from the previous year. However, Project Safety Net funding will end on September 30, 2012 and the Substance Abuse and Mental Health Service Administration has not released a new funding announcement under the Garrett Lee Smith Memorial Act. Therefore, the Office of Suicide Prevention will explore new federal funding opportunities to support youth suicide prevention and intervention efforts in Colorado.

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

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	83	85	83	85	82
Annual Indicator	81.4	80.5	82.7	80.5	89.2
Numerator	725	749	767	749	793
Denominator	891	930	928	930	889
Data Source		Birth certificates	Birth Certificates	Birth Certificates	Birth Certificates
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	89.5	90	90	90.5	90.5

Notes - 2011

Data shown for reporting year 2011 represent calendar year 2010 births. The denominator represents very low birth weight births to Colorado residents.

Data reported in the previous four years of block grants (FY09-FY12) underestimated the actual values by about six percentage points due to misclassification of one hospital. This error has been corrected for reporting year 2011. The percentage for reporting year 2011 of 89.2 reflects the corrected list of facilities for high risk delivery and neonates.

Notes - 2010

Data shown for reporting year 2010 represent calendar year 2009 data. The denominator represents very low birth weight births to Colorado residents.

Notes - 2009

Data shown for reporting year 2009 represent calendar year 2008 data. The denominator represents very low birth weight births to Colorado residents.

a. Last Year's Accomplishments

The indicator for reporting year 2011 showed that 89.2 percent of very low birth weight infants were delivered at hospitals for high-risk deliveries and neonates. The target for reporting year 2011 was 82.0 percent; therefore, the target was met.

The Colorado Perinatal Care Council (CPCC) is comprised of obstetric and neonatal providers and hospital administrators, representing the majority of birthing hospitals in Colorado. The Council's work mainly focused on hospital's designation of obstetric and neonatal care levels, yet the Council also addressed other perinatal issues. The Council continued work to improve quality of care, including decreasing elective deliveries without medical indication, decreasing central line associated bloodstream infections (CLABSI) in newborns, promoting breastfeeding by encouraging hospitals to become "baby friendly," and addressing antenatal steroid use.

A Women's Health Branch staff member participates on the CPCC, shares related information, and collaborates with other members.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CPCC worked on hospital Level III designation				X
2. Decreased elective deliveries without medical indication				X
3. Decreased central line associated bloodstream infections				X
4. Promoted breastfeeding by encouraging hospitals to become "baby friendly"				X
5. Addressed antenatal steroid use				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The target for reporting year 2012 is 89.5 percent.

The CPCC continues to monitor hospital perinatal levels of care designations.

A Women's Health Branch staff member continues to participate on the CPCC.

c. Plan for the Coming Year

The target for reporting year 2013 is 90.0 percent.

Activities will continue from the previous year.

A Women's Health Branch staff member will continue to participate on CPCC.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	84	84	82	77	78
Annual Indicator	79.7	78.1	76.9	77.7	79.0
Numerator	55354	53828	52298	52185	51457
Denominator	69430	68957	67985	67167	65114
Data Source		Birth certificates	Birth certificates	Birth certificates	Birth certificates
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	79.5	80	80.5	81	81.5

Notes - 2011

Data shown for reporting year 2011 are calendar year 2010 births. The number of pregnant women whose onset of prenatal care is unknown have been excluded. Data were obtained from the Colorado Health Information Dataset (CoHID) at <http://www.chd.dphe.state.co.us/cohid/Default.aspx.us/cohid/Default.aspx>.

Notes - 2010

Data shown for reporting year 2010 are calendar year 2009 data. The number of pregnant women whose onset of prenatal care is unknown have been excluded. Data were obtained from the Colorado Health Information Dataset (CoHID) at <http://www.cdphe.state.co.us/cohid/index.html>.

Notes - 2009

Data shown for reporting year 2009 are calendar year 2008 data. The number of pregnant women whose onset of prenatal care is unknown have been excluded. Data were obtained from the Colorado Health Information Dataset (CoHID) at <http://www.cdphe.state.co.us/cohid/index.html>.

a. Last Year's Accomplishments

The indicator for reporting year 2011 showed that 79.0 percent of infants were born to pregnant women receiving prenatal care beginning in the first trimester. The target for reporting year 2011 was 78.0 percent; therefore, the target was met.

The MCH Access to Care Workgroup held its last meeting in October 2010 and shared results of a five- county survey to determine whether or not women with Medicaid Presumptive Eligibility were likely to enroll in prenatal care during their first trimester of pregnancy. Overall, survey findings indicated that women who applied for Medicaid Presumptive Eligibility did not have higher rates of first trimester prenatal care than their non-presumptive eligibility counterparts. Based on the results of the evaluation, MCH funding was no longer used to provide presumptive eligibility application services.

The Maternal Wellness Unit Manager co-chaired the Healthy Women Healthy Babies (HWHB) Access to Care Workgroup, which met monthly. The workgroup focused its efforts primarily on strengthening connections and referral relationships between prenatal care providers and service providers, such as Prenatal Plus and Nurse-Family Partnership, in an effort to increase enrollment of Medicaid clients into these programs.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Shared results of presumptive eligibility study				X
2. Participated in Healthy Women Healthy Babies Access to Care Workgroup			X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The target for reporting year 2012 is 79.5 percent.

Maternal Wellness staff continues to monitor activities of the HWHB Access to Care Workgroup and participate in opportunities related to the MCH priorities. The Access to Care Workgroup was awarded a small grant from the Marquez Foundation focused on strengthening comprehensive prenatal care, including decreasing cost and improving outcomes. Specifically, the workgroup collaborates with local community partners to create pathways for implementation of wrap-around prenatal services such as, Nurse-Family Partnership, Prenatal Plus and Centering Pregnancy models of care.

Access to care is included under the MCH priority to reduce barriers to a medical home approach. Activities under this priority focus on population-based, system level change as led by an MCH Implementation Team (MIT) dedicated to providing guidance and direction on MCH plan development and implementation for this priority. The new direction will focus on reducing barriers to care by addressing local and statewide systems.

c. Plan for the Coming Year

The target for reporting year 2013 is 80.0 percent.

Based on the HCP medical home systems building pilot conducted with five local public health agencies, local public health agencies participating in the MCH planning process will focus at least one of the objectives in their medical home action plans on early childhood. The decision to require an early childhood focus was based on the importance of early identification of special needs, and the opportunity to align and build upon existing statewide early childhood systems building efforts. Local public health agencies may choose to include additional objectives in their local action plans that target the population of youth and/or women of reproductive age.

State MCH staffs will continue to monitor the indicator for this performance measure and will participate in the HWHB Access to Care Workgroup as related to the MCH priorities.

D. State Performance Measures

State Performance Measure 1: *Percent of sexually active women and men ages 18-44 years using an effective method of birth control to prevent pregnancy.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					73
Annual Indicator		74.4	68.6	72.2	73.3
Numerator					
Denominator					
Data Source		Behavioral Risk Factor Surveillance System			
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	74	75	76	77	78

Notes - 2011

Data for reporting year 2011 represent 2010 data. Effective methods of birth control include tubes tied, vasectomy, hysterectomy, pill, contraceptive implants, shots (Depo-Provera, Lunelle), contraceptive patch, contraceptive ring, and IUD. Respondents who are pregnant or trying to get pregnant are excluded.

Notes - 2010

Data for reporting year 2010 represent 2009 data. Effective methods of birth control include tubes tied, vasectomy, hysterectomy, pill, contraceptive implants, shots (Depo-Provera, Lunelle), contraceptive patch, contraceptive ring, and IUD. Respondents who are pregnant or trying to get pregnant are excluded.

Notes - 2009

Data for reporting year 2009 represent 2006 data. Effective methods of birth control include tubes tied, vasectomy, hysterectomy, pill, contraceptive implants, shots (Depo-Provera, Lunelle), contraceptive patch, contraceptive ring, and IUD. Respondents who are pregnant or trying to get pregnant are excluded.

a. Last Year's Accomplishments

The indicator for reporting year 2011 showed that 73.3 percent of sexually active women and men ages 18-44 used an effective method of birth control to prevent pregnancy. The target for reporting year 2011 was 73 percent; therefore, the target was met.

The Colorado Reproductive Health Waiver application submitted in 2008 to the Centers for Medicare and Medicaid Services sought to provide expanded eligibility for family planning services to all men and women ages 19 to 50 for up to 200 percent of the federal poverty level. The Colorado Reproductive Health Waiver Application was withdrawn by the Department of Health Care Policy and Financing (HCPF) in 2011 based on an extensive evaluation of all current circumstances, including the passage of health care reform.

The Colorado Title X Family Planning Program received funding for the Colorado Family Planning Initiative (CFPI) to address unintended pregnancy. CFPI funded the development of contraceptive guidelines by Health TeamWorks, a nonprofit, multi-stakeholder collaborative working to redesign the healthcare delivery system and promote integrated communities of care, using evidence-based medicine and innovative systems. Maternal Wellness staff served as the guideline development committee co-chair. In January 2011, the guideline was sent to approximately 5,500 providers across Colorado, with approximately 1,000 additional providers (including school nurses) receiving the materials electronically. Health TeamWorks conducted Rapid Improvement Activities to ensure successful guideline-to-practice integration. In June 2011, CDPHE hosted a Women's Health and Family Planning Conference to provide educational and collaborative opportunities to partners across Colorado.

The Maternal Wellness Team formed a Preconception Health Advisory Committee (PHAC), comprised of external stakeholders from various agencies in Colorado, which met quarterly starting in the summer of 2011 and provided feedback, advice and guidance to the state Maternal Wellness Team to help advance activities related to this performance measure.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Funded development of contraceptive clinical guidelines				X
2. Hosted the Women's Health and Family Planning Conference			X	X
3. Developed a statewide advisory committee				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The target for reporting year 2012 is 74.0 percent.

The Maternal Wellness Team continues to meet quarterly with the PHAC. The Team conducted key informant interviews about preconception health initiatives in several U.S. states, which informed strategic planning for the preconception health priority. Interview summaries can be found online: <http://www.cdphe.state.co.us/pp/womens/prenatal.html>.

The Maternal Wellness Team, in collaboration with EPE staff and the MIT, completed a state level logic model and action plan to address intended pregnancy. In March 2012, the action plan was shared via webcast with 40 participants, including partners from the U.S. Department of Health and Human Services, Colorado Department of Health and Human Services, 14 Colorado local public health agencies, local network partner agencies and academicians.

The Maternal Wellness Team, along with Title X Family Planning staff, is enhancing Colorado Title X policies and protocols to assist Family Planning clinicians with providing and documenting preconception care.

In January 2012, CFPI partnered with Vermillion, Inc. to create a public awareness campaign promoting conversation and community knowledge of available family planning and reproductive health services in Colorado (www.beforeplay.org). One MCH strategy is to promote the Beforeplay campaign by providing content for interactive website features and using the site to expand reproductive life planning concepts to women and men ages 18--29.

c. Plan for the Coming Year

The target for reporting year 2013 is 75.0 percent.

To integrate reproductive life planning and preconception care into family planning clinic protocols and practices, Title X providers will be surveyed to determine gaps in providing preconception care during office visits. The MIT and the Preconception Advisory Committee will jointly develop guidance for Title X clinicians about services that are components of preconception care and reproductive life planning for women and men. Maternal Wellness staff will participate in a collaborative with the CDPHE Health Systems Unit and Colorado Clinical Preventive Services to identify women's preventive services and preconception care billing and diagnosis codes. Maternal Wellness will partner with CFPI to design, guide and inform development of comprehensive clinical training on preconception and contraception clinical guidelines included in CFPI's sustainability plan.

CFPI funding will be provided to all Title X agencies to continue increasing the use of long acting reversible contraception methods; maintain increased client numbers; provide tubal ligations and vasectomies; and position Title X clinics to sustain themselves in the era of health care reform by accessing new and increasing funding sources. Examples of "repositioning" include capacity building in insurance and Medicaid billing, business operations management and self-sufficiency strategies. Title X will continue to partner with 28 delegates statewide to ensure family planning services for men and women. The goal is to provide quality, subsidized family planning services to 65,000 clients, of which 89 percent will be at or below 150 percent of the federal poverty level.

State Performance Measure 2: *Percent of live births to mothers who were overweight or obese based on BMI before pregnancy.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance					35.5

Objective					
Annual Indicator		35.0	34.8	35.9	43.2
Numerator		22468	22770	23832	27885
Denominator		64160	65385	66398	64520
Data Source		Birth certificate	Birth certificates	Birth certificates	Birth certificates
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	43	42.5	42	41.5	41

Notes - 2011

Data for reporting year 2011 represent calendar year 2010 births.

Data for reporting year 2011 use the 2009 IOM BMI categories for weight gain during pregnancy. Data for reporting years 2010 and earlier use the 1990 IOM BMI categories for weight gain during pregnancy. Thus, data for reporting year 2011 is not comparable to data from earlier reporting years.

Notes - 2010

Data for reporting year 2010 represent calendar year 2009 births.

Notes - 2009

Data for reporting year 2009 represent calendar year 2008 births.

a. Last Year's Accomplishments

The 2011 indicator showed that 43.2 percent of live births were to mothers who were overweight or obese based on BMI before pregnancy. The 2011 target was 35.5 percent; the target was not met. Because of recent changes in the Institute of Medicine's guidelines for calculating BMI for pregnancy weight gain, the 2011 indicator cannot be directly compared to the 2011 target. Generally speaking, the new guidelines capture more women who are overweight and obese compared to the old guidelines.

Multiple presentations about the Colorado Clinical Guideline for Preconception and Interconception Care were given to audiences at local, national and international levels, which included the recommendation to attain or maintain a healthy body weight prior to pregnancy.

CDPHE published a Health Watch titled, How Healthy Are Colorado Women of Reproductive Age? An Evaluation of Preconception Risk and Protective Factors (<http://www.cdphe.state.co.us/hs/pubs/preconception3.pdf>). The report described preconception risk and protective factors related to maternal and infant health outcomes among women ages 18-44 using data gathered from the Colorado Behavioral Risk Factor Surveillance System for years 2004-2006. A webinar highlighting the results was presented in February 2011.

The Maternal Wellness team began interviewing key-informants from other national preconception initiatives to help inform Colorado's plan (<http://www.cdphe.state.co.us/pp/womens/prenatal.html>) and formed a Preconception Health Advisory Committee of interested stakeholders. The advisory committee met quarterly since the summer of 2011 to implement an action plan related to this performance measure.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service
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	DHC	ES	PBS	IB
1. Presented on the Colorado Clinical Guideline for Preconception and Interconception Care				X
2. Published preconception health-focused Health Watch				X
3. Interviewed key-informants from other national preconception initiatives				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The target for reporting year 2012 is 43.0 percent.

The Maternal Wellness team continues to meet quarterly with the Preconception Health Advisory Committee, which is comprised of 19 external stakeholders from various entities around the state. The committee provides feedback and guidance around the state preconception healthy weight strategies, objectives, and activities. This work is done in collaboration with the Early Childhood Obesity Prevention MCH Implementation Team (MIT).

A woman's preconception weight and weight gain during pregnancy are two of the most important determinants of childhood obesity. The MIT for Early Childhood Obesity Prevention has identified these factors as key focus areas for the early childhood obesity prevention priority. Healthy weight strategies and activities for preconception and pregnancy are integrated into the Early Childhood Obesity Prevention plan (See NPM 14). The Maternal Wellness Project Coordinator participates on the Early Childhood Obesity Prevention MIT to determine how to integrate these efforts with preconception healthy weight messages.

c. Plan for the Coming Year

The target for reporting year 2013 is 42.5 percent.

Preventing obesity requires collaborative, multi-sector approaches at state and local levels. The Preconception Health MIT works collaboratively with the Early Childhood Obesity Prevention (ECOP) MIT to address childhood obesity and preconception healthy weight. One strategy related to preconception healthy weight includes promoting breastfeeding-friendly practices in child care facilities to support longer duration of breastfeeding. The activities for this strategy during the coming year are to identify and evaluate existing standards and best practices for breastfeeding support in child care.

The ECOP MIT, which includes representatives of health care organizations and public health programs will complete a message testing project to identify, disseminate, and promote consistent and effective preconception health messages. The group will work to complete a professional development plan, including at least two professional development opportunities for public health and health care professionals to improve knowledge and skills related to obesity prevention and effective messaging. Collectively, partners will explore effective organizational systems changes to support healthy weight practices among women of child bearing age. Colorado WIC will begin a 3-year WIC work plan to strengthen early childhood and maternal obesity prevention practices in WIC operations and nutrition education plans, through trainings, improved resources and promotion of consistent messaging.

The state ECOP plan also includes the completion of an inventory of Colorado early childhood obesity prevention efforts (including preconception healthy weight efforts), which will enable CDPHE to promote local collaborative obesity efforts. The ECOP MIT continues to partner with and provide technical assistance, and support to local public health agencies in implementation of action plans, which include strategies intended to improve weight status of women of reproductive age.

State Performance Measure 3: *Percent of mothers reporting that a doctor, nurse, or other health care worker talked with them about what to do if they felt depressed during pregnancy or after delivery.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					73
Annual Indicator				72.6	75.1
Numerator					
Denominator					
Data Source				Pregnancy Risk Assessment Monitoring System	Pregnancy Risk Assessment Monitoring System
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	75.5	76	77	78	79

Notes - 2011

Data for reporting year 2011 represent 2010 data.

Notes - 2010

Data for reporting year 2010 represent 2009 data.

a. Last Year's Accomplishments

The indicator for reporting year 2011 showed that 75.1 percent of mothers reported that a doctor, nurse, or other health care worker talked with them about what to do if they felt depressed during pregnancy or after delivery. The target for reporting year 2011 was 73.0 percent; therefore, the target was met.

The Maternal Wellness MCH Implementation Team (MIT) and Epidemiology, Planning and Evaluation (EPE) Branch staff conducted a pilot project aligned with the Brownson seven-stage framework for evidence-based public health to ensure decisions and action plans around pregnancy-related depression were based on the best available scientific evidence. The project result was a portfolio of materials that provided supporting evidence for the action plan and interventions, including a literature review, logic model and work plan with prioritized strategies. Through the process, staff members gained knowledge of and skills with following the public health process while simultaneously designing program interventions. Staff was able to apply these skills and develop a comprehensive 3-year work plan for the MCH priority.

The Maternal Wellness team solicited interested stakeholders to form a Pregnancy-Related Depression Advisory Committee. The committee met quarterly starting in the summer of 2011 to

provide feedback, advice and guidance to the state Maternal Wellness team to help move forward activities that address this performance measure.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Completed Brownson’s model pilot portfolio project				X
2. Developed logic model and work plan				X
3. Formed statewide Advisory Committee				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The target for reporting year 2012 is 75.5 percent.

The Maternal Wellness team continues to meet quarterly with the Pregnancy-Related Depression Advisory Committee, which is comprised of 18 external stakeholders from various agencies in Colorado providing feedback and guidance on the 3-year pregnancy-related depression work plan strategies, objectives, activities.

The Maternal Wellness team in collaboration with EPE staff and the MCH Implementation Team completed the Brownson model pilot project and developed evidence-guided state and local county logic models and 3-year action plans. In March 2012, local health agency logic models and action plans were shared with local health agency MCH staff during the Colorado MCH conference.

As part of the strategy to advocate for improved Medicaid and private insurance coverage for screening and treatment of pregnancy-related depression, the Maternal Wellness Team is researching Medicaid benefits for pregnancy-related depression in other states as well as federal Medicare rates and benefits for depression screening. The MIT and advisory committee are also exploring an Illinois mechanism allowing pediatric providers to bill under a child's Medicaid number for a mother's pregnancy-related depression screening.

c. Plan for the Coming Year

The target for reporting year 2013 is 76.0 percent.

Currently in Colorado, reimbursement for screening and identification of pregnancy-related depression is not available through most private and public health plans and availability of practitioners with expertise to address the issue varies widely across the state. Overall pregnancy-related depression resources are limited. The work of the state health department includes strategies aimed at advocating for improved Medicaid and private insurance coverage for screening and treatment of pregnancy-related depression; developing a coordinated approach to address pregnancy-related depression across systems; develop a coordinated statewide initiative to train and support providers on the pregnancy-related depression needs of women; and raise public awareness on the symptoms, risk factors and stigma associated with pregnancy-related depression.

The Maternal Wellness Team, MIT and advisory committee will work to assess and communicate the costs and benefits of expanding Colorado Medicaid reimbursement code 99420 to include pregnant and postpartum women. The team will also assess and document the feasibility and impact of including pediatric practitioners as billable providers when seeing an infant whose mother exhibits signs of depression.

In an effort to address the strategy to develop an integrated approach for addressing pregnancy-related depression across systems, the Maternal Wellness Team, MIT and advisory committee will spearhead efforts to improve accessibility to information about available pregnancy-related depression resources for treatment and support; and the Maternal Wellness Team will collaborate with local health agencies and state-level partner organizations to identify and develop an online statewide referral resource for treatment and support.

Part of the 3-year strategy to develop a coordinated statewide initiative to train and support providers with pregnancy-related depression needs of women includes an objective to develop, distribute and evaluate the use of a standard, clinical-based practice guidelines focusing on screening and referral protocols for pregnancy-related depression.

State Performance Measure 4: *Percent of parents asked by a health care provider to fill out a questionnaire about development, communication, or social behavior of their child ages 1 through 5.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					44
Annual Indicator		44.2	48.2	43.8	43.8
Numerator					
Denominator					
Data Source		Colorado Child Health Survey			
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	45	46	47	48	49

Notes - 2011

Data for reporting year 2011 represent 2010 Colorado Child Health Survey results.

The 2011 Child Health Survey results were not available by the time of application submission. Since new results were not available for reporting year 2011, the annual performance objectives were kept the same.

Notes - 2010

Data for reporting year 2010 represent 2010 Colorado Child Health Survey results.

Notes - 2009

Data for reporting year 2009 represent 2009 Colorado Child Health Survey results.

a. Last Year's Accomplishments

The annual indicator for reporting year 2011 showed that 43.8 percent of parents were asked by a health care provider to fill out a questionnaire about development, communication, or social behavior of their child ages one through five. The target for reporting year 2011 was 44.0 percent and the target was not met.

The work related to this performance measure was in partnership with the Assuring Better Child Health and Development (ABCD) project. The current, three-year (2010-2012) strategic plan includes the goal of increasing the number of practices/primary care providers using a standardized developmental screening tool.

Activities related to this goal included continued outreach to primary care providers who have not yet incorporated the use of a standardized developmental screening tool into their practices. ABCD continued its partnership with the Colorado Child Health Access Program (CCHAP) whose mission is to increase the number of Medicaid providers in Colorado. All practices that work with CCHAP were referred to ABCD in the interest of including developmental screening tools in quality improvement.

ABCD also embarked on a project to inventory existing messaging around child development in the interest of utilizing those resources to increase consumer awareness of developmental screening. ABCD reviewed current messaging available through national organizations and local organizations that recently performed focus groups with parents related to early intervention messaging.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conducted outreach to primary care providers			X	
2. Conducted messaging inventory			X	
3. Funded ABCD State Coordinator position				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The target for reporting year 2012 is 45.0 percent.

Through the MCH block grant, CDPHE is funding the ABCD State Coordinator position to implement local technical assistance. This MCH partnership has allowed ABCD to create a regionalized technical assistance structure to support additional communities in implementing ABCD practices. State and local logic models and action plans were developed to guide this work over the next three years.

ABCD continued to build upon the provider outreach described above and the partnership with CCHAP. ABCD also established a baseline of how many recruited practices are meeting the American Academy of Pediatrics guideline of three child screenings by age three: about 90 percent of providers surveyed met this guideline. ABCD reached out to medical and nursing education programs to ensure that the importance of developmental screening is emphasized in

higher education curricula. Finally, ABCD is shifting its focus to the more sustainable role of supporting communities in conducting provider outreach. This includes ABCD representatives sharing best practices on visit structure and messaging, and accompanying local representatives to provider visits in order to model. While local data are not yet available, communities report successfully recruiting some providers.

ABCD is developing a continuing medical education event for health care providers on developmental screening, referral and related issues for fall 2012.

c. Plan for the Coming Year

The target for reporting year 2013 is 46.0 percent.

During the coming year, efforts for this priority will focus on the development of a state policy agenda for developmental screening. This will involve an inventory of perceived barriers to implementing developmental screening and referral. Staff will leverage the ABCD State Team/Implementation Team to identify which barriers require policy change and to prioritize the policy changes. Staff will also continue work on developing a data tracking mechanism for developmental screening. Work is currently underway to include access to Newborn Screening results through the immunization registry, which may pave the way for developmental screening. CDPHE will develop an internal advisory to provide expertise on the authority, information technology, and programmatic aspects of this work and develop a plan to move forward. Finally, the implementation team will partner with our Maternal Wellness team to consider opportunities for integrating pregnancy-related depression screening into ABCD efforts. This will involve cross-representation and Implementation Team meetings, and continuing discussions with ABCD related to one to two community pilots to incorporate maternal depression screening into ABCD efforts.

State Performance Measure 5: *Percent of Early Intervention Colorado referrals coming from targeted screening sources.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					42
Annual Indicator			34.3	41.7	42.5
Numerator			2885	3796	4059
Denominator			8420	9101	9557
Data Source			Early Intervention Colorado	Early Intervention Colorado	Early Intervention Colorado
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	43	44	45	46	47

Notes - 2011

Data for reporting year 2011 represent calendar year 2011. Data are provided by Early Intervention Colorado.

Notes - 2010

Data for reporting year 2010 represent calendar year 2010. Data are provided by Early Intervention Colorado.

Notes - 2009

Data for reporting year 2009 represent calendar year 2009. Data are provided by Early Intervention Colorado.

a. Last Year's Accomplishments

The indicator for reporting year 2011 showed that 42.5 percent of Early Intervention Colorado referrals came from targeted screening sources. The target for reporting year 2011 was 42.0 percent and it was met.

Last year, the Assuring Better Child Health and Development (ABCD) project was able to integrate its work with The Colorado Trust's Early Childhood Health Integration Initiative (HI), which funds Colorado's Early Childhood Councils to better integrate health into the early childhood system. Eight councils have chosen to implement ABCD within their communities using their HI funding and many others are now expressing interest in implementing developmental screening and referral.

Two ABCD workgroups were developed that relate to SPM 5; one for referral and one for systems and sustainability. The referral workgroup identified that the messages that primary care providers use to refer to early intervention were different from the messages that were used by early intervention professionals when they contacted parents to schedule an evaluation. This difference in messaging led to confusion for parents and was a factor that contributed to the significant number of children referred to early intervention who never received an evaluation. The workgroup developed messaging for providers on referring to early intervention.

The systems and sustainability workgroup mapped the entire system from developmental screening to services. The workgroup identified a data gap between billing codes for screening and the referral received by early intervention professionals, as there is no way of determining which children did not pass the screening. As a result, primary care providers may now use a diagnosis code to identify children who have not passed the screening and follow them through the Medicaid system.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Supported HI communities in implementation of ABCD practices				X
2. Developed referral messaging			X	
3. Completed data mapping of state level systems				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The target for reporting year 2012 is 43.0 percent.

Currently, ABCD and CDPHE have continued providing technical assistance to Early Childhood Councils to better integrate health into the early childhood system. The referral workgroup is also examining ways of further developing local relationships between primary care and early intervention, which is also a role for Early Childhood Councils in this work. ABCD will work with communities to develop referral protocols that streamline systems and processes.

The ABCD state team has developed a model communities best practices document which was used to inform the development of the state and local logic models and action plans for this MCH priority. The development of these tools allowed staff and partners to clearly identify and delineate the state and local roles in supporting developmental screening. The identified local role involves developing and/or leveraging the appropriate partnerships to impact systems level changes related to screening, developing a roadmap for screening and referral, conducting outreach to primary care, and building local capacity to sustain these efforts. The state role is described in the next section.

This model communities best practices document is currently being further developed for additional audiences, such as Early Intervention and Early Childhood Councils.

c. Plan for the Coming Year

The target for reporting year 2013 is 44.0 percent.

During the coming year, efforts for this priority will focus on the development of a state policy agenda for developmental screening. This will involve an inventory of perceived barriers to implementing developmental screening and referral. MCH will leverage the ABCD State Team/Implementation Team to identify which barriers require policy change and to prioritize the policy changes. Staff will also continue work on developing a data tracking mechanism for developmental screening. Work is currently underway to include Newborn Screening results on the immunization registry, which may pave the way for developmental screening. CDPHE will develop an internal advisory to provide expertise on the authority, information technology, and programmatic aspects of this work and develop a plan to move forward. Finally, the implementation team will partner with our Maternal Wellness team to consider opportunities for integrating pregnancy-related depression screening into ABCD efforts. This will involve cross-representation at Implementation Team meetings, and continuing discussions with ABCD related to 1-2 community pilots to incorporate maternal depression screening into ABCD efforts.

State Performance Measure 6: *Percent of live births where mothers gained an appropriate amount of weight during pregnancy according to pre-pregnancy BMI.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					34
Annual Indicator		32.0	32.3	33.0	33.3
Numerator		19242	19574	19974	19559
Denominator		60040	60688	60500	58684
Data Source		Birth certificates	Birth certificates	Birth certificates	Birth certificates
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016

Annual Performance Objective	34	34.5	35	36	37
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Notes - 2011

Data for reporting year 2011 represent 2010 births. The data represent singleton births, 23+ weeks gestation. Appropriate weight gain according to prepregnancy body mass index for each week of gestational age was calculated based on the 2009 IOM Guidelines for Pregnancy Weight Gain.

Data for reporting year 2011 are not comparable to data in earlier reporting years.

Notes - 2010

Data for reporting year 2010 represent 2009 births. Appropriate weight gain according to prepregnancy BMI was calculated based on the 1990 IOM Guidelines for Pregnancy Weight Gain.

Notes - 2009

Data for reporting year 2009 represent 2008 births. An adjustment for weight gain was made for gestational ages 37-40 weeks. Appropriate weight gain according to prepregnancy BMI was calculated based on the 1990 IOM Guidelines for Pregnancy Weight Gain.

a. Last Year's Accomplishments

The indicator for reporting year 2011 showed that 33.3 percent of live births were to mothers who gained an appropriate amount of weight during pregnancy. The target for reporting year 2011 was 34 percent; the target was not met. Because of recent changes in the Institute of Medicine's guidelines for weight gain during pregnancy, the 2011 indicator cannot be directly compared to the 2011 target which was developed based on the previous guidelines.

The hiring of the Early Childhood Obesity Prevention Specialist, described in NPM 14, devotes resources to the broad spectrum of early childhood obesity prevention, which includes appropriate gestational weight gain as a component and key focus area. The release of the September 2011 Early Childhood Obesity Prevention Report (See NPM 14), informed the prioritization of appropriate gestational weight gain as a focus area for early childhood obesity prevention during the 2011-2012 year.

Appropriate gestational weight gain continues to be a focus area of Colorado WIC activities. The 2010 WIC State Meeting highlighted appropriate gestational weight gain, in the context of obesity prevention in children, and several local WIC agency nutrition education plans targeted healthy lifestyles among pregnant women receiving WIC services. The implementation of the WIC computer system advanced the use of the revised prenatal weight gain grids in electronic form, and the system has improved the assessment, healthy lifestyle counseling, and benefit delivery for pregnant women.

The Maternal Wellness team identified revised messaging for the Healthy Baby Campaign Materials, which were updated during the 2011-2012 year. This messaging focuses more upon gaining the "appropriate amount of weight" during pregnancy, rather than gaining "enough weight", to address concerns among the Colorado population of pregnant women for both inadequate weight gain and excessive weight gain.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Released 2011 Early Childhood Obesity Prevention Report				X
2. Completed WIC appropriate gestational weight gain activities		X	X	X
3. Identified of new messaging for Healthy Baby Campaign				X

materials				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The target for reporting year 2012 is 34 percent.

The activities of the early childhood obesity prevention implementation teams described in NPM 14, including the development of state and local logic models and action plans, included pregnant women as a target population and appropriate gestational weight gain as a desired outcome. Activities of the health care systems and public health collaborative (see NPM 14), and those of the individual organizations within the group, also include appropriate gestational weight gain as targets in creating systems change. The collaborative project to identify key messages for pregnant women and parents/caregivers (see NPM 14) includes three focus groups of pregnant women.

All of Colorado WIC's activities reported for NPM 14, also include pregnant women as a target population of WIC participants and appropriate gestational weight gain as a desired outcome. In addition, Colorado WIC offered the Maternal Nutrition Intensive Course to CDPHE staff and local WIC staff, which is a training program regarding the latest prenatal nutrition science and research.

The Healthy Baby campaign will continue to promote appropriate prenatal weight gain and preconception healthy weight using the life course perspective. Consumer and provider outreach will continue via state and local agency activities. Campaign brochures and provider packets are updated to reflect current campaign branding and appropriate prenatal weight gain messaging in five languages.

c. Plan for the Coming Year

The target for reporting year 2013 is 34.5 percent.

The plans for the coming year for NPM 14 is an integrated plan addressing critical periods in the life course, including the pre-conception, prenatal, and early childhood periods. The NPM 14 plan also reflects the plan for SPM 6, with the exception of those sections pertinent to the childcare setting (See NPM 14). These plans include pregnant women as a target population and appropriate weight gain as a desired outcome.

State Performance Measure 7: Percent of parents reporting that their child (age 1 through 5) first went to the dentist by 12 months of age.

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					3.4

Annual Indicator		2	2.8	3.4	3.4
Numerator					
Denominator					
Data Source		Colorado Child Health Survey			
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	4	4.5	5	5.5	6

Notes - 2011

Data for reporting year 2011 represent 2010 Colorado Child Health Survey results.

The 2011 Child Health Survey results were not available by the time of application submission. Since new results were not available for reporting year 2011, the annual performance objectives were kept the same.

Notes - 2010

Data for reporting year 2010 represent 2010 Colorado Child Health Survey results.

Notes - 2009

Data for reporting year 2009 represent 2009 Colorado Child Health Survey results.

a. Last Year's Accomplishments

The indicator for reporting year 2011 showed that 3.4 percent of parents reported their child (age one through five) first went to the dentist by 12 months of age. The target for reporting year 2011 was 3.4 percent, which was met.

This state performance measure corresponds with one of the nine MCH priorities being addressed by an MCH Implementation Team with representation from CDPHE's Prevention Services Division, several funders (Caring for Colorado, Delta Dental Foundation), pediatric dentists, registered dental hygienists, Cavity Free at Three Initiative, state oral health coalition and local public health agencies. The team held their first meeting in December 2010. Two strategies quickly emerged: 1. Adoption of the statewide Guidelines for Oral Health Care during Pregnancy and Early Childhood, and 2. Establishment of Colorado Healthy Community Standards, Oral Health.

Both prenatal and oral health providers are limited in providing oral health care during pregnancy by their lack of understanding about its impact and safety. Many dentists needlessly withhold or delay treatment of pregnant patients because of fear about injuring either the woman or the fetus or fear of litigation. A set of oral health practice guidelines during pregnancy and early childhood have been developed to assist health care professionals in delivering safe and effective oral health services to pregnant women and their children based on a review of the current science-based literature. Adoption of these guidelines by the Colorado Dental Association will give Colorado providers an easily accessible and recognized reference to agreed upon treatment protocols for pregnant women and young children.

Both New York and California currently have their own guidelines in place around the appropriate oral health care during pregnancy and early childhood. The authors of both sets of guidelines have been contacted for advice and technical assistance in the adoption of the guidelines as Colorado's own.

The Community Standards for Oral Health are envisioned as aspirational goals for all Colorado communities to achieve. The Standards were produced by the work of the Implementation Team

and vetted with local and state level stakeholders. The Standards have been enthusiastically embraced by oral health advocates statewide and are being used as the framework for the State Oral Health State Plan planned for release in 2012.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Adoption of Guidelines for Oral Health Care during Pregnancy and Early Childhood				X
2. Establishment of Colorado Community Health Standards for a healthy dental community				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The target for reporting year 2012 is 4.0 percent.

The MCH Implementation Team is making great progress on the two identified strategies designed to improve the oral health of this vulnerable population.

The adoption of Guidelines for Oral Health Care during Pregnancy and Early Childhood, has been handed off to the Colorado Dental Association. The CDA has assumed the responsibility of 1) updating the existing California Guidelines, 2) branding of the new Guidelines as Colorado's own and 3) distributing the new Guidelines to Colorado medical and dental providers (with assistance from the Oral Health Unit at CDPHE) and other interested stakeholders. The MCH Implementation Team will continue to support and provide technical assistance as requested.

The second activity involving the establishment of Community Standards for Oral Health is complete. The Standards have been updated after vetting with state and local level stakeholders. A companion document to the Standards, A Toolkit for the Promotion of Oral Health in Colorado Communities, is being developed to assist local public agencies, Early Childhood Councils and local oral health coalitions address the oral health needs of their communities. The Toolkit will be posted on the state oral health coalition's website, OralHealthColorado.org. A description of the Toolkit and a link from the Colorado Department of Public Health and Environment's Oral Health web page to the host site will be created.

c. Plan for the Coming Year

The target for reporting year 2013 is 4.5 percent.

Activities previously described will continue.

In addition, the Oral Health Unit will continue to support and expand the efforts of Cavity Free at Three, an ongoing statewide initiative to prevent oral disease in children from infancy to age three by educating health professionals about the consequences of early childhood caries and their role in preventing this disease. Since many children will see doctors and nurses earlier and more

often than dentists, the CF3 model integrates caries risk assessments, anticipatory guidance, parent counseling and goal setting, establishment of a dental home, and fluoride varnish application into well child care visits. Training sessions lead by dental professionals give medical providers hands on practice with infants and toddlers for oral exams and fluoride varnish applications. Members of the Oral Health Unit (OHU) will receive training/education from the administrators of the CF3 program on how to, in turn, deliver trainings to local health providers interested in implementing the CF3 program in their community or private practice.

Oral health was recently named as one of CDPHE's 10 Winnable Battles. As a result, a Tri-agency Collaborative, consisting of representation from three state agencies (CDPHE, Colorado Department of Human Services and Health Care Policy and Finance) and state partners, has been formed to address the oral health needs of Colorado. The Collaborative meets approximately every six weeks to discuss and formulate strategies to improve the oral health of Colorado's citizens with special emphasis on early intervention and prevention activities.

A national advertising campaign from The Ad Council to improve children's oral health is set to launch in 2012. The Oral Health Unit and state partners are looking for ways to capitalize on this public health educational opportunity.

State Performance Measure 8: *Percent of sexually active high school students using an effective method of birth control to prevent pregnancy.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					27
Annual Indicator			19.3	26.4	29.1
Numerator					
Denominator					
Data Source			Youth Risk Behavior Survey	Youth Risk Behavior Survey	Youth Risk Behavior Survey
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	30	31	31	32	32

Notes - 2011

Data for reporting year 2011 represent 2011. The 2011 YRBS was weighted. Effective birth control includes birth control pills and Depo-Provera.

Notes - 2010

Data for reporting year 2010 represent 2009. The 2009 YRBS was weighted. Effective birth control includes birth control pills and Depo-Provera. Data are available at <http://apps.nccd.cdc.gov/youthonline/App/Default.aspx?SID=HS>

Notes - 2009

Data for reporting year 2009 represent 2005. The 2005 YRBS was weighted. Effective birth control includes birth control pills and Depo-Provera. Data are available at <http://apps.nccd.cdc.gov/youthonline/App/Default.aspx?SID=HS>.

a. Last Year's Accomplishments

The indicator for reporting year 2011 showed that 29.1 percent of sexually active high school students used an effective method of birth control to prevent pregnancy. The target for reporting year 2011 was 27.0 percent, which was met.

The Youth Sexual Health Team, previously known as the Adolescent Sexual Health Coordination Team, began work with Colorado Youth Matter and its subcontractor, the Healthy Colorado Youth Alliance, to develop a statewide youth sexual health "call to action." In addition, the Children and Youth Branch collaborated with the STI/HIV Section to develop a web-automated human interaction (WAHI) website about youth sexual health (www.mylifecolorado.com).

Team members have also partnered with the Colorado Department of Human Services on the Personal Responsibility Education Program (PREP). In addition, team members presented a session on positive youth development during the Women's Health and Family Planning Conference in June 2011. The goal of the conference was to provide educational and collaborative opportunities for professionals working to prevent unintended pregnancy and promote women's health across Colorado.

Colorado Youth Matter (then the Colorado Organization on Adolescent Pregnancy, Parenting, & Prevention) also worked in partnership with the team to create its annual report, the "State of Adolescent Sexual Health in Colorado," which provides a brief summary of relevant state and national data, along with providing a picture of how Colorado has progressed over time.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Developed a youth sexual health plan				X
2. CDPHE STI/HIV Branch and Children and Youth Branch released mylifecolorado.com			X	
3. Completed PREP activities				X
4. Colorado Youth Matter released reports relevant to youth sexual health				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The target for reporting year 2012 is 30.0 percent.

Colorado Youth Matter and its subcontractor, the Healthy Colorado Youth Alliance, under the direction of the YSHT, completed a statewide youth sexual health "call to action," called Youth Sexual Health in Colorado: A Call to Action. This plan is based on input from communities across the state and outlines strategies and actions for communities to effectively affect youth sexual health.

Other MCH action plan items included CDPHE developing a statewide youth sexual health network, which will connect youth-serving professionals who are working on the topic. CDPHE also researched parent/child communication curriculums and is planning to implement trainings regionally over the next year.

Team members continue to partner with The Colorado Initiative to Reduce Unintended

Pregnancies and Vermilion Inc. on the public awareness campaign, Beforeplay, which launched in February 2012. Campaign materials are placed in various media across the state. The website (www.beforeplay.org) provides a clinic locator and interactive reproductive health information for teens, parents, men, women and health care professionals.

In January 2012, Colorado announced Unintended Pregnancy as one of 10 Winnable Battles. Prevention of Teen Pregnancy is included in this Winnable Battle. The Unintended Pregnancy Winnable Battle has a Google Group listserv for sharing information. Local agencies have also identified preventing unintended pregnancy as a priority.

c. Plan for the Coming Year

The target for reporting year 2013 is 31.0 percent.

Activities will continue from the previous year.

CDPHE will begin implementation of the statewide youth sexual health "call to action," including partnering with members of the Youth Sexual Health Team to provide resources, trainings and assistance to local communities. CDPHE and the Youth Sexual Health Team will develop a youth sexual health network, which will connect providers and communities members across the state.

Team members will work with a contractor to provide evidence-based, parent-child connectedness trainings across Colorado.

CDPHE will continue partnering with The Colorado Initiative to Reduce Unintended Pregnancies and Vermilion Inc. on the public awareness campaign, Beforeplay.

State Performance Measure 9: Motor vehicle death rate for teens ages 15-19 years old.

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					12.5
Annual Indicator		17.0	14.0	12.7	12.1
Numerator		61	51	46	41
Denominator		358249	363012	362423	339475
Data Source		Death certificates	Death certificates	Death certificates	Death certificates
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	12	11.5	11	10.8	10.5

Notes - 2011

Data for reporting year 2011 represent calendar year 2010 deaths.

Notes - 2010

Data for reporting year 2010 represent calendar year 2009 deaths.

Notes - 2009

Data for reporting year 2009 represent calendar year 2008 deaths.

a. Last Year's Accomplishments

The indicator for reporting year 2011 was 12.1 deaths per 100,000 teens ages 15-19 years old caused by motor vehicles. The target for reporting year 2011 was 12.5 deaths per 100,000 teens and the target was met.

CDPHE continued to convene the Colorado Teen Driving Alliance. The Alliance implemented strategies outlined in the Child Injury Prevention Policy Plan to educate the public about the importance of the graduated driver's license (GDL) law. The group agreed to become the Implementation Team (MIT) for SPM 9, establishing a subcommittee to focus on providing technical assistance to local communities on this issue.

The Alliance partnered with the Department of Revenue on a pilot project that involved putting televisions in some of the largest motor vehicle offices in the state that play short, informational videos about graduated driver's licensing.

Colorado was one of ten states to receive a Motor Vehicle Policy grant from the Centers for Disease Control and Prevention. The ISVP Branch will receive \$750,000 over five years to 1) strengthen Colorado's GDL law by increasing the minimum driving age and expanding the restricted driving hours for teens; and 2) establish a statutory requirement that allows for primary enforcement of Colorado's seat belt law. This project began on August 1, 2011 and will continue through July 2016.

During the 2011 legislative session, the Alliance provided information regarding the strengths of Colorado's current GDL law. The ISVP Unit provided a bill analysis on a bill that would allow 14-year-old children living in agricultural districts to obtain a driver's license.

The Colorado Child Fatality Prevention State Review Team's 2010 Legislative report included recommendations to establish a statutory requirement that allows for primary enforcement of the seat belt law and to increase parental awareness and support enforcement of the GDL Law.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Coordinated and maintained the Colorado Teen Driving Alliance				X
2. Conducted policy analysis activities for proposed legislation				X
3. Implemented a policy plan to strengthen Colorado's GDL Law				X
4. Created a subcommittee to provide technical assistance to local communities implementing teen motor vehicle safety programs				X
5. Wrote and received a five-year Child Motor Vehicle Policy grant				X
6. Completed a report to the legislature containing recommendations related to strengthening graduated drivers license and seat belt laws				X
7.				
8.				
9.				
10.				

b. Current Activities

The target for reporting year 2012 is 12.0 deaths per 100,000 teens.

The ISVP Branch continued to convene the Colorado Teen Driving Alliance. The Alliance developed a three-year state logic model and action plan to reduce teen motor vehicle fatalities. The Alliance, local health departments, and other key local partners developed a complementary local logic model and action plan template. These logic models and action plans are aligned with the goals and objectives in the ISVP Branch's CDC Motor Vehicle Policy grant. The ISVP Branch and the EPE Branch also developed evaluation plans for state and local action plans.

The Alliance created a Safety Advocate Section of the www.coteedriver.com website to house resources for local programs working on SPM #9. Additionally, the ISVP Branch developed a collaborative website for motor vehicle partners (www.teendrivingcoalitionco.com).

The ISVP Branch expanded CIPS to include additional policy partners and renamed the group the Injury and Violence Policy Committee (IVPC). The IVPC provides strategic policy direction to the Alliance.

The ISVP Branch and the Colorado Department of Transportation administered a telephone survey for adults to assess knowledge of current motor vehicle laws and to gauge support for potential improvements.

The ISVP Branch held a Motor Vehicle Policy Symposium in July 2012 for community-based motor partners.

c. Plan for the Coming Year

The target for reporting year 2013 is 11.5 deaths per 100,000 teens.

The ISVP Branch will continue to convene the Colorado Teen Driving Alliance and the IVPC. The Alliance will implement activities outlined in the three-year state action and evaluation plans to reduce teen motor vehicle fatalities.

The Alliance will provide technical assistance to local health departments and other community-based agencies that are implementing local motor vehicle safety activities. The Alliance will convene the Local Community Workgroup on a quarterly basis to provide opportunities for local motor vehicle partners to discuss successes and challenges.

The ISVP Branch will offer grant opportunities to local teams that attended the 2012 Motor Vehicle Policy Action Symposium to implement their local motor vehicle action plans. Members of the Alliance will conduct site visits with each of these communities to provide technical assistance.

The ISVP Branch will maintain the motor vehicle collaboration website. The Colorado Department of Transportation will maintain the www.coteedriver.com website and ensure that the Safety Advocate Section is up-to-date.

The ISVP Branch and its partners will continue to implement activities under Colorado Child Motor Vehicle Policy Grant.

The Colorado Child Fatality Prevention State Review Team's 2012 Legislative report will include recommendations to establish a statutory requirement that allows for primary enforcement of the seat belt law and to increase parental awareness and support enforcement of the GDL Law.

State Performance Measure 10: *The percent of group members that invest the right amount of time in the collaborative effort to build a youth system of services and supports.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					30
Annual Indicator				20.0	90.0
Numerator				2	9
Denominator				10	10
Data Source				Wilder Collaboration Factors Inventory	Wilder Collaboration Factors Inventory
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	90	90	90	90	90

Notes - 2011

Data for reporting year 2011 were collected in November 2011.

Notes - 2010

Data for reporting year 2010 were collected in October 2010 as the baseline for this state performance measure.

a. Last Year's Accomplishments

The annual indicator for reporting year 2011 was 90.0 percent. This exceeded the reporting year 2011 target of 30.0 percent.

The Prevention Services Division (PSD) Healthy Youth Team, or PHYT, was designated as the Implementation Team for this MCH priority. PHYT accomplishments include:

1. An interactive website identifying and describing each PSD youth-serving program and initiative (<http://www.cdphe.state.co.us/pp/development/psdyouthprograms>)
2. An accessible email distribution list and Google Group to improve communication between PSD youth-serving programs
3. The development of a draft "Youth-Friendly Policy" that outlines expectations of how employees can:
 - Allow youth to successfully work and gain valuable experience in the public health sector
 - Promote, value and incorporate youth input and feedback in programs and initiatives that affect youth; and
 - Improve work with our community partners who have similar goals in improving youth health and well-being.

This policy was developed by a young person employed by the department, after serving on the Youth Partnership for Health (the department's youth advisory council) for the previous three years.

4. Hosted one learning community for all youth-serving professionals within the Division related to integration of youth health programs and initiatives.
5. A gaps analysis that identified the need to hire young people to work within PSD. As a result, the division hired nine youth consultants who guided the work related to social media, healthy eating/active living and the Tony Grampsas Youth Services Program (a violence prevention program). In addition, resource documents, including an orientation for employees, was developed to ensure that meaningful youth-adult partnerships were developed that resulted in positive work experiences and project outcomes.

In addition to the internal efforts to coordinate youth-serving programs within PSD, CDPHE provided leadership for the creation of the Colorado 9to25 Network (CO9to25). The group was developed to take collaborative action to ensure that all young people ages 9-25 are safe, healthy, educated, connected and contributing.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Developed an on-line interactive tool identifying and sharing the goals of each PSD youth-serving program and initiative				X
2. Developed and utilized a shared email list and Google Group to create an efficient communication mechanism				X
3. Drafted a policy in partnership with a young person for all PSD youth-serving professionals				X
4. Hosted a learning community				X
5. Conducted a gaps analysis				X
6. Hired nine youth consultants to guide and inform the work				X
7. Developed a leadership structure and charter				X
8. Drafted a framework, including identifying goals and outcome indicators				X
9.				
10.				

b. Current Activities

The target for reporting year 2012 is 90.0 percent.

As the MIT for this MCH priority, the PSD Healthy Youth Team created a state logic model and action plan, incorporating both the internal and external youth systems-building work, which have been developed and shared with local public health agencies and partners.

The "Youth Friendly Policy," now titled "Youth Friendly Guidance," has been formally adopted by both the Prevention Services Division and the Department.

Two more Learning Communities were hosted by PSD Healthy Youth Team members.

Two youth advisors/consultants were hired to work on MCH youth priorities -- youth sexual health and youth systems building.

Two MCH personnel were invited to and participated in AMCHP's Youth Systems Roundtable in Washington D.C.

In June 2012, CO9to25 unveiled the collaborative's vision, goals, outcomes and strategic map with public and private partners, including young people and families. Partners included, but are not limited to representatives from various programs within CDPHE, CDE, CDHS, Department of Local Affairs, Kaiser Permanente, youth serving non-profits, University of Colorado, local public health agencies and local school districts.

c. Plan for the Coming Year

The target for reporting year 2013 is 90.0 percent.

In order to increase the capacity of PSD youth-serving staff to integrate the CO9to25 Framework into their work, learning communities, trainings and technical assistance will be conducted.

The coordination of state and local youth systems efforts will be supported through the mobilization of partnerships. This will include ensuring that the public health role in youth systems building is understood and valued by key internal and external stakeholders and conducting bimonthly leadership team and quarterly all-network meetings.

Webinars and trainings will be used to promote and assess utilization of the CO9to25 Framework by internal and external partners across Colorado in order to increase alignment of youth efforts.

On-going communication, quarterly meetings and training will be used to develop and maintain the infrastructure for the CO9to25 Network.

A common communication mechanism and trainings will be used to coordinate and enhance the capacity of the statewide network of youth advisory councils/groups.

Trainings that promote skill-building and opportunities to practice those skills with young people will be used to build the capacity of state and local adult partners to engage youth.

Standards for effective and meaningful youth engagement will be developed and promoted.

Policies that support a coordinated and integrated youth system will be assessed and developed.

Focus groups conducted with local health agencies will be used to develop a local youth systems logic model and action plan that can be implemented in 2013-14.

E. Health Status Indicators

Brief narratives are shown below regarding each of the Health Status Indicators. The years referenced are reporting years, which refer to data from the previous year.

Health Status Indicator #01A

The low birth weight rate in Colorado began to decline in 2007, and reached 8.8 percent in 2011, its lowest level since 2000 (when it was 8.4 percent). A recent examination of possible factors contributing to the decline is inconclusive.

The prevalence of smoking among pregnant women has fallen, but the rate has been falling since data were first collected in 1990. Inductions and C-sections, which have been implicated in low birth weight and prematurity, have climbed since the late 1990s, although the proportion of inductions remained constant at about one in five while C-sections reached the highest level ever (26.4 percent) in 2010. The first decline in C-sections since the mid-1990s occurred in 2011 (24.4 percent). The prematurity rate (births occurring before 37 weeks gestation) has fallen, dropping to 9.1 percent in 2011 after a high of 10.2 percent in 2006. Multiple births, a known contributor to low birth weight, have remained between 3.2 percent and 3.4 percent of all births every year since 2003.

Another factor that should be considered is the impact on the low birth weight rate of a decline in the number of births statewide since 2008. From a high of 70,804 births in 2008, the number dropped to 70,028 in 2009, 68,605 in 2010 and 66,346 in 2011. It is possible that births have declined among higher-risk groups, thus contributing to an improved low birth weight rate. However, data from the Pregnancy Risk Assessment Monitoring System show no significant changes in the characteristics of women giving birth.

The Prevention Services Division tracks the low birth weight rate closely and will continue to

monitor the rate and the factors contributing to the rate.

Health Status Indicator #01B

The singleton low birth weight rate for 2011 was 6.9 percent, lower than the highest rate in 2006 when the rate was 7.3 percent.

Trends in low birth weight are discussed above.

Health Status Indicator #02A

The state very low birth weight rate for 2011 was 1.3 percent, the same as the rate in other years. The very low birth weight rate was only slightly lower at 1.2 percent in 2000 and 2010.

Health Status Indicator #02B

The singleton very low birth weight rate for 2011 was 1.0 percent. This rate has fluctuated between 0.9 percent and 1.0 percent since 2000.

Health Status Indicator #03A

The child death rate due to unintentional injuries declined from 6.6 per 100,000 in 2010 to 6.3 per 100,000 in 2011. This rate fell from a high of 8.6 per 100,000 in 2000, so progress over the last decade is evident.

Health Status Indicator #03B

The child death rate due to motor vehicle crashes in 2011 was 2.0, the lowest rate yet attained for this indicator.

Health Status Indicator #03C

The death rate for youth due to motor vehicle crashes for 2011 was 14.5 per 100,000. Although it looks like the rate increased, the number of deaths actually decreased to a low of 100. The population estimates in Colorado were adjusted based on the 2010 census and estimates for this age group were noticeably affected. Thus, the decrease in the denominator caused the rate to increase, even though the number of deaths decreased.

Changes in Graduated Driver Licensing laws (first instituted in 1999) are being credited with much of the decline. In 2005, Colorado strengthened the laws to limit passengers riding with inexperienced drivers, to prohibit learners' permit holders to use cell phones while driving, and to require seatbelts for all occupants under age 18. A new driver under age 18 cannot have any passengers under age 21 until the driver has held a driver's license for at least six months. In addition, a new driver under age 18 cannot have more than one passenger under age 32 until the driver has had his license for at least one year.

Health Status Indicator #04A

The rate of non-fatal injuries for children 14 and younger decreased to 160.4 per 100,000 in 2011, the lowest rate achieved over the last decade. This rate reflects a decrease from 2004 when the comparable rate was 187.4 per 100,000.

Health Status Indicator #04B

The rate of non-fatal injuries due to motor vehicle crashes for children 14 and younger decreased to 19.5 per 100,000 in 2011. This is the first time this rate has fallen below 20.0 per 100,000, a 44 percent drop from 2004 when the rate was 35.1 per 100,000.

Health Status Indicator #04C

The injury hospitalization rate declined for the seventh consecutive year to 102.5 per 100,000 in 2011. Since 2004 the rate has declined 42 percent, from 175.5 per 100,000.

Health Status Indicator #05A

In 2011, the chlamydia rate reached the highest rate (28.8 per 1,000) since it was first included in

this grant in 1997. The number of cases is less than in 2009 and 2010. The population estimates in Colorado were adjusted based on the 2010 census estimates, and this age group was most affected by the adjustment. Thus, the decrease in the denominator caused the rate to increase, even though the number of cases decreased.

Health Status Indicator #05B

The chlamydia rate in 2011 decreased slightly to 10.6 per 1,000. This is a decrease from the highest rate which was reported in 2010 (10.8 per 1,000).

Health Status Indicator #06 A & B

Colorado has a population of slightly larger than 1.7 million under the age of 25. This is lower than the 1.8 million reported last year because of the adjustment of the population estimates based on the 2010 census. The population is predominately White (includes Hispanic ethnicity) with small minority groups.

Colorado's population has a large Hispanic representation. Almost three in ten people under the age of 25 is Hispanic. This is up slightly from the previous year.

Health Status Indicator #07 A & B

The vast majority of births are classified as White (includes Hispanic ethnicity) and occur to women between the ages of 20 and 34.

Approximately 30 percent of births are Hispanic. Hispanic births outnumber non-Hispanic births for women below age 20, while the reverse is true for older women.

Health Status Indicator #08 A & B

There were a total of 1,024 deaths in the population below age 25 in 2010. The largest number of deaths was among infants.

About 30 percent of deaths under the age of 25 were among Hispanics.

Health Status Indicator #09 A & B

One-quarter of children in Colorado live in a household headed by a single parent. Almost two percent of children are in TANF families and a little more than one percent of children are living in foster home care. Almost one in three children in Colorado is enrolled in Medicaid; about one in thirteen children is enrolled in the Colorado Child Health Plan Plus program (CHP+).

In a given month, about one in seven children participate in the food stamp program. Children are only eligible for WIC until age 5; almost one-quarter of children age 0-4 were enrolled in WIC.

The percentage of high school drop-outs is highest among American Indian/Native Alaskan and Black adolescents.

Child race data are not available for the percent in household headed by a single parent, number living in foster home care, number enrolled in food stamp program, or the rate of juvenile crime arrests.

A higher percentage of Hispanic children (compared to non-Hispanic children) in Colorado live in TANF families.

A higher number of Hispanic compared to non-Hispanic children in Colorado are enrolled in Medicaid, but ethnicity was not reported for nearly 105,000 children. The number of children enrolled in the Colorado Child Health Plan Plus (CHP+) is slightly higher for non-Hispanics compared to Hispanics. Ethnicity was not reported for almost 25,000 children in this program.

A higher number of Hispanic compared non-Hispanic children age 0-4 were enrolled in WIC.

The percentage of high school drop-outs is more than double among Hispanic youth compared to non-Hispanic youth.

Child ethnicity data are not available for the percent in household headed by single parent, number living in foster home care, number enrolled in food stamp program, or the rate of juvenile crime arrests.

Health Status Indicator #10

Nearly one million Colorado children live in urban areas, but a substantial number, nearly 400,000, live in rural areas. Just two percent live in frontier areas, counties with fewer than 6 people per square mile.

Health Status Indicator #11

About 3 out of every 10 Colorado residents live at or below 200% of the federal poverty level; 1 of every 8 lives at or below 100% percent of the federal poverty level; and 1 in 17 lives below 50% percent of the federal poverty level.

Health Status Indicator #12

More than 1 out of every 3 Colorado children lives at or below 200% of the federal poverty level; more than 1 of every 6 lives at or below 100% percent of the federal poverty level; and about 1 in 13 lives below 50% percent of the federal poverty level.

F. Other Program Activities

The majority of MCH Block Grant supported programs have been addressed within the report, below are two programs not previously discussed in the measures.

The Family Healthline

The Family Healthline is an information referral helpline sponsored by the MCH Program and managed by the contractor Maximus. The Healthline assists women, families, and individuals in locating free or low-cost health care services. Information is provided about other programs such as emergency shelters, food subsidies, mental health, or parenting support groups. The Healthline specialists speak fluent Spanish and English, and arrangements are made for assisting the hearing-impaired and callers who speak other languages.

The phone line received 10,969 calls from October 2008 to September 2009, approximately 500 more calls than the previous year. The Family Healthline specialists make referrals, usually within each caller's own community. The Healthline's referral network covers many categories: low-cost or free medical care, dental health services, domestic violence counseling, and other basic subsistence resources.

Fourteen percent of the calls were answered on the Spanish line. Maximus also maintained an average call abandonment rate (the proportion of calls not answered) of 6.13 percent, far less than the standard of 10 percent. The majority of the referrals requests are for WIC office information, with most calls for services benefitting individuals under age 25. Ninety-five percent of callers speak English with 43 percent indicating that they do not have health insurance.

Assuring Better Child Health and Development Project (ABCD)

The CASH and HCP Units are working to implement the Assuring Better Child Health and Development Project that focuses on promoting the use of standardized developmental screening tools in primary health care settings to help increase early identification of developmental concerns. The project is supported by the MCH Block Grant and funds from Colorado-based private foundations. The program manager and a trainer for the project is housed at the Arapahoe County Early Childhood Education Council and personnel are working with 25 counties

to increase the use of developmental screenings.

/2012/ The Family Healthline received 8,139 calls from October 2009 to September 2010. Thirteen percent of the calls were answered on the Spanish line. Maximus also maintained an average call abandonment rate (the proportion of calls not answered) of 6.11 percent, far less than the standard of 10 percent. The majority of the referrals requests are for WIC office information, with most calls for services benefitting individuals under age 21. Ninety-two percent of callers speak English with 46 percent indicating that they do not have health insurance. //2012//

/2013/ The Family Healthline received 6,954 calls from October 2010 to September 2011. Eleven percent of the calls were answered on the Spanish line. Maximus also maintained an average call abandonment rate (the proportion of calls not answered) of 6.23 percent, far less than the standard of 10 percent. The majority of the referrals requests are for WIC office information, with most calls for services benefitting individuals under age 21. Ninety-one percent of callers speak English with 57 percent indicating that they do not have health insurance. //2013//

G. Technical Assistance

Colorado's technical assistance need is shown on Form 15. The program is seeking assistance in evaluating systems building initiatives.

/2012/ For FY 2012, the program is seeking assistance in learning about other states' strategies for early childhood obesity prevention. //2012//

/2013// For FY2013, the program is seeking assistance with measuring progress towards incorporating the Life Course model into MCH programming. We would like to request the development of a national set of Life Course measures instead of every state developing their own. //2013//

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2011		FY 2012		FY 2013	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
1. Federal Allocation <i>(Line1, Form 2)</i>	7249480	7178335	7236694		7178335	
2. Unobligated Balance <i>(Line2, Form 2)</i>	0	0	0		0	
3. State Funds <i>(Line3, Form 2)</i>	4736061	5383752	5427521		5383752	
4. Local MCH Funds <i>(Line4, Form 2)</i>	701049	0	0		0	
5. Other Funds <i>(Line5, Form 2)</i>	0	0	0		0	
6. Program Income <i>(Line6, Form 2)</i>	0	0	0		0	
7. Subtotal	12686590	12562087	12664215		12562087	
8. Other Federal Funds <i>(Line10, Form 2)</i>	121013718	139107088	93663980		139107088	
9. Total <i>(Line11, Form 2)</i>	133700308	151669175	106328195		151669175	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2011		FY 2012		FY 2013	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Federal-State MCH Block Grant Partnership						
a. Pregnant Women	2661982	1622981	2321893		1750000	
b. Infants < 1 year old	0	0	0		0	

c. Children 1 to 22 years old	3494280	4346786	4295272		4350000	
d. Children with Special Healthcare Needs	5830436	5583588	5527472		5550000	
e. Others	0	0	0		0	
f. Administration	699892	1008732	519578		912087	
g. SUBTOTAL	12686590	12562087	12664215		12562087	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	94160		75492		86947	
c. CISS	127058		118124		151704	
d. Abstinence Education	0		0		0	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	115191075		88324209		120524907	
h. AIDS	0		0		0	
i. CDC	1203569		1040539		11715654	
j. Education	0		0		0	
k. Home Visiting	0		0		0	
k. Other						
ACA-ECVP	0		0		302272	
ACF-CBCAP	0		0		728188	
HRSA	0		468930		1083056	
SAMSHA- ProjSafetyNet	0		0		533944	
TITLE X	0		0		3980416	
ACA - Early Childhoo	0		4310		0	
ACF - CBCAP	0		481836		0	
SAMSHA-Proj Safety N	0		312715		0	
Title X	2640093		2837825		0	
CBCAP	776422		0		0	
CSHCN	609036		0		0	
Suicide Prevention	372305		0		0	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2011		FY 2012		FY 2013	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Direct Health Care Services	450000	1219897	420000		1200000	
II. Enabling Services	2755000	1921757	3300000		1900000	
III. Population-Based Services	3700000	3206687	3400000		3297531	

IV. Infrastructure Building Services	5781590	6213746	5544215		6164556	
V. Federal-State Title V Block Grant Partnership Total	12686590	12562087	12664215		12562087	

A. Expenditures

Information on annual expenditures is contained in Form 3, Form 4, and Form 5.

2010 expenditures were allocated 9.37% to Administration; 33.86% to Children with Special Health Care Needs; 39.68% to Child and Adolescent and 17.09% to Maternal and Infant Services.

Form 3

Line 1 - Federal Allocation -- The Federal allocation award in FY 2010 was slightly higher than budgeted for the year by \$12,786 (\$7,249,480 vs. \$7,236,694).

Line 4 -- Local MCH Funds -- Local funds from MCH partners were not utilized for match purposes. State funding was sufficient, therefore match was wholly from State funds.

Line 8 - Other Federal Funds - The variation between budgeted and expended (\$121,013,718 vs. 139,107,088) is due to the two following reasons: 1. Under estimation of the Women, Infants & Children (WIC) and Child & Adult Care Food Program (CACFP) expensing; and 2. The MCH Director responsible for the administration of the Title V program assumed management of additional programs majorly funded from the CDC.

Form 4

Line 1. a. - Pregnant Women -- Budgeted vs. expended - A change in match sources has caused a decrease in the amount of state funds used for the pregnant women population, however, the match for the Children 1 -22 years old population has increased.

Line 1. c. - Children age 1 to 22 - Budgeted vs. expended -- An increase is due to a new state match source, School Based Health Centers serving this population.

Line 1. d. Children with special health care needs - Budgeted vs. expended did not substantially vary.

Line 1. f. Administration -- Expended was greater than budgeted due to State fund match expended for allowable administrative costs. This is a change from previous grant years.

Form 5

Line I - Direct Health Care Services - Budgeted vs. expended - The Colorado MCH program has been working at both the state and local levels to decrease the amount of Block Grant funding spent on direct health care services in order to increase effort at the population-based and infrastructure building levels. Progress towards that goal has changed due to a new match source, State General Funds, appropriated for School Based Health Centers. About 80% of the sub-contracted funds are defined as Direct Health Care Services. The Year 2013 budget was adjusted to align with progress.

Line II - Enabling Services - The Colorado MCH program has been working at both the state and local levels to decrease the amount of Block Grant funding spent on enabling services in order to increase effort at the population-based and infrastructure building levels. The state feels that a great proportion of the total MCH population is served with this approach.

Line III -- Population-Based Services -- Budgeted vs. expended did not substantially vary.

Line IV -- Infrastructure Building Services - Budgeted vs. expended did not substantially vary.

B. Budget

Budget information is contained in Forms 2, 4, 5, and 10.

Form 2

Line 1 - Federal allocation - is \$7,178,335 for 2013. Of these dollars, a total of 39.8603% (\$2,861,306) will be estimated and budgeted for preventive and primary care for children; 34.0086% (\$2,441,251) for children with special health care needs, and 9.3729% (\$672,818) administration. These proportions meet the MCH Block Grant requirements.

Line 3 - State MCH Funds - is \$5,383,752 meeting the minimum match requirement of 3/4th of the federal allocation.

Line 7 - Total state match - consists of state general funds in the amount of \$4,170,784 and cash funds in the amount of \$1,212,968 (genetics counseling fees).

Line 9. g. - Other Federal Funds - WIC - funds include \$96,192,628 for Women, Infants & Children; \$24,332,279 Child & Adult Care Food Program.

Line 9. i. - Other Federal Funds - Centers for Disease Control - Funding includes Diabetes Prevention, Colorectal Cancer Prevention, Integrating Colorectal Cancer, Women's Wellness Connection Cancer Control, BCPPT Rape Prevention, Cancer Registry, Tobacco Education & Prevention, Colorado Physical Activity & Nutrition, Heart Disease and Stroke Prevention, Healthy Communities Tobacco Education, Sudden Infant Death Registry, Early Hearing, Detection and Intervention Surveillance (EHDI), Injury Surveillance; Core II Child Injury Prevention; Sexual Violence Prevention, Child & Adolescent Health Injury Prevention.

Line 9. k. - Other Federal Funds - Funds include Affordable Care Act Maternal, Early Childhood Visitation program; Administration for Children & Families, Community Based Family Resource; HRSA, Integrated Community Systems; HRSA, Heritable Disorders Screening; SAMSHA, Project Safety Net; Title X, Family Planning Program. //2012//

Form 4

Line 1. a. - Pregnant Women -- the FY13 Budget is estimated to be 9% less than FY11.

Line 1. c. - Children age 1 to 22 -- the FY13 Budget is estimated to remain the same as FY11.

Line 1.d.-Children with Special Healthcare Needs -- the FY13 Budget is estimated to be within 1% of FY11 actual expenditures.

Line 1. f. Administration -- Total administrative costs for FY13 are estimated to be approximately 7.2% of both Federal and State funds.

Form 5

Line I - The Colorado MCH program has been working at both the state and local levels to decrease the amount of Block Grant funding spent on direct health care services in order to increase effort at the population-based and infrastructure building levels. Progress towards that goal has changed due to a new match source, State General Funds, appropriated for School Based Health Centers. About 80% of the sub-contracted funds are defined as Direct Health Care Services. The Year 2013 budget was adjusted to align with progress.//2012//

Line II -- Enabling Services - The Colorado MCH program has been working at both the state and

local levels to decrease the amount of Block Grant funding spent on enabling services in order to increase effort at the population-based and infrastructure building levels. The state feels that a great proportion of the total MCH population is served with this approach.

Form 10

Line 10.e. - Included in the total for "others" are women of childbearing-age, and in some cases, all of the MCH population, who are reached by population-based MCH efforts; any one category does not apply to these two populations.

VI. Reporting Forms-General Information

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note

Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents

A. Needs Assessment

Please refer to Section II attachments, if provided.

B. All Reporting Forms

Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents

Please refer to Section III, C "Organizational Structure".

D. Annual Report Data

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.