Maternal and Child Health Services Title V Block Grant

Colorado

FY 2017 Application/ FY 2015 Annual Report

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I. General Requirements

I.A. Letter of Transmittal

COLORADO
Department of Public Health & Environment

Dedicated to protecting and improving the health and environment of the people of Colorado

July 15, 2016

Michele Lawler, Director
Division of State and Community Health
Maternal and Child Health Bureau
Health Resources and Services Administration
5600 Fishers Lane
Rockville, MD 20857

Dear Ms. Lawler:

It is with pleasure that I submit the 2017 MCH Title V Block Grant application for Colorado. The application illustrates the impact of this funding stream to the MCH population in Colorado and the variety of ways it is used to promote the health and well-being of women, children, youth, children and youth with special health care needs and families in our state.

We look forward to another year of funding and continued partnership with your office.

Sincerely,

Karen Trierweiler

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John W. Hickenlooper, Governor | Larry Wolk, MD, MSPH, Executive Director and Chief Medical Officer

I.B. Face Sheet

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

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix C of the 2015 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2015; expires December 31, 2017.

I.E. Application/Annual Report Executive Summary

Geography and Demographics

Colorado is the eighth largest state in the nation, located in the Rocky Mountain region of the western U.S. The Continental Divide runs from north to south through west central Colorado, dividing the state into the more mountainous western slope and the eastern plains. Eighty-six percent of the state's population lives in 16 urban counties along the Front Range of the Rocky Mountains; the north-south corridor just east of the mountains, with the remaining residing in rural (27) and frontier (21) counties within the state.

Colorado ranks 22nd among states in population size with a total state population in 2016 of 5,538,581. Twenty percent of the state's population is females ages 15-44; 29 percent are children and youth ages 0-21; and approximately 217,000 are children and youth with special health care needs (CYSHCN). Sixty-nine (69.4) percent of Coloradans identify as White non-Hispanic, 20.9 percent as of Hispanic origin, Black/African-American (4.0 percent), Asian and Native Hawaiian/Pacific Islander (2.9 percent), American Indian and Alaska Native (1.0 percent), and people who report another race (4.6 percent) or more than one race (3.5 percent).

The number of births in 2015 totaled 66,545, consistent with 2014, with declines noted among younger women. The Colorado Family Planning Initiative resulted in over 40,000 long-acting reversible contraceptives (IUDs and implants) being used by women between 2009 and 2015. Birth rates have fallen dramatically, especially among young women, because these methods are virtually 100 percent effective.

Employment, Income and Poverty

As of March 2016, Colorado's unemployment rate was 2.9 percent (U.S. rate – 5.0 percent), the 3rd lowest in the nation. In 2014, the median household income in Colorado was $61,303, exceeding the national median of $53,657, with variations noted by county. Douglas County, in metro Denver, demonstrates a median income ($102,626) triple that of Costilla County, in southern Colorado ($31,534). The percentage of Coloradans in poverty decreased since 2012. In 2014, 29 percent of Coloradans lived in low-income families (below 200 percent of the Federal Poverty Level), a five percent decrease from 30.6 percent in 2012. Almost thirty-seven percent of children younger than 18 were living in low-income families ($47,700 for a family of four). Poverty among children in Colorado declined since 2012, with the state tied for the 5th lowest child poverty rate in the nation in 2014.

Education

Colorado's population is highly educated with over one-third (38.4 percent) of all Coloradans age 25 and older having a college or advanced degree, second in the nation. Inequities in educational attainment still exist, with only

23.2 percent of Black/African Americans and 13.7 percent of Hispanics attaining a college/advanced degree. The percentage of students overall who graduate from high school remains low at 77.3 percent in 2014, with 35 states demonstrating higher rates. Disparities in high school graduation rates match those for college.

Health Insurance and the ACA

In Colorado, the uninsured rate dropped by more than 50 percent from 14.3 percent in 2013 to 6.7 percent in 2015. Coloradans ages 30-39 years are most likely to be uninsured at 13.4 percent. Only 2.5 percent of children ages 0 -18 years were uninsured in 2015. White non-Hispanics demonstrate the highest rates of health insurance coverage at 5.0 percent uninsured. By contrast, 11.0 percent of Hispanics in Colorado were uninsured. The uninsured rate was highest among Coloradans with incomes at or below 100 percent of the federal poverty level (10.6 percent) and those with incomes between 101 to 200 percent FPL (7.8 percent).

The ACA exerted the greatest impact on coverage through Medicaid expansion and Connect for Health Colorado, the state's health insurance marketplace. Enrollment via the exchange increased from 52,783 in 2013 to 152,470 in 2015. Approximately 13 percent of all enrollees are children ages 0 -17 years and seven percent are youth ages 18 - 25 years. As of April 2016, 553,887 children were enrolled in Medicaid and 54,838 children were enrolled in the Children's Health Insurance Program, CHP+.
Emerging issues in 2016 include youth marijuana use (no increase but less perceived risk), Zika virus (low prevalence expected) and the development of an internet panel survey for pregnant and postpartum women to provide real-time data for surveillance and evaluation.

Colorado's MCH Program

Colorado's efforts to improve MCH are focused at the public health and systems level of the pyramid, with the exception of enabling services provided to the CYSHCN population. Both the MCH and CYSHCN components are housed in the Prevention Services Division (PSD) of the Colorado Department of Public Health and Environment (CDPHE). CDPHE is one of 19 Colorado state agencies comprising the executive branch under the direction of Governor John Hickenlooper.

The PSD consists of seven branches:
-Children, Youth and Families (CYFB) (housing most MCH programming)
-Health Services and Connections (Title X Family Planning, Breast and Cervical Cancer Screening and School-Based Health Center programs)
-Nutrition Services (WIC and Child and Adult Care Food Programs)
-Violence/Injury Prevention and Mental Health Promotion (Injury, Suicide and Violence Prevention, Prescription Drug and Marijuana programming)
-Health Promotion and Chronic Disease Prevention and Fiscal and Communications.

The newborn metabolic and hearing screening programs are housed in the Laboratory Division; Critical Congenital Heart Disease (CCHD) screening is located in the state's birth defects registry. The Immunization program is housed in the Disease Control and Environmental Epidemiology Division.

Colorado collaborates consistently with key partners. The Department of Health Care Policy and Financing (HCPF) houses Colorado's Medicaid and CHP+ programs along with the Accountable Care Collaborative and State Innovation Model projects. The Colorado Department of Human Services (CDHS) includes the Office of Early Childhood (the Maternal, Infant and Early Childhood Home Visiting Program (MIECHV), Early Intervention, Child Maltreatment, Project Launch) and The Children, Youth and Families Division which coordinates the state's youth state plan and other collaborations such as CO9to25. While the substance use and behavioral health treatment programs are located at CDHS, prevention programming is housed in PSD. MCH staff partners with the Colorado

Department of Education's Health and Wellness and Dropout Prevention Units. Colorado receives both a federal Healthy Start and Early Childhood Systems grant, administered by two non-profit partners.

MCH block grant funding is allocated via formula to each of Colorado's 54 local public health agencies (LPHAs). Each LPHA is governed locally; the state has no formal organizational alignment or oversight over local jurisdictions.

Colorado completed a comprehensive needs assessment process to identify priorities for the 2016-2020 MCH Block Grant cycle. In addition, the state identified three fundamental components common to all: community engagement, performance management/quality improvement/evaluation and health equity. Colorado chose the following 7 priorities for 2016-2020.
1. Women's mental health, including pregnancy-related depression
2. Reducing disparities in infant mortality among the African American population
3. Early childhood obesity prevention
4. Developmental screening and referrals
5. Bullying and youth suicide prevention
6. Medical home for children and youth with special health care needs
7. Substance misuse reduction (tobacco, marijuana and prescription drugs) among pregnant and postpartum women

FY16 Progress
Colorado's priority-related work focused primarily on planning during the first half of FY16. MCH priority logic models (LMs) and action plans (APs) were once again developed to steer both state and local-level work for each individual priority. The resulting action plans include evidence-based and population-based goals, objectives, activities and measures. Implementation teams began execution of the state-level APs on October 1, 2015. Local APs were developed in consultation with community partners to guide implementation at the local level on October 1, 2016. Colorado's MCH Program has launched a performance management initiative (MCH Impact) to increase performance monitoring, via collection/review of data on a monthly basis, to assure continued progress for ultimate impact.

Accomplishments and challenges are outlined below by domain for Colorado's continuing and new priorities.

Domain: Women/Maternal Health
Women's Mental Health, including Pregnancy-Related Depression
Pregnancy-Related Depression (PRD)
NewSPM 1: 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.
This indicator has demonstrated positive change, from 73.8 percent in 2010 to 78.0 percent in 2015. (2015 target: 79 percent; target not met.) Assuring consistent referral to services and treatment remains a challenge. Even when women are screened and referred for treatment, stigma continues to act as a barrier.

Reduction of Cesarean Births among low risk, first time births. (NPM 2)
ESM 2.1: Completion of a report identifying NTSV data/rates for all Colorado delivering hospitals to identify targets for reduction/QI.
Staff completed planning for this new NPM and an analysis of rates is underway.

Domain: Perinatal/Infant Health
Reduction of Infant Mortality among the African American population

New SPM 2: Infant mortality rate among African Americans in Arapahoe and Denver counties. (2017 target - 11.0; 2018 - 9.0).
Staff completed planning for this new priority and developed a set of statewide preterm birth prevention recommendations.

Early Childhood Obesity Prevention (NPM 4)
ESM 4.1: Number of delivering hospitals in Colorado (out of 56) that will be certified as Baby-Friendly. (2017 target - 9; 2018 – 12).
Five delivering hospitals have been designated as Baby-Friendly during FY16, including the state's largest delivering hospital, for a total of eight since this priority began.

Domain: Child Health
***Early Childhood Obesity Prevention (ECOP)* (NPM 8)**
ESM 8.1: Number of licensed child care centers in select counties in Colorado (out of a total of 1,190) that will have physical activity as a part of the daily curriculum. (2017 target -10; 2018 – 25).
Staff continues to implement physical activity programs in early childhood, to assure children ages six through eleven years are accustomed to being physically active. Planning for this new NPM has been completed.

***Developmental Screening* (NPM 6)**
ESM 6.1: Number of LPHAs, community and/or health care partners in Colorado that have implemented ABCD quality standards that support early childhood screening, referral and treatment services for developmental needs. (2017 target - 40; 2018 – 60).
For 2015, 56.3 percent of parents were asked by a primary care provider to fill out a parent questionnaire about development of their child ages 1 through 5. (2015 target: 68 percent; target not met.) Interestingly, in 2014, 67.1 percent of parents were asked to fill out a developmental questionnaire, well above the 2014 target of 56 percent. The sample size is historically small for this indicator with wide confidence intervals. While this change is not statistically significant, the overall rates of screening remain unchanged, despite considerable work at the state and local levels. The revised logic model and action plan are focused on the role of the state in addressing locally identified state-level systems barriers to improve screening, a new approach for FY16.

Domain: Adolescent Health
Bullying (NPM 9) and Youth Suicide Prevention (NPM 7)
ESM 7.1 & 9.1: Number of local partners reporting use of the Positive School Environment Toolkit (2017 target - 8; 2018 – 12).
Staff completed planning for these new NPMs.

Domain: Child and Youth with Special Health Care Needs (CYSHCN)
Medical Home (NPM 11)
ESM 11.1: The percentage of CYSHCN who receive HCP Care Coordination services who have an inter-agency shared plan of care (2017 target – 37%; 2018 – 41%).
Updated data on medical home participation is not currently available. Staff completed planning for this updated, continuing priority. Efforts to better integrate services between local public health agencies, providers and the state's regional care collaboratives should lead to improvements in medical home percentages.

Domain: Cross-Cutting/Life Course
Substance use/misuse among pregnant and postpartum women
Tobacco (NPM 14)

ESM 14.1: Percent of pregnant women who report their provider talked to them about how tobacco use could affect their baby (2017 target – 70.2%; 2018 – 71.8%).
ESM 14.2: Percent of pregnant and postpartum women who report that their health care provider advised them during pregnancy and postpartum about the harms of their child's exposure to SHS (2017 target – 35.9%; 2018 – 37.3%).
ESM 14.3: Percent of children whose parents report that their child's health care provider talked to them about their child's exposure to secondhand smoke. (2017 target - 29.5 %; 2018 – 30.3%).
The Colorado QuitLine Pregnancy Program served 289 pregnant women and 28 postpartum women from February 2015- 2016. Medicaid providers and clients, including pregnant women, received technical assistance and training to increase awareness and promote utilization of the Colorado Medicaid tobacco cessation counseling/pharmacotherapy benefit. Staff completed planning to address exposure to second hand smoke.

Other Substance Use
New SPM 3: Percent of women who report using marijuana at any time during their pregnancy (2017 target – 6.2%; 2018 – 6.1%).
New SPM 4: Rate of emergency department visits for prescription drug poisoning per 100,000 women ages 15 through 44 (2017 target – 216.7; 2018 – 212.9).
New SPM 5: Rate of hospitalization for prescription drug poisoning per 100,000 women ages 15 through 44 (2017 target –; 92.8; 2018 – 91.2).
Staff completed planning for this new priority. Pregnant and postpartum marijuana users participated in focus groups to inform the development of a marijuana public education campaign addressing the risks of marijuana use during pregnancy and while breast feeding. The statewide campaign is scheduled to be launched in the Summer of 2016. CDPHE currently provides online trainings, clinical guidance documents, and webinars to health care providers on health effects of marijuana use for pregnant or postpartum women. One hundred eighty-two (182) providers have been trained from October 2015 - February 2016.
During the latter half of FY16, the MCH program will further identify key priorities to assure that the state has the ability to move the needle substantially among highest priority needs.

II. Components of the Application/Annual Report

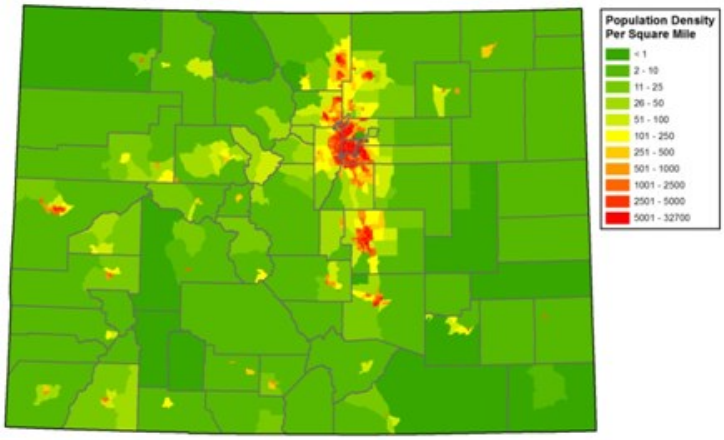
II.A. Overview of the State

This section provides an overview of factors impacting health status and health services delivery. It also includes a brief discussion of the Affordable Care Act (ACA), Colorado statutes and regulations related to MCH, and a description of the MCH data- to- action process. For more background data on the MCH population, see the updated C MCH Snapshot: https://www.colorado.gov/pacific/sites/default/files/LPH_MCH_Snapshot.pdf.

Geography

Colorado is known for its 58 mountains over 14,000 feet high, all of which are located in the western half of the state. The eastern half of the state is flat and home to 86 percent of the population, who live in 16 urban counties along the Front Range; the north-south corridor just east of the mountains. These urban counties include the metropolitan areas of Denver, Boulder, Fort Collins, Greeley, Colorado Springs and Pueblo, as well as Grand Junction on the western edge of the state. In the map below, the urban areas are designated by dark red shading indicating more than 5,000 people per square mile. The remaining 13 percent of the state's population lives in 27 rural (non-urban) counties and 21 frontier counties (which contain six or fewer persons per square mile). Colorado's geography makes access to resources and travel difficult for residents living outside of the Front Range.

Population Density Per Square Mile, Colorado, 2010-2014 Five Year Average
American Community Survey



Population and Demographics

Colorado ranks 22nd among states in population size with a total state population in 2016 of 5,538,581. In terms of theMCH population, 20 percent of the state's population is females ages 15-44; 29 percent are children and youth ages 0-21; and approximately 217,000 are children and youth with special health care needs. Estimates from the American Community Survey (2014) of the U.S. Census Bureau show that 69.4 percent of Coloradans identify themselves as White non-Hispanic and 20.9 percent identify themselves as of Hispanic origin. Other non-Hispanic groups include Black/African-American (4.0 percent), Asian and Native Hawaiian/Pacific Islander (2.9 percent), American Indian and Alaska Native (1.0 percent), and people who report another race (4.6 percent) or more than one race (3.5 percent). Among the high school population in Colorado, 9.4 percent identify themselves as gay, lesbian or bisexual. Among adults in Colorado, 4.3 percent identify themselves as gay, lesbian or bisexual.

Approximately 17 percent of Colorado residents ages five and older speak a language other than English at home; 70 percent of those speaking another language in the home speak Spanish. Three 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.

Although Colorado is a mid-sized state, it has one of the fastest population growth rates of all states, and migration continues to be an important factor in the state's growth. Between 2015 and 2020, thepopulation is expected to grow

from 5,443,612 to 5,935,912. While natural increase (births minus deaths) will contribute 170,700 persons, net migration is expected to supply nearly twice as many people, contributing 321,600 to the total increase of 492,300. The number of births in 2015 was 66,545, similar to the number recorded in each of the previous five years. While increases in the number of births among older women have taken place, they have not equaled the declines among younger women. A large statewide initiative to address unintended pregnancy, particularly among young women, has been credited with the downward trend. The initiative resulted in over 40,000 long-acting reversible contraceptives (IUDs and implants) being used by women who received family planning at the state's Title X clinics between 2009 and 2015. Because these methods are virtually 100 percent effective, birth rates have fallen dramatically, especially among young women.

Employment

As of March 2016 Colorado's unemployment rate was 2.9 percent. This was lower than the national unemployment rate for the same time period, 5.0 percent. Colorado's unemployment ranking was the 3rd lowest in the nation.

Income and Poverty

Colorado has an income advantage. In 2014, the median household income in Colorado was $61,303, considerably more than the national median of $53,657. However, the median household income varies a great deal among Colorado's counties. Douglas County, located just south of Denver along the Front Range, had the highest median household income at $102,626. While Crowley County, located in Colorado's Southern Plains, had the lowest at $31,534. The percent of Colorado residents in poverty has been decreasing since 2012. In 2014, 29 percent of Coloradans lived in low-income families (below 200 percent of the Federal Poverty Level), a five percent decrease from 30.6 percent in 2012. Among children younger than 18 years of age, 36.9 percent were living in families with incomes below 200 percent of the Federal Poverty Level ($47,700 for a family of four). Poverty among children in Colorado decreased from 2012. Colorado went from being tied for the 17th lowest child poverty rate in the nation in 2012 to being tied for the 5th lowest child poverty rate in the nation in 2014.

Housing and Built Environment

For Colorado-specific information on housing and the built environment, see the MCH Snapshot (link provided above).

Education

Overall, Colorado has a highly educated population. Over one-third (38.4 percent) of all Coloradans age 25 and older have a college degree or more, and Colorado is ranked second nationally in the percentage of the population with a college degree. Inequities in educational attainment exist among different racial and ethnic groups in Colorado, however, with over half (51.5 percent) of Asians earning a college degree or more, along with 40.0 percent of White non- Hispanics. One in four (23.2 percent) Black/African Americans, and 13.7 percent of Hispanics have a college degree or more.

However, the percentage of students overall who graduate from high school is relatively low; 35 states have higher high school graduation rates. The on-time high school graduation rate (graduation within four years) in Colorado was 72.4 percent in 2010 and increased to 77.3 percent in 2014. Disparities in high school graduation rates continue to match those in college graduation attainment among adult Coloradans, with American Indians and Alaska Natives having the lowest high school graduation rate and Asians having the highest. For Colorado data on early childhood education, see the MCH Snapshot (link provided above).

Social Engagement and Civic Engagement

For Colorado-specific information on social and civil engagement, see the MCH Snapshot (link provided above).

Social and Emotional Support

For Colorado data on social and emotional support, see the MCH Snapshot (link provided above).

Racism

Racism and discrimination are two important social determinants of health for which data are limited. Adults have reported that within the past 30 days, 6.3 percent have felt emotionally upset (angry, sad or frustrated), as a result of

how they were treated based on their race and/or ethnicity. Among high school students, 14.4 percent have been a victim of teasing or name-calling because of their race/ ethnicity in 2013.

Health Insurance and the ACA

In Colorado, the uninsured rate dropped by more than 50 percent from 14.3 percent in 2013 to 6.7 percent in 2015. The highest rate of uninsured was among ages 30-39 years at 13.4 percent followed by ages 19-29 years at 12.9 percent. Only 2.5 percent of children ages 0-18 years were uninsured in 2015. The highest rate of health insurance coverage was among White non-Hispanics with 5.0 percent uninsured in 2015. By contrast, 11.0 percent of Hispanics in Colorado were uninsured in the same year. The uninsured rate was highest among Coloradans with incomes at or below 100 percent of the federal poverty level (10.6 percent) and those with incomes between 101 to 200 percent of the federal poverty level (7.8 percent).

The passage of the Affordable Care Act and Medicaid's state health care reform efforts, including Colorado's decision to expand Medicaid eligibility, created pathways to coverage for MCH and CYSHCN populations. The ACA had the most impact on coverage for uninsured adults through Medicaid expansion and Connect for Health Colorado, the state's health insurance marketplace. Enrollment in the marketplace jumped from 52,783 individual enrollments in 2013 to 152,470 in 2015. The majority of enrollees are ages 55-64 years (28 percent). Approximately 13 percent of all enrollees are children ages 0-17 years and seven percent are youth ages 18-25 years. Since the marketplace opened, the percentage of uninsured Coloradans dropped from 14.3 percent in 2013 to 6.7 percent in 2015.

Pregnant women and children living in households at or below 260 percent of the federal poverty level are eligible for health insurance coverage either through Child Health Plan Plus (CHP+) or Medicaid. As of April 2016, 553,887 children were enrolled in Medicaid and 54,838 children were enrolled in CHP+. Medicaid now serves more than one out of every five Coloradans. The 2015 Colorado Health Access Survey states that only 2.5 percent of children in Colorado are uninsured.

In state fiscal year (SFY) 2014-2015, an average of 38 percent of Colorado children ages birth to 18 were enrolled in Medicaid during the year (approximately 515,000), an increase of more than 73,000 from the prior fiscal year. While Medicaid eligibility for children was not expanded through the Affordable Care Act, the eligibility cutoff for adults with dependent children was raised from 100 to 138 percent of FPL. When newly eligible adults enrolled in Medicaid, those with children had the option to enroll them in the program, thus enrolling children who were previously Medicaid-eligible but uninsured. Beginning in 2014, with Medicaid expansion, CYSHCN in Colorado had the ability to be part of the Medicaid Buy-In Program for Children with Disabilities. This program allows qualifying families of children with a disability to "buy-into" Colorado Medicaid for that child. Family income must be below 300 percent of the Federal Poverty Level. Eligible families receive Medicaid benefits by paying a monthly premium on a sliding scale based on their adjusted income.

Other health care services available to low-income and uninsured persons in Colorado include 20 Community Health Centers (CHCs) that operate 186 clinic sites in 40 counties and provide care to patients living in 61 of the state's 64 counties. Colorado CHCs provide care to almost 650,000 of their community members (nearly one in eight Coloradans). Ninety-three percent of patients at CHCs have family incomes below 200 percent of the federal poverty level.

The state Medicaid program, located within the Department of Health Care Policy and Financing (HCPF),implemented the Accountable Care Collaborative (ACC) in 2011 to build a comprehensive statewide program to support a medical home infrastructure for all populations. This program includes seven Regional Care Collaborative Organizations (RCCOs) to support community-based solutions to care. The responsibility of each RCCO is to develop a comprehensive network of primary care medical providers, enhance the network of specialty providers, collect and analyze data to support population health, and provide care coordination for members. In June of 2015, over 899,596 of Colorado Medicaid's clients were enrolled in the Accountable Care Collaborative Program (ACC), more than 70 percent of all Colorado Medicaid clients, a 48 percent increase since June of 2014. Within the ACC, 76 percent are connected to a medical home. RCCOs across the state support a network of providers; manage and coordinate member care; connect members with non-medical services; and report on costs, utilization and outcomes for their population of members.

Beginning in 2014, Primary Care Medical Providers (PCMPs) within the ACC Program, became eligible to receive additional payment for demonstrating the capacity to provide enhanced medical home services to their ACC clients. To be eligible for the additional payment, PCMPs must meet at least five of the nine enhanced primary care factors. These factors were developed by HCPF through a stakeholder process and incorporate elements of the NCQA recognition. Each RCCO is responsible for certifying which practices within their region meet the criteria for receiving the additional payment. In state fiscal year 2014-15, 269 practices were awarded incentive payments as an enhanced PMCP sites out of a total of 520 ACC providers.

In SFY 14-15, the ACC achieved cost avoidance of $121,288,048, with net costs avoided totaling $37,683,795, sans administrative expenses. As Colorado Medicaid plans for the further growth and expansion of the ACC program, full integration of all health services, medical, dental and behavioral is planned. With a focus on coordination and education, the ACC program is working to shift costs from inefficient and expensive periodic treatment to whole-person centered approaches to health care and health outcomes.

Between February 2015 and January 2019, the State of Colorado will receive up to $65 million from the Center for Medicare and Medicaid Innovation (CMMI) to implement and test its State Innovation Model (SIM). Colorado's State Health Care Innovation Plan creates a system of clinic-based and public health supports to spur innovation. The state will improve the health of Coloradans by: (1) providing access to integrated primary care and behavioral health services in coordinated community systems; (2) applying value-based payment structures; (3) expanding information technology efforts, including telehealth; and (4) finalizing a statewide plan to improve population health. Funding will assist Colorado in integrating physical and behavioral health care in more than 400 primary care practices and community mental health centers (including 100 pediatric practices); a total of 1,600 primary care providers. In addition, the state will work to establish a partnership between their public health, behavioral health and primary care sectors.

The first cohort of SIM practices officially launched in February 2016, with 100 participating practices. Two additional cohorts of 150 practices each will be on-boarded in 2017 and 2018. The SIM practices will play an integral role in achieving Colorado SIM's goal of providing access to integrated physical and behavioral health care services in coordinated systems, with value-based payment structures, for 80 percent of Colorado residents by 2019. Each practice will work with a Practice Facilitator to design and implement a Practice Improvement Plan that outlines a pathway toward greater integration of care based on the practice's unique strengths and needs. Additionally, practices have committed to reporting their progress toward a common set of clinical quality measures.

For more on the ACA, see section II.F.4.

Utilization and Medical Home

Two important health care quality indicators for the child population are receipt of standardized health screenings and provision of care within a medical home. Regular developmental and behavioral screening of young children helps enable early identification of health concerns, which is important for following up with appropriate care, referrals and promoting healthy development. In 2015, 56.3 percent of children ages one through five had a health care provider who asked their parent to fill out a questionnaire about the child's development, communication or social behavior.

In 2015, 61.3 percent of children ages 1-14 years in Colorado received care that met medical home criteria. The Colorado Medical Home Initiative is a systems-building effort to promote high quality health care for all children in Colorado through the development of state and local infrastructure that supports a medical home team approach for all children. Coordinated by CDPHE and HCPF, the *Colorado Medical Home Initiative* partners with government agencies, families, health providers, non-governmental organizations and policy-makers to identify and promote solutions to state and local barriers to developing a quality-based system of health care that supports a medical home team approach for all children.

Racial and Ethnic Disparities in Health Status

As part of the FY2016-2020 MCH Needs Assessment, a series of twelve MCH issue briefs were created, each including a section on health disparities and social determinants of health. Indicators vary by issue, depending on the

availability of Colorado data, but typically include age, gender, race, education, income and geographic information. For more details, see Section II.B.1. Thehe briefs can be downloaded from www.mchcolorado.org.

Private Sector

There are four major private foundations that have historically partnered with Colorado government to improve the health of all Coloradans, including the MCH population. They are the Colorado Health Foundation, The Colorado Trust, Caring for Colorado and the Rose Community Foundation.

State Statutes and Regulations

Included below are descriptions of some state statutes most relevant to current MCH work in Colorado.

Breastfeeding and Family Friendly Employment Practices

1. Breastfeeding. [CRS §25-6-302]

Mothers may breastfeed in public spaces. A mother may breastfeed in public, and in any place she has the legal right to be.

2. Workplace Accommodations for Nursing Mothers Act. [CRS §8-13.5-101-104]

Colorado employers shall provide lactation accommodations, including break time to express breast milk, reasonable efforts to provide a room, other than a toilet stall, during the work day for up to two years after the child's birth. Employers may not discriminate against women for expressing milk in the workplace.

3. Prohibition of Discrimination – Pregnancy, Childbirth, and Related Conditions. [CRS §24-34-402.3]

An employer shall provide reasonable accommodations to perform the essential functions of the job to an applicant for employment or an employee for health conditions related to pregnancy or the physical recovery from childbirth, unless the accommodation would impose an undue hardship on the employer's business.

Immunizations

1. **Infant Immunization Act.** [§25-4-1701 to 1709]
   Creates the Infant Immunization Fund to ensure immunizations are not a cost prohibitive factor for parents/caregivers of infants up to the age of 24 months.
2. **School Entry Immunization.** [§25-4-901 to 910]
   A student may not attend school unless he or she has presented an up to date immunization certificate to the appropriate school official. The department will determine the list of immunizations. Exemptions are allowed for medical, religious and personal beliefs.
3. **Immunization Registry Act.** [§25-4-2401 to 2403]

Establishes the state immunization information registry for authorized individuals and entities to access immunization information collected by public agencies.

Bullying and Suicide Prevention

1. Suicide Prevention Commission – Created – Responsibilities. [CRS §25-105.111]

The Suicide Prevention Commission is created to serve as the interface between the public and private sectors in establishing data-driven and evidence-based statewide suicide prevention priorities. The Commission focuses on current resources and expands the network of partnerships across the state.

2. Colorado Suicide Prevention Plan – Established. [CRS §25-105.111]

The Colorado Suicide Prevention Plan is created in the Office of Suicide Prevention to reduce suicide rates and numbers in Colorado through system level implementation of the Colorado plan in criminal justice and health care systems.

3. Safe2tell Act. [CRS §24-31-601(-610)]

The Safe2tell program offers a comprehensive program of education, awareness, and training and a tool that allows students and the community to easily provide anonymous information about unsafe, potentially harmful, dangerous, violent, or criminal activities in schools, or the threat of these activities, to appropriate law enforcement and public safety agencies and school officials.

Child Fatality Prevention

1. Child Fatality Prevention Act. [CRS §25-20.5-401-405]

County and district local public health agencies must establish a local or regional child fatality prevention review team to review child deaths (ages 0-17) and identify prevention recommendations related, at minimum, to the following

causes of child fatality: undetermined causes, unintentional injury, violence, motor vehicle crashes, child abuse or neglect, sudden unexpected infant death, and suicide.

2.Colorado State Child Fatality Prevention Review Team. [CRS §25-20.5-4]

The state review team aggregates data collected locally and issues state-level policy recommendations.

Early Childhood Screenings

1. Newborn Screening and Genetic Counseling and Education Act. [CRS §25-4-1002]

State policy regarding newborn screening and genetic counseling and education should be made with full public knowledge, in light of expert opinion, and should be constantly reviewed to consider changing medical knowledge and ensure full public protection.

2. Newborn Heart Defect Screening. [CRS §25-4-1004.3]

A birthing facility that is below seven thousand feet of elevation shall test all infants born in the facility for critical congenital heart defects using pulse oximetry.

3. Newborn Hearing Screening. [CRS § 25-4-1004.7]

Newborn hearing screenings must be conducted for at least 95 percent of infants born in hospitals. An advisory committee collects data and provides recommendations to stakeholders.

Early Childhood (Child Care)

1. Colorado Child Care Assistance Program (CCCAP). [§26-2-801 to 809]

A county shall provide child care assistance to qualifying participants to increase access to high-quality child care for low-income families.

a. **Exemptions from Cooperating.** [§26-2-805]

Teen parents, victims of sexual violence, harassment or stalking are exempt from child support requirements for CCCAP services.

b. **Cliff Effect Pilot Program.** [§26-2-808]

Authorizes a pilot to CCCAP to mitigate the cliff effect, which can occur when working adult participants in CCCAP receive a minor increase in their income that makes them ineligible for assistance and the increase in wages is not enough to cover the costs for child care without the assistance.

2. Colorado Preschool Program Act. [§22-28-101 to 114]

Creates aprogram to serve three to five year-old children who lack overall learning readiness due to significant family risk factors, who are in need of language development.

Youth Sexual Health

1. Minors - Birth Control Services Rendered by Physicians. [CRS §13-22-105]

With the minor's consent, a physician may provide birth control procedures, information and supplies to any minor of any age who requests and is in need of them (see statute for complete list of minors who may obtain such care).

2. Policy, Authority and Prohibitions Against Restrictions. [CRS §25-6-102]

All medically acceptable contraceptive procedures, supplies, and information shall be readily and practicably available to each person desirous of the same regardless of sex, sexual orientation, race, color, creed, religion, disability, age, income, number of children, marital status, citizenship, national origin, ancestry, or motive.

Health Care Program for Children with Special Needs

1. Powers and Duties of Department. [CRS §25-1.5-101(1)(r)]

CDPHE may operate and maintain a program for children with disabilities to provide and expedite provision of health care services to children who have congenital birth defects or who are the victims of burns or trauma or children who have acquired disabilities.

Medical Home for Children

1. Medical homes for children [CRS 25.5-1-123]

The Department of Health Care Policy and Financing, in conjunction with the Colorado Medical Home Initiative and CDPHE, shall develop systems and standards to maximize the number of children enrolled in the state medical assistance program or the children's basic health plan who have a medical home.

Marijuana Use/Abuse

1. Ongoing Prevention and Education Campaign. [CRS § 25-3.5-1004]
CDPHE shall develop, implement, and evaluate an ongoing statewide prevention and education campaign to address the long-term marijuana education needs in the state. Information shall be provided to the general public regarding:

- § The law surrounding the legal use of retail marijuana;
- § People in the retail marijuana industry regarding restricting youth access to retail marijuana;
- § Retail marijuana users and other relevant populations identified as high-risk regarding the potential risks associated with the use of marijuana; and
- § The general public regarding the dangers associated with the over-consumption of marijuana-infused products.

2. Powers and Duties of State Licensing Authority. [CRS §12-43.3-202 & 12-43.4-202]
Prohibits the production and sale of edible medical and retail (recreational) marijuana infused products that are in the distinct shape of a human, animal or fruit.

Positive Youth Development

1. Statewide Youth Development Plan. [CRS §26-1-111.3]
The Colorado Department of Human Services shall convene a group of interested parties to create a Colorado State Youth Development Plan to identify key issues affecting youth and align strategic efforts to achieve positive outcomes for all youth.

School-Based Health

1. School Based Health Center Grant Program. [CRS §25-20.5-503]
The school-based health center (SBHC) grant program assists with the establishment, expansion, and ongoing operations of SBHCs in Colorado. The grant program is funded by money appropriated each year by the General Assembly.

MCH program's roles and responsibilities

MCH Steering Team

The MCH Steering Team has been re-chartered as the MCH Leadership Team in service of Colorado's new priorities. The team will continue to provide guidance, oversight and accountability for implementation of the new and continuing priorities. The team includes the MCH and CYSHCN Directors; the managers of the MCH Section, the Population and Community Health Section and the CYSHCN Section, as well as the Family and Community Engagement Unit Supervisor. The Team meets bi-monthly to oversee the direction of state MCH work, to identify and develop support for MCH Implementation Teams (MITs), and to define expectations and guidance for MIT leads throughout the process. Progress on the MITs' state and local logic models is reviewed in monthly MCH Impact sessions. The Leadership Team has designed these oversight processes to maximize impact on intended outcomes for the MCH priorities.

MCH Implementation Teams (MITs)

MCH Implementation Teams consisting of key internal and external partners execute the work associated with each priority. Teams are led by a state content expert for the priority area. Each MIT lead is responsible for achievement of outcomes within their work plan while implementing activities to increase community engagement and reduce health inequities. Progress is measured via performance management, evaluation, and continuous quality improvement. During FY16 and FY17, the success of this effort is being measured through monthly quantitative and qualitative reporting and the ongoing identification of opportunities to rapidly tweak existing efforts for greater impact, as well as through the employment of formative evaluation plans.

Priority-related Logic Models and Action Plans

MCH priority logic models (LMs) and action plans (APs) were once again developed to steer both state-level and local-level work for each individual priority. The resulting action plans include evidence-based and population-based goals, objectives, activities and measures along with related data sources. Implementation teams began execution of the state-level APs on October 1, 2015 with customized evaluation plans being finalized during Year 1 of implementation. Local APs were developed in consultation with community partners and were unveiled during a December 2015 planning summit as well as a February 2016 statewide conference. These will begin guiding implementation of local contracts on October 1, 2016.

MCH Generalist Consultants

The MCH Generalist Consultants, in partnership with the MITs, provide ongoing support and coordination for achievement of program goals at the local public health level. The MCH Generalist Consultants work to enhance local implementation through development of contracts, identification of capacity-building needs, provision of technical assistance, and monitoring of performance to achieve MCH impact.

MCH Performance Improvement Specialist

CDPHE recently renewed its commitment to performance management and quality improvement by hiring a Director of Performance Improvement. To align with CDPHE's effort as well as to align with the Maternal and Child Health's Bureau's emphasis on performance monitoring and quality improvement, Colorado's MCH Program hired a Performance Improvement (PI) Specialist. Increased performance monitoring of state-level MCH priority efforts have resulted in the identification of quality improvement opportunities that will ultimately increase the effectiveness and impact of Colorado's MCH work. The PI Specialist has implemented key change management strategies to develop and implement performance management and quality improvement principles and practices within MCH through an initiative named MCH impact.

II.B. Five Year Needs Assessment Summary

Needs Assessment Update (as submitted with the FY 2017 Application/FY 2015 Annual Report)

Update:

Medicaid Expansion

A new report on Medicaid expansion in Colorado reveals that, in the two years since implementation, expansion in the state has and will continue to have a significant positive effect on the economy. Colorado has added 30,074 jobs, increased economic activity by $3.8 billion and raised annual household earnings by $643 as a result of state Medicaid expansion under the Affordable Care Act. By fiscal year 2034-2035, Colorado is projected to add a total of 43,018 new jobs, increase economic activity by $8.5 billion and raise average household earnings by $1,033.Commissioned by the Colorado Health Foundation and prepared by the Colorado Futures Center at Colorado State University, the report updates a 2013 analysis of the estimated economic and budgetary impact of Medicaid expansion. The executive summary and infographic provide additional detail.

Competent Approaches to Service Delivery

Local MCH contractors are guided to assess MCH data and conduct program planning with a goal of reducing health inequities. Contractors are provided technical assistance in using the Colorado Health Indicators website, which provides county, regional and state level data on a variety of health, environmental and social topics. Data are organized based on the CDPHE Health Equity Model. This model demonstrates how the social determinants of health, coupled with other health factors impact overall population health outcomes. In addition, CDPHE has adopted the *National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care* (the *National CLAS Standards*). By December 31, 2015, all employees were required to participate in a language services on-line training to effectively address limited English proficiency. Department efforts in this area are supported by a dedicated CLAS Coordinator and support services in interpretation, translation and quality assurance. MCH contractors are all expected to align their work with the CLAS Standards as well.

MCH staff are also involved with the the Health Equity and Environmental Justice Collaborative (Collaborative). This group formed in 2012 with representation from every division within CDPHE. The Collaborative focuses on populations who experienced disproportionate disease, illness and environmental burden such as racial and ethnic minorities; lesbian, gay, bisexual and transgender persons; persons experiencing disabilities; place of residence; and socio-economic status. The strategic goals of the collaborative include impacting organizational policy, engaging leadership across the department and implementing required staff training for all department employees. A representative from the MCH Leadership Team helps guide the direction of the Collaborative's Steering Committee, while various MCH staff is involved in the workgroups. CDPHE also executed a department policy to provide the authority to integrate health equity and environmental justice principles and practices into department programs, where authority is not specifically identified in regulation or statute.

Additionally, this past year, MCH leadership appointed an MCH Health Equity Coach who is reviewing all logic models and action plans through a health equity lens. She has drafted a logic model and identified steps to more fully integrate health equity strategies into MCH work at the state and local levels. Examples include developing an MCH Equity Statement with talking points and a list of things that state and local MCH can do to improve equity in their work, such as engaging the most affected stakeholders; looking at data differently; and identifying and addressing root causes through policy change.

Through partnership with the Office of Health Equity, staff is aligning definitions, communication and strategies to develop a model for MCH to ensure health equity strategies are integrated into each MCH priority with the goal of

decreasing health disparities of the MCH population.

The MCH Leadership Team also chose “community engagement” as a fundamental strategy for inclusion in all MCH priority action plans. Colorado’s community engagement efforts encompass engagement with families, youth and communities. MCH staff conducted a literature review, developed the MCH Community Engagement Continuum and a community engagement logic model. Strategies to support all MCH Implementation Teams and Local Public Health Agencies will be implemented throughout this funding cycle.

For the past several years, CDPHE supported the development of the Family Leadership Training Institute (FLTI) so that families are trained to partner in program planning and implementation. On July 1, 2016, FLTI transferred to Colorado State University Extension (CSUE). CSUE is a learning institution, with statewide reach and program expertise related to community based leadership and family engagement, and has been a long-standing and active FLTI partner. For these reasons, CSUE is perfectly positioned to maintain and expand FLTI as a statewide training hub. Kyle Christiansen, a current FLTI facilitator in Larimer County, and the CSUE program coordinator for FLTI, is the new point person.

With the operation of FLTI anchored at CSUE, Eileen Forlenza, who managed FLTI at CDPHE, will now exclusively focus on promoting a systemic approach to family engagement. She will continue to manage the Family Leadership Registry and work with other state agencies to align the principles of family engagement. She will also represent CDPHE on a more formalized Civic Design Team. LaShay Canady will continue to provide technical assistance and onboard the new Family Resource Center (FRC) sites through September 30, 2016, while training a new technical assistance (TA) provider hired by CSUE. She will then serve as a consultant for CSUE from October through December 2016 to ensure program implementation at current and/or pending FLTI sites continues throughout the transition without interruption.

For more on family collaboration and partnerships and on youth leaders and partnerships see Section II.F.3.

State Innovation Model (SIM)

The SIM Children & Families Behavioral Health Integration Specialist was hired and sits within the Maternal Wellness & Early Childhood Unit that also supports the MCH work on pregnancy-related depression and developmental screening. This position helps align work across grant opportunities specifically related to the integration of behavioral health services for children and families. Of the 100 practices selected to participate in the SIM practice transformation activities during the first year, fifteen of those practices are child-serving. In addition, clinical quality measures have been selected to track patient and process outcomes, two of which directly track maternal depression screening and developmental screening. Additional opportunities to leverage SIM to expand provider training have also been identified, including 1) creation and piloting of a provider education module on perinatal mood and anxiety disorders; and 2) inclusion of maternal depression and developmental screening resources in the toolkit created for those guiding the SIM practice transformation efforts.

Other Partnerships

MCH staff in the Youth and Young Adult Unit is collaborating with the CDHS, Office of Children and Youth to ensure that the work of CO9to25 is aligned with CDHS' youth development plan. This has resulted in increased funding to the CO9to25 backbone organization, awareness of CO9to25 and support from the Governor's Office to develop a regionalized positive youth development training and technical assistance system in partnership with the Injury and Violence Precention - Mental Health Promotion Branch.

MCH staff is also coordinating with the Colorado Department of Health Care Policy and Financing on an initiative called the Colorado Opportunity Project. It's based on the Brookings Institute's Social Genome Project and aims to

deliver evidence-based initiatives and community-based promising practices that remove roadblocks for all Coloradans, so that everyone will have the opportunity to reach and maintain their full potential.

Data Updates

Substance Use Data Desert

Very little data is currently available on drug use among women in Colorado. PRAMS questions on marijuana use were not added until 2014. The weighted 2014 data set on marijuana use before, during, or after pregnancy in Colorado is not yet available. PRAMS does not ask about prescription misuse. Similarly, BRFFS only has one year of data on past 30-day marijuana use from 2014. Questions on misuse of prescription drugs will be asked in 2015 BRFFS.

Child Fatality Review

The CFPD is a statewide, multidisciplinary, multi-agency effort to prevent child deaths. The system is comprised of 48 Local Child Fatality Review teams (seven regional teams and 41 single-county teams)and one State Review Team (46 members). The CFPS is housed at CDPHE in the Prevention Services Division.

State Review Team Updates - In Fiscal Year 2016, the structure of the State Review Team changes to reflect the transition of multidisciplinary reviews from the state-level to local child fatality review teams. On an annual basis, the State Review Team reviews aggregate child fatality data provided by the local teams in order to develop policy and practice recommendations to prevent child fatalities. The State Review Team members also participate on prevention workgroups to provide guidance to implement prevention programs strategies related to infant safe sleep promotion, accident and injury prevention, child maltreatment prevention, violence prevention, suicide prevention and motor vehicle safety.

2016 CFR Recommendations - Based on 2010-2014 child fatality data, the CFPS determined that child fatalities can be reduced in Colorado if the following recommendations are adopted and implemented:

-Establish a statutory requirement that allows for primary enforcement of Colorado's adult seat belt law, making it possible to stop a driver and issue a citation if anyone (the driver and all passengers in all seating positions) in the vehicle is not properly restrained.

-Enhance the Graduated Drivers Licensing (GDL) law to increase the minimum age for a learner's permit to 16 years and expand restricted driving hours to 10:00pm-5:00am.

-Mandate that all healthcare settings develop and implement policies to provide education and information about infant safe sleep promotion and require the practice and modeling of safe sleep.

-Enable the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit to be used for Sudden Unexpected Infant Death (SUID) risk screening and safe sleep education.

-Mandate comprehensive suicide prevention in schools including implementation of evidence-based programs to promote protective factors such as life skills and school connectedness and provision of training to all school staff in gatekeeper skills and making referrals. Support policies that ensure the long-term financial stability of free full-day preschool and free full-day kindergarten.Support policies that ensure paid parental leave for families.

Maternal Mortality Review

Colorado's Maternal Mortality Review Committee (MMRC) reviews all pregnancy-associated deaths that occur during pregnancy up to one year postpartum. In 2015, the Committee reviewed cases from 2011 and 2012. The MMRC identified a total of 37 pregnancy-associated deaths in 2011, with the majority to women during pregnancy (29.7%; n=11) and 43 days to one year postpartum (56.8%; n=21). In 2012 there were 21 pregnancy-associated deaths with about a quarter (23.8%; n=5) to women while pregnant and the remainder to women 43 days to one year postpartum (76.2%; n=16). Colorado's MMRC reviewed 30 of the 37 2011 cases and 18 of the 21 2012 cases.

The Committee determined suicide (n=6), motor vehicle accidents (n=5), recreational drug abuse (n=4), and prescription drug abuse (n=3) to be the leading primary causes of death in 2011; with prescription drug abuse (n=4) and obesity (n=3) as the top two secondary causes of death. Similar trends were noted in 2012, with recreational drug abuse (n=5), suicide (n=4), and motor vehicle accidents (n=2) to be the top three primary causes of death; and obesity (n=5), recreational drug abuse (n=1), prescription drug abuse (n=1), and mental health conditions (n=1) identified as secondary causes of death. The MMRC is currently reviewing all 2013 cases.

Panel Surveys

Population-based surveys, such as the Behavioral Risk Factor Surveillance System (BRFSS) and the Pregnancy Risk Assessment Monitoring System (PRAMS), provide valuable data for public health program surveillance and evaluation. Due to space and timeliness constraints, alternative data collection systems with the same level of scientific rigor are being pursued. Panel surveys are potential alternatives where respondents are recruited to answer questions over a period of time such as months or years. In the spring of 2016, Colorado launched a panel survey pilot to assess tobacco and marijuana attitudes and behaviors among adults ages 18 years and older. Multiple methods were used to recruit survey respondents including web advertising, telephone to web, and mail to web. In addition, respondents from existing panel surveys were rented. Upon completion of data collection, sample matching will be used to weight responses to the population. The cleaned and weighted dataset will be analyzed to compare prevalence estimates from the panel survey pilot to those from current population-based surveys. If results prove comparable, CDPHE plans to pilot a PRAMS-like survey tentatively titled Health eMoms in the fall of 2016.

Environmental Assessment

In FY2017, an environmental issues/exposures needs assessment will be conducted to explore environmental concerns for the MCH population. Lead, mercury, indoor air, and healthy housing efforts will be explored.

Five-Year Needs Assessment Summary
(as submitted with the FY 2016 Application/FY 2014 Annual Report)

II.B.1. Process

Colorado's MCH staff invested significant staff time, expertise and funding in order to design and implement a data-driven needs assessment process for the 2016-2020 Block Grant funding cycle. The team employed rigorous research methodology, skilled and knowledgeable staff, an expert Advisory Group, and extensive stakeholder engagement to ultimately identify seven priorities to drive state and local MCH public health work for the next five years. A summary of the needs assessment process and findings is presented below, and a report with supporting documentation, tools, resources and data is available online at http://goo.gl/yXNQBf. Information from the online report is referenced throughout this summary.

Leadership

Colorado MCH hired a Needs Assessment Project Manager to develop/manage the needs assessment process between February 2014 through April 2015. The Project Manager previously served as the MCH Section Manager and has a Master's in Public Health as well as experience with the 2010 MCH needs assessment process. It was advantageous to designate a point person for this process, particularly one with extensive knowledge of the MCH program and relationships with many state and local MCH staff.

The Project Manager convened an Advisory Group (see below) to lead the needs assessment process. Eleven MCH leaders were invited to participate; nine from CDPHE and two from LPHAs.

CO MCH Title V Director

CO CYSHCN Director

Population and Community Health Section Manager

CYSHCN Section Manager

MCH Section Manager

Family and Community Engagement Specialist

MCH Epidemiologist

MCH Program Specialist/ Block Grant Coordinator

Public Health Nurse Consultant, Office of Planning and Partnerships

Nurse Manager, Tri-County Health Department

Executive Director, Summit County Department of Public Health

The primary role of the Advisory Group was to guide the development and implementation of the needs assessment process to determine the final priorities. The Advisory Group completed a Team Charter that outlined the roles, responsibilities and expectations (see Appendix A at http://goo.gl/yXNQBf). The Advisory Group met monthly from February 2014 through February 2015.

A smaller group, including five members of the Advisory Group, also met monthly to inform the Project Manager on day-to-day decisions.

Goal and Guiding Frameworks

The Advisory Group identified the goal of Colorado's 2016-2020 needs assessment process: to collect and examine data to inform the selection of MCH priorities leading to a measurable improvement in the health of the MCH population. The Advisory Group selected the life course approach, the socio-ecologic framework, Colorado's MCH mission, and health equity as guiding frameworks. The use of the life course approach also facilitated alignment with the six population domains identified by Title V.

The socio-ecologic framework provided Advisory Group members with a lens through which to consider potential MCH priority issues and strategies. Potential priorities were examined at the individual level in the context of communities and societies.

The Advisory Group was responsible for identifying priorities that upheld the mission of the MCH program in Colorado -- To optimize the health and well-being of the MCH population by employing primary prevention and early intervention public health strategies. Colorado MCH values population-based and primary prevention approaches to address health issues. MCH Leadership also recognizes the value of providing early intervention and client-level services to disparate populations such as children and youth with special health care needs.

Finally, the Advisory Group aimed to promote health equity by reviewing data, considering priorities, and developing strategies with the social determinants of health at the forefront of thought and discussion.

Key Principles

The Advisory Group developed key principles (see below) that the group operationalized in the design and implementation of the needs assessment process. These principles provided guidance for implementation, while the aforementioned conceptual frameworks established the theoretical framework for the assessment.

MCH Target Population: Children and youth (birth-25), children and youth with special needs (birth – 21), women of reproductive age (15-44) and their families.

Strengths-based Approach: Consider assets and gaps, risk and protective factors, and positive outcomes.

MCH Community and Stakeholder Integration: Seek MCH community and stakeholder experience and perspective to inform efforts and results.

Don't Reinvent the Wheel: Maximize resources/current efforts.

Health Equity: Apply a health equity lens throughout the process.

Communication: Systematically communicate to the MCH community and stakeholders.

Data-driven Decisions: Use quantitative and qualitative data to inform decision making.

Best Practices: Apply best practices to methodology and planning efforts.

Openness to New Key Principles: Be open to new principles and questions during the process.

Fun: Have fun!

The Project Manager developed a key principles matrix to document the operationalization of the key principles (see Appendix B at http://goo.gl/yXNQBf).

Mid-Course Review

One of the key principles of the needs assessment process was to maximize resources and current efforts to conduct the highest quality process given the available capacity and resources. The first step involved reflecting on the progress and impact of the current MCH priority work at the state and local level. In March 2014, the MCH Steering Team completed a systematic review of current state and local MCH priority efforts (MCH mid-course review).

To assess state-level priority efforts, the Steering Team reviewed quantitative measures such as progress on short-term objectives from priority logic models. Qualitatively, Steering Team members assessed momentum and whether an investment of time or funding had been made beyond the initial investment.

Local-level efforts were also assessed. Staff reviewed the quality of technical assistance available to local MCH partners; local staff capacity in implementing the action plan and their progress; and agency, community and political will.

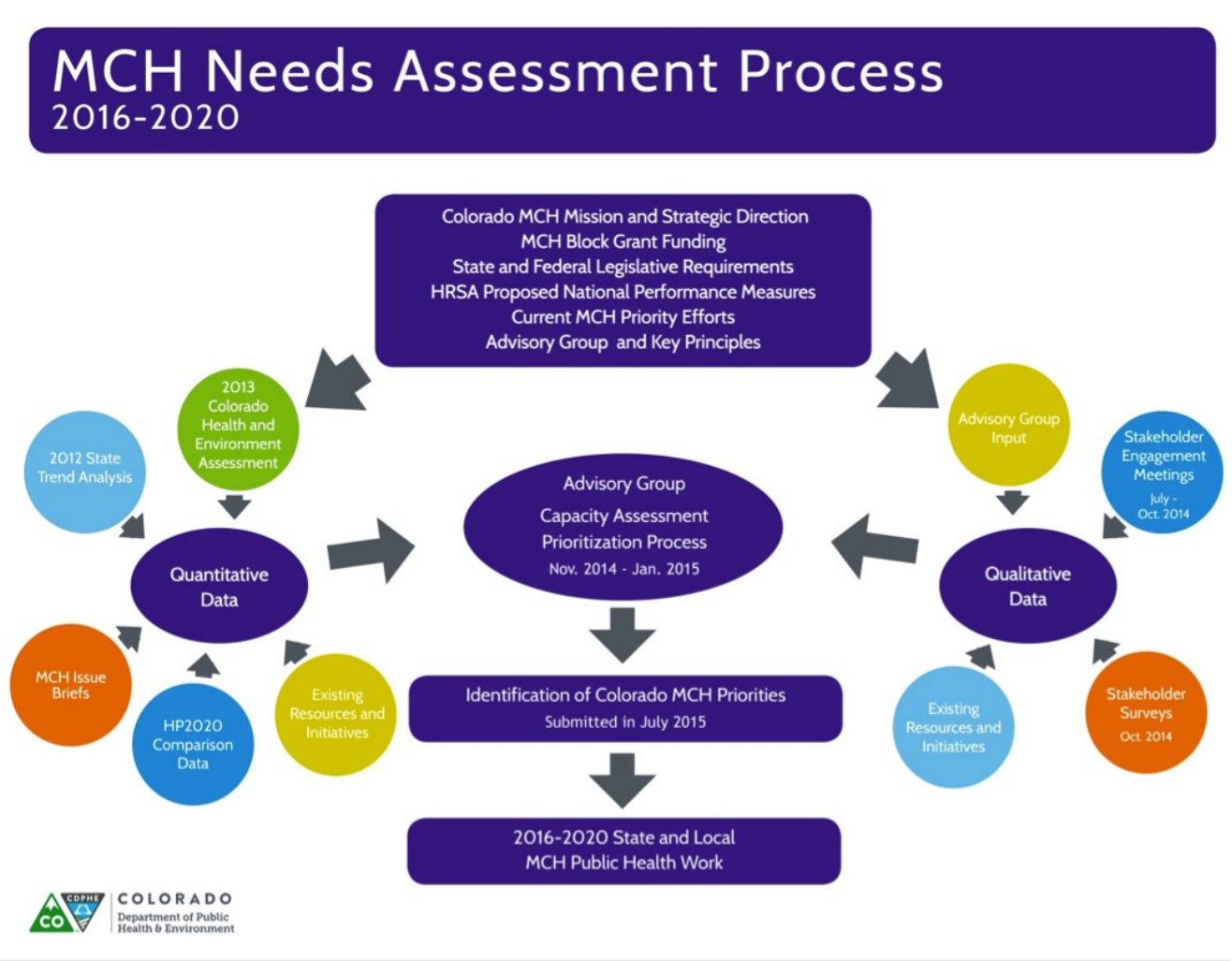
The mid-course performance review demonstrated significant progress on four current priorities: Early childhood obesity prevention; pregnancy-related depression; developmental screening; and youth systems. Work on these priorities will continue into the next Block Grant cycle.

Some progress was also demonstrated in the other MCH priority areas of youth sexual health, oral health and medical home, though it was determined during the mid-course review that the strategies for these priorities needed to be refined through quality improvement. Medical home will continue to be a priority, while youth sexual health and oral health will not.

Strategies involving teen motor vehicle continue to be effective. However, there was such a significant decrease in the teen motor vehicle fatality rate in recent years that state-level policy changes would need to occur to further decrease the rate. Several other groups are monitoring the political climate to identify a window of opportunity to pursue such changes.

Methodology

Using a best practice and mixed methods approach, the Advisory Group designed a needs assessment process that involved the collection of quantitative and qualitative data to assess MCH health status, state and local capacity, partnerships and collaboration. The data collected informed the prioritization process leading to the selection of seven MCH priorities that address the most pressing issues among the MCH population in Colorado as well as meet federal Block Grant requirements. An illustration of the needs assessment design is included.



Existing Efforts and Resources

In addition to the mid-course review, many Colorado organizations including the CDPHE and LPHAs have recently conducted health assessments that address MCH. The Advisory Group systematically reviewed available reports to discern "what do we already know about the needs and strengths of the MCH population in Colorado?" Multiple Advisory Group work groups reviewed sentinel documents that met identified criteria. Key documents included:

- 2014-15 LPHA priorities –MCH issues being addressed by LPHAs with MCH and agency funds.
- 2014 Colorado Health and Environmental Assessment – The CDPHE recently conducted a statewide

assessment, which featured key MCH issues in Colorado, along with utilization of the department's health equity framework.

- Proposed national performance measures – The Advisory Group reviewed the new Title V Block Grant Guidance, in order to assure alignment with new federal requirements.

This review process validated the findings of the mid-course review. Four of the current MCH priorities have significant momentum as they address a CDPHE priority or "winnable battle"; have been prioritized by a large number of local public health agencies; and have strong agency, community and/or political will.

In addition to existing efforts and reports, the Advisory Group spent time reviewing best practice needs assessment methods and designs, including an overview of Colorado's 2010 process and lessons learned. The Advisory Group used the conceptual framework, the key principles, and findings from the mid-course and existing resource review to inform the design of the 2016-2020 needs assessment process.

Quantitative Data

Key quantitative data were identified, collected and synthesized primarily through a series of twelve issue briefs and one snapshot, developed between mid 2012-late 2014. Assessment of the previous method of collecting and reporting data in a 140+ page report indicated that the product was not user-friendly and not widely used. The MCH Steering Team revised this approach, investing time and effort in developing issue briefs on current and emerging MCH issues. The resulting twelve briefs provided Advisory Group members with key data to inform the prioritization process (see Appendices C-Q http://goo.gl/yXNQBf).

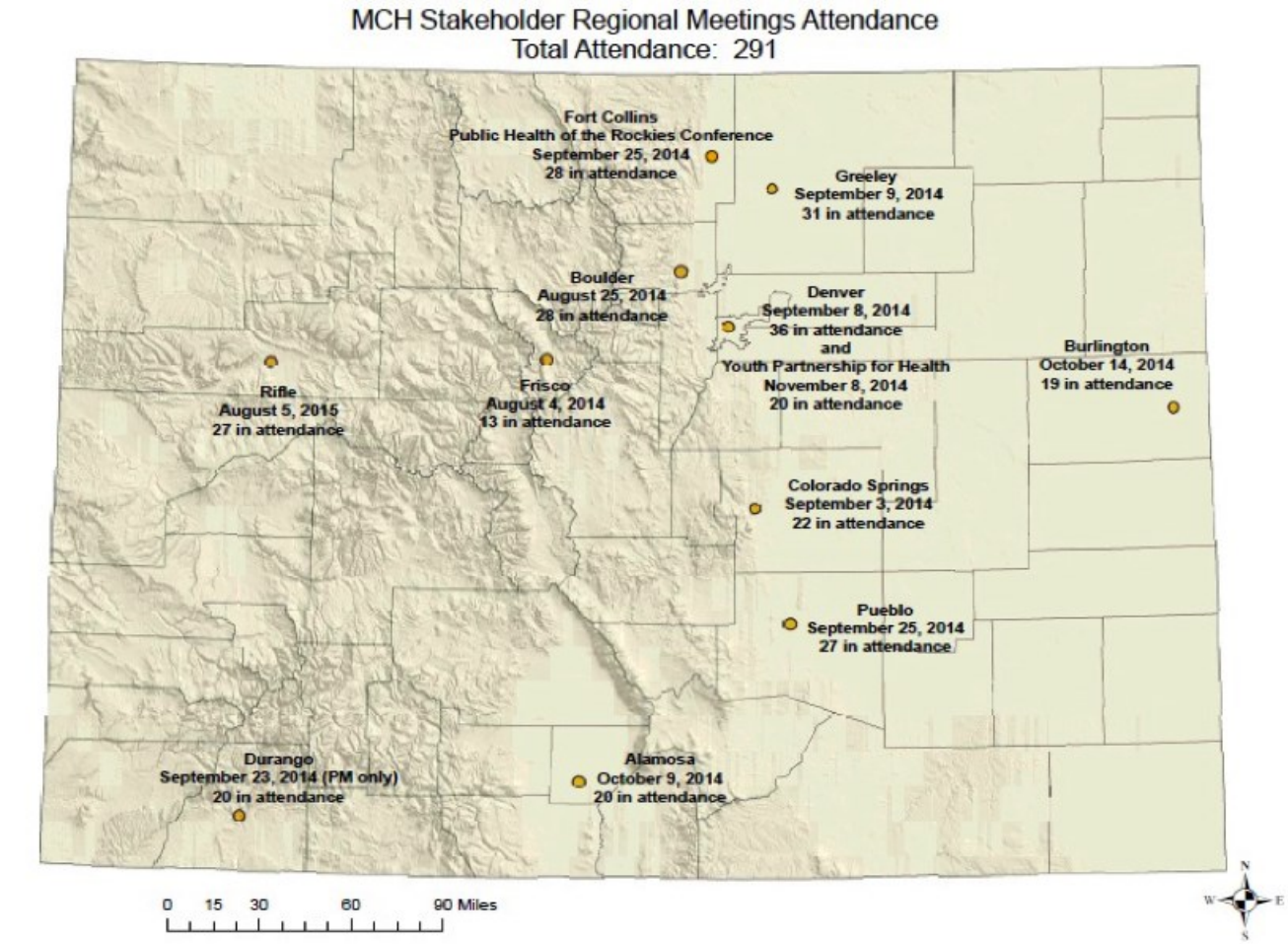
Each issue brief includes incidence and prevalence and relevant health disparity data, as well as pertinent information on current policies or initiatives. Indicator data were identified and selected through a collaborative planning process with the state MCH epidemiologist and other expert state program staff. Commonly used data sources included the Healthy Kids Colorado Survey, the Child Health Survey, PRAMS, Vital Statistics data, and the American Community Survey. The Title V and MCH Section Directors reviewed and approved each brief. A Colorado MCH Snapshot was also developed as a companion document, providing contextual, state data organized around the social determinants of health framework.

In addition to the issue briefs, the MCH Epidemiologist identified and synthesized Colorado data on 48 potential priorities compared with HP2020 targets; baseline data for Colorado on the proposed national performance measures; and a five-year trend analysis on 37 key MCH indicators developed in 2012 (see Appendices R-T at http://goo.gl/yXNQBf).

Qualitative Data

The Advisory Group invested considerable time in developing qualitative data collection methods since stakeholder engagement was a core component of this process. A comprehensive, inclusive, and mixed methods stakeholder engagement effort was designed and implemented, utilizing two primary methods: regional stakeholder meetings and survey administration.

The Advisory Group, in partnership with staff from the CYSHCN Section, conducted twelve meetings throughout Colorado to learn about the health status of the MCH/CYSHCN population to build relationships in local communities, and to provide an opportunity for local partners to influence the process and selection of MCH priorities. The meetings were called "Your Community, Your Voice".



In total, 291 local MCH partners, including families and youth attended. Most of the stakeholders were local public health agency staff and community-based partners, though staff facilitated a session specifically with youth at the Youth Partnership for Health meeting in November 2014. Staff also partnered with Family Voices of Colorado to foster family leader participation.

At the regional meetings, staff collected information on three main topics: the health status of the MCH population, the capacity of local communities to address priority MCH issues, and the availability of systems and supports for CYSHCN throughout Colorado. CDPHE's Youth Advisors, Family Voices of Colorado, and the MCH Advisory Group consulted with MCH and CYSHCN staff on designing and facilitating the meetings. The meetings included interactive activities that were developed to collect data in a way that would be useful for future prioritization efforts.

In the High Five activity, participants organized themselves into small groups by population (children, youth, and women/infants), working together to identify, discuss and prioritize their top five issues facing the population in their community. The current MCH priorities and the proposed national performance measures were shared as resources to inform discussions. The responses from every group/meeting were coded and provided to the Advisory Group as frequencies. In activities focused on children and youth with special health care needs, stakeholders explored systems of supports and services and helped identify those supports and services that were available, available but insufficient, and lacking. These responses were also coded and frequencies presented to the Advisory Group for prioritization.

A survey was designed and administered to solicit stakeholder feedback when a facilitated conversation was not feasible. Again, youth advisors and family leaders consulted on survey design. Surveys were administered at both the Family Summit where 70 respondents completed the survey, as well as at the Youth Summit where 165 young people completed the survey. The survey asked participants to select the most important three issues out of current MCH priorities and proposed national performance measures. The survey also asked for their ideas on other important issues. Family leaders responded to questions on children, youth, and women/infants. Youth responded to questions about youth. Survey results were aggregated and shared with the Advisory Group to inform the prioritization process.

To support the stakeholder engagement, a communication plan was developed and implemented. The communication plan included an introductory webinar in Spring 2014; fact sheets; a dedicated MCH needs assessment web page with routine updates; updates on the Prevention Services Divisions' blog COPrevent; monthly updates to the Children, Youth and Families Branch; and a webinar, written summary, and multiple in-person presentations with key stakeholder groups on the needs assessment results in Spring of 2015.

Prioritization Process

The Advisory Group designed the prioritization process after researching best practice methods and commonly

used criteria. The prioritization process (illustrated below) was divided into two phases with each including different quantitative and qualitative data, including capacity/partnership information, that describe the importance and feasibility of potential priority issues. Phase one was designed to assist Advisory Group members in narrowing from 48 to 19 potential priorities. In phase two, Advisory Group members determined the final seven priorities.

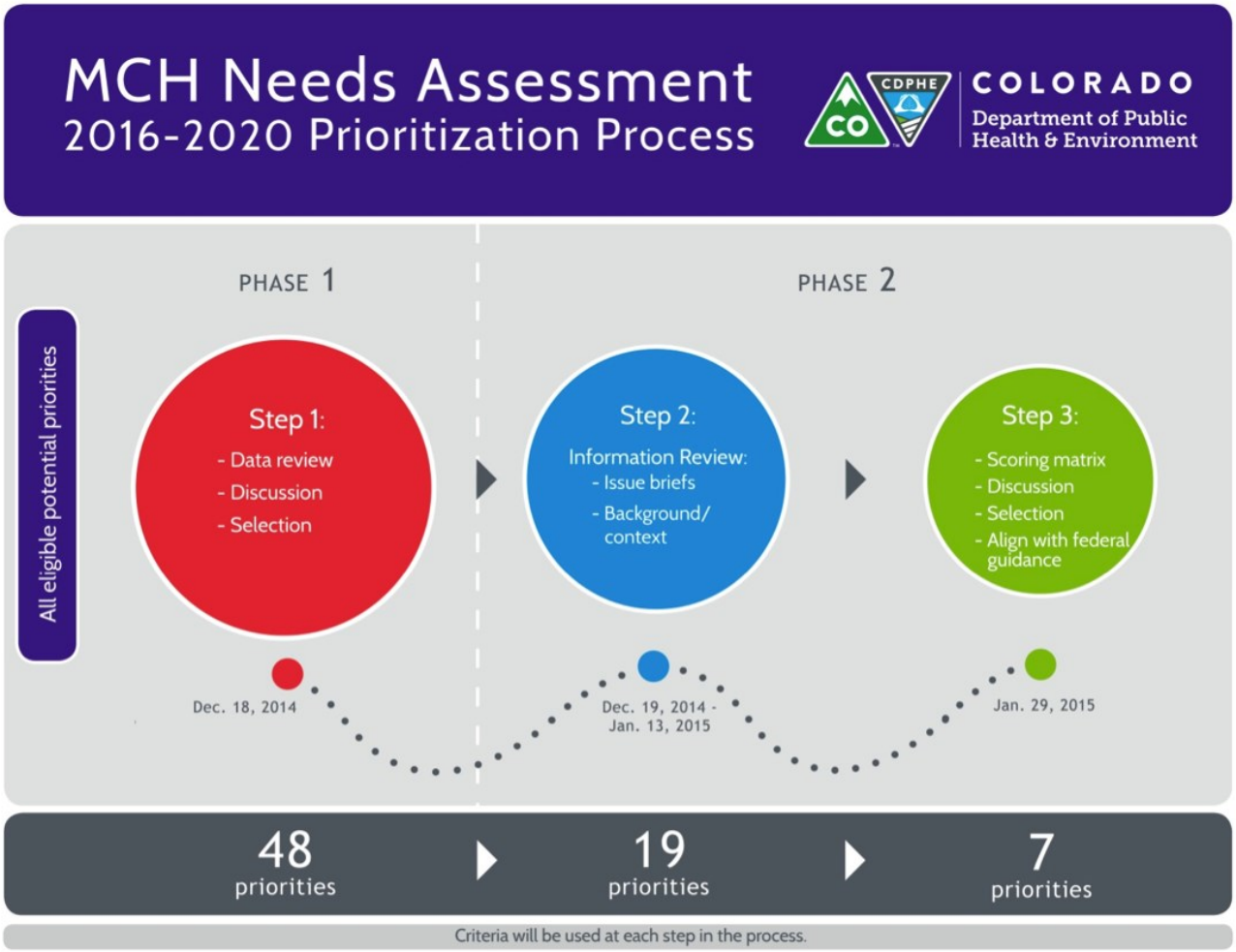


Table II.B.1.a. Prioritization Criteria by Phase

Prioritization Criteria		
Phase One Discussion	**Phase Two Scoring Rubric**	**Phase Two Final Discussion**
Consistent with mission, conceptual framework and scope of MCH		Consistent with mission, conceptual framework and scope of MCH
Incidence/prevalence	Incidence/prevalence	
Severity - Health impact of issue on	Severity	

individual such as quality of life, short- or long-term disability, or death		
Urgency		
Health equity – Disproportionate incidence/effects among subgroups		Health equity
State and local progress on current MCH priorities		
Federal/state political will - Related to proposed National Performance Measures, MCHB focus, CDPHE Winnable Battle		Federal/state political will
Local public health agency prioritization		
Local community/agency interest and support for the issue	Capacity to make an impact - Including state and local staff time and expertise, data and technology resources, agency/community will, infrastructure	Capacity to make an impact - Including state and local staff time and expertise, data and technology resources, agency/community will, infrastructure
	Evidence-based/informed strategies available	Evidence-based/informed strategies available
	Feasibility of a population-based or systems-level approach	Feasibility of a population-based or systems-level approach
	Cost of implementing strategies and amount of funding needed to make an impact	Cost of implementing strategies and amount of funding needed to make an impact
	Efforts will make a measurable impact in two, five, and ten years	Efforts will make a measurable impact in two, five, and ten years

Phase One

The first phase of the prioritization process involved review and synthesis of large amounts of quantitative and qualitative data including capacity/partnership information collected through the methods described earlier. Advisory Group members each received a prioritization binder containing data and information pertaining to the 48 potential priorities. One key document, the Phase One Data Synthesis Table, is an excel spreadsheet that summarized and color-coded eight data sources to educate the Advisory Group on the importance and feasibility of the potential priority issues (see Appendix U at http://goo.gl/yXNQBf).

Members reviewed the binder prior to the first three-hour prioritization meeting and then discussed and voted on priorities, one-by-one, based on the phase one criteria identified in the table above. A two-thirds majority vote was used to determine the status of those priorities lacking consensus. At this point in the process, the federal population domains were not yet finalized so the information was organized by the three population groups:

Women and infants, children and youth, and children and youth with special health care needs. However, the Advisory Group strongly considered the proposed national performance measures, federal population domains, and Block Grant requirements during this stage of decision-making to assure alignment in the final decision-making process. As a result of this process, the Advisory Group narrowed the 48 potential priorities down to 19. The discussion and decision on each priority was documented.

Phase Two

The second phase of prioritization involved three primary components. In the first component, state program staff completed a prioritization template for each of the 19 potential priority topics and attended a retreat to entertain questions from members of the Advisory Group. The prioritization templates included key information such as potential evidence-based strategies and state and local capacity (see Appendices V-AM at http://goo.gl/yXNQBf). During the next step, the Advisory Group members completed a scoring rubric to assess each of the 19 potential priorities on importance, feasibility, and impact--defined by select criteria (see table above). Reviewers were anonymous, and scores were totaled and averaged so that a ranking of issues, by federal population domain, could be used to guide the final prioritization discussion and decisions (see Appendix AN at http://goo.gl/yXNQBf). The third component of the process involved the Advisory Group reviewing the results of the scoring rubric and discussing final decisions while applying several criteria (table above) and aligning with the final Block Grant guidance. Seven priorities for the 2016-2020 Block Grant cycle were ultimately identified. (See Section II.C).

Capacity and Partnerships/Collaboration

Advisory Group members assessed state and local program capacity and state partnerships/collaboration during the regional stakeholder meetings, as well as during the prioritization process through the use of the prioritization templates and discussions with state program staff. At the regional stakeholder meetings, participants completed an activity entitled “Success Stories” where they shared their insights on an MCH issue that culminated in observed success. After coding responses from all the meetings, it became apparent that there was strong capacity and success among several of the current local MCH priority efforts such as early childhood obesity prevention, pregnancy-related depression, developmental screening among young children, and youth sexual health. Participants reported that partnerships/collaboration, funding, and partner buy-in were key in addressing these issues locally.

State program staff researched and reported on capacity for the 19 potential MCH priorities in the prioritization templates. The prioritization templates included capacity information relative to staff time and expertise, current and potential funding sources, existing or potential partnerships and collaborations, data and technology resources, local progress and interest, and state and federal will. To review this information, see sections 8 through 11 of the prioritization templates available in Appendixes V-AM at http://goo.gl/yXNQBf. Advisory Group members used this information about state and local capacity in selecting the final priorities.

Strengths and Challenges

The Advisory Group participated in two debrief processes to assess the needs assessment process. The first debrief, a facilitated discussion, focused on the stakeholder engagement strategies that were implemented, including the regional meetings and stakeholder surveys. Key strengths that were identified included:

- A large number of varied stakeholders were engaged statewide in meaningful and interactive activities, and

valuable input was gathered and used to influence the selection of MCH priorities.
- The regional meetings provided an opportunity to build partner relationships and strengthen the visibility of Colorado's MCH Program.
- The meetings were effective at assessing the needs of the entire MCH population.

Challenges identified in the stakeholder engagement process included:

- It is always difficult to engage as many different stakeholders as desired given the capacity limitations of staff time and cost.
- Because an average of five state staff attended each regional meeting, there was a significant demand on staff time to conduct this process.

The second debrief included a review and analysis of the overall needs assessment process. Advisory Group members participated in a survey that collected feedback on the strengths, challenges, and opportunities afforded by the process, culminating in a discussion at the final meeting in February, 2015. Key findings on the strengths of the needs assessment process included:

- There was a dedicated and high caliber Advisory Group who represented state and local public health agencies as well as families. Members contributed a generous amount of time, were well-prepared for meetings, and were effective decision-makers.
- According to the survey, there was "excellent project management with detailed planning and timelines, openness to adapt or modify as needed, and multiple opportunities for input".
- The design included an optimal balance of quantitative and qualitative data. The large amount of data was also synthesized in a user-friendly fashion that facilitated decision-making.
- The prioritization process was efficient and effective in selecting priorities, despite the difficulty of the decisions.
- Communication throughout the process was clear and consistent.

Key challenges identified included:

- In several cases, the Block Grant requirements limited Colorado's selection of priorities. In the maternal and cross-cutting population domains, the quantitative and qualitative data collected did not support the selection of the required national performance measures. Colorado was compelled to determine how to best align areas of need with the mandated choices.
- A best practice needs assessment process requires a significant amount of funding, staff time and effort. The twelve regional stakeholder meetings were particularly demanding for Advisory Group and other state staff members.

Opportunities for future process improvement included:

- There is an opportunity to engage a young person, another family member or an additional local public health agency staff member in the future advisory group.

A cost analysis of the needs assessment process was also conducted. In total, Colorado's MCH needs assessment process cost an estimated $173,000. The debrief findings and cost information will be utilized to inform the 2021-2025 needs assessment process.

II.B.2. Findings

II.B.2.a. MCH Population Needs

The overall health of the MCH population in Colorado is relatively strong when compared with relevant Healthy

People (HP) 2020 targets, as indicated in the HP2020 Comparison Data Table (see Appendix R at http://goo.gl/yXNQBf). As described in the MCH Snapshot, many Colorado residents are well-educated with high socio-economic status. However, health inequities across MCH populations are prevalent and persistent, particularly among lower-income, minority, and less educated individuals. For example, Colorado has one of the higher childhood poverty rates in the nation. The gap between the rich and poor in Colorado also ranks in the top 20 nationwide. During the needs assessment process, mental health, substance use and obesity emerged as cross-cutting issues that deserved the attention of Colorado's MCH program.

The Block Grant guidance advised states to discuss the strengths and needs of the MCH population groups. The documents in the table below provide a comprehensive overview of the health status of Colorado's MCH population and contain a majority of the data collected and synthesized throughout the needs assessment process (see Appendices A-AU at http://goo.gl/yXNQBf).

Table II.B.1.h. Key Findings in the 2016-2020 MCH Needs Assessment

2011-2015 Colorado MCH Mid-Course Review
Colorado MCH Snapshot
HP2020 Comparison Data Table
12 Issue Briefs (Unintended pregnancy, mental health among women of reproductive age, substance use among women of reproductive age, infant mortality, early childhood obesity, immunization, child/adolescent injury, child and youth obesity, mental health among children and adolescents, substance use among adolescents, oral health)
Oral Health Fact Sheet Among Pregnant Women
Youth Sexual Health Data Document
Colorado's Special Report: Drug Overdose and Death 1999-2013
2015 Prescription Drug Overdose Data
Healthy Kids Colorado – Marijuana Data
Future of Covering Kids Report
Phase One Prioritization Data Synthesis Table – Includes key quantitative and qualitative data indicators for 48 documented MCH issues
Regional Meeting Capacity Summary (Success Story Summarization)
Regional Meeting CYSHCN Data Summary
19 Potential Priority Information Templates
Phase Two Prioritization Scoring Rubric TOTALS

Colorado also used more specific and complex criteria, cited in the table earlier, to organize, analyze, and prioritize MCH issues. Specifically, the Advisory Group selected 19 out of 48 potential priorities that met selected criteria to move from phase one to phase two prioritization (See the tables below). The 29 issues that were not selected for phase two prioritization did not meet the phase one criteria, e.g., consistency with the MCH mission and conceptual framework, compelling incidence/prevalence, or sufficient capacity to address the issue (see Appendix U at http://goo.gl/yXNQBf).

In some instances, the Advisory Group's data-driven prioritization choices were not fully realized because of the requirements of the Block Grant. For example, the maternal health NPMs had minimal supporting data,so the

choice of NPMs for that domain was not completely data-based.

Table II.B.1.b. Women/Maternal Health Issues Summary

Phase One	Phase Two
Unintended pregnancy	Well-woman care
Low-risk cesarean deliveries	Mental health
Medical home	Pregnancy-related depression
Healthy eating/active living	Inadequate maternity leave (considered as a strategy for breastfeeding)
Safety/injury of women	

Table II.B.1.c. Perinatal/Infant Health Issues Summary

Phase One	Phase Two
Perinatal regionalization	Breastfeeding (duration)
	Safe sleep
	Reducing disparities in infant mortality among the African-American population

Table II.B.1.d. Child Health Issues Summary

Phase One	Phase Two
Healthy eating/active living (6-11 year olds)	Developmental Screening
Mental health	Early childhood obesity
Health care access	
Medical home	
Safety/injury	
Affordable and quality preschool	
Child abuse and toxic stress	
Household smoke	
Immunizations	
Diabetes, asthma	

Table II.B.1.e. Children and Youth with Special Health Care Needs Health Issues Summary

Phase One	Phase Two
Pediatric specialty care (already working on this)	Medical home
	Respite

	Transition

Table II.B.1.f. Adolescent Health Issues Summary

Phase One	**Phase Two**
Safety/injury	Bullying
Active living/healthy eating	Mental health
Medical home	Suicide
Adolescent well visit/health care access	Youth sexual health
Transitions	
Concussions	
Diabetes, Asthma	
Homelessness	
Overmedication of foster kids	

Table II.b.1.g. Cross-cutting/Life Course Health Issues Summary

Phase One	**Phase Two**
Adequate insurance coverage	Substance use including marijuana, prescription drugs, tobacco and alcohol
	Oral Health

The Needs Assessment Advisory Group ultimately refined the state's priority needs into seven state priorities. Final priority selections are discussed in sections II.C. and II.D.

A discussion of the current MCH priority efforts as they relate to the priority needs is available under the Mid-course Review in section II.B.1. For more information on capacity and partnerships/collaborations related to the priority needs, see the Capacity and Partnerships/Collaborations information in section II.B.1.

II.B.2.b Title V Program Capacity

II.B.2.b.i. Organizational Structure

CDPHE is one of 19 Colorado state agencies, under the direction of Governor John Hickenlooper. Dr. Larry Wolk is the Executive Director and Chief Medical Officer. A CDPHE org chart is attached.

The MCH and CYSHCN programs are located within the Prevention Services Division (PSD) of CDPHE. Elizabeth Whitley, PhD, RN is the Division Director and Karen Trierweiler, MS, CNM is the Division Deputy Director and the Title V MCH Director. PSD consists of seven branches: Children, Youth, and Families (CYFB); Health Services and Connections; Nutrition Services; Violence and Injury Prevention – Mental Health Promotion; Health Promotion and Chronic Disease Prevention; Fiscal, Compliance, Contracts and Operations; and Communications.

The CYFB houses the majority of state MCH staff and includes: the Population and Community Health Sections, the Maternal and Child Health Section, the Children and Youth with Special Health Needs Section and the Branch Operations Section.

II.B.2.b.ii. Agency Capacity

The following table lists the names and qualifications of senior level management who serve in lead MCH-related positions as well as program staff who contribute to the state's planning, implementation, evaluation, and data analysis capabilities. It includes years of experience as well as the population domains and performance measures.

Table II.b.2.ii.a.

Staff Member	Role	Qualifications	Domain(s)	Performance Measure	Total FTE	Tenure with State of Colorado
Trierweiler, Karen	**MCH Director**, Prevention Services Division Deputy Director	MS, CNM, RN	-All Domains	-All PMs	1.0	23
Hutson, Rachel	**CYSHCN Director**, Children, Youth and Families Branch Chief	MSN, RN, CPNP	-All Domains	-All PMs	1.0	14
Bakulski, Mandy	Maternal Wellness and Early Childhood Unit Manager	RD, MPH(c)	-Women/Maternal Health -Perinatal/Infant's Health -Child Health	-NPM 1 -NPM 6 -Potential SPM TBD	1.0	10
Baumgartner, Heather	MCH Section Manager	MSS	-All Domains	-All PMs	1.0	13
Bishop, Audra	Youth and Young Adult Unit Supervisor	CACIII	-Adolescent Health	- NPM 7	1.0	4
Braga, Anne-Marie	Population and Community Health Section Manager	MSSW, LCSW	-Women/ Maternal Health -Perinatal/ Infant's Health -Child Health -Adolescent Health	-NPM 1 -NPM 6 - NPM 7 -Potential SPM TBD	1.0	9
Breitzman, Shannon	Violence and Injury Prevention —Mental Health Promotion Branch	MA	-Cross-Cutting/Life Course	-NPM 14 -Potential SPM TBD	1.0	14
Davis, Julie	MCH Generalist Consultant	BSN	-All Domains	-All PMs	0.8	10
Febbraro, Gina	Performance Improvement Manager	MPH	-All Domains	-All PMs	0.6	8
Forlenza, Eileen	Family and Community Engagement Specialist	BS	-All Domains	-All PMs	1.0	11
Friedman, Risa	MCH Program Specialist	MPH	-All Domains	-All PMs	0.6	4
Goodger, Angie	HCP Consultant, CYSHCN Section	HSA, MPH	-CSHCN	-NPM 11	1.0	3
Henry, Meredith	Children's	MPP	-CSHCN	-NPM 11	1.0	1

	Medical Home Policy Coordinator					
Hortel, Leslie	MCH Generalist Consultant	MPH	-All Domains	-All PMs	1.0	5
Juhl, Ashley	MCH Epidemiologist	MSPH	-All Domains	-All PMs	1.0	6
Lujan, Kate	Public Health Nurse Consultant	RN, MPH	-All Domains	-All PMs	0.4	12
McDermott, Kristin	Evaluation Unit Manager	MA	-All Domains	-All PMs	1.0	6
Minor, Kelsey	HCP Consultant, CYSHCN Section	MPH	-CSHCN	-NPM 11	1.0	2
Munthali, Jennie	CYSHCN Section Manager	MPH	-CSHCN	-NPM 11	1.0	6
Myers, Lindsey	Injury and Substance Abuse Prevention Section Manager	MPH	-Cross-Cutting/ Life Course	-NPM 14 -Potential SPM TBD	1.0	7
Ulric, Erin	Nutrition Services Branch Chief and WIC Director	MPH	-Perinatal/ Infant's Health -Child Health	- NPM 4 -NPM 8	1.0	1
White, Cathy	Public Health Nurse Consultant	RN, MSN	-All Domains	-All PMs	1.0	12

Each of Colorado's 54 local public health agencies is appropriated Block Grant funding to serve the MCH and CYSCHN populations. Contract expectations for the 14 largest LPHAs include implementing care coordination and medical home approaches for CYSHCN and focusing a portion of funds (30 percent in FY 2015) on other MCH priorities. With the adoption of a population and poverty-based funding formula, a majority of the resources are focused on priority area objectives within the highest population areas. Data on staff implementing Title V programming for these agencies is listed below:

Table II.b.2.ii.b.

Jurisdiction	**2015 Staff Number** *(including vacancies)*	**2015 Total FTE** *(excludes subcontractors)*
Boulder	11	4.71
Denver	15	7.50
El Paso	6	4.97
Jefferson	8	4.25
Larimer	9	3.26
Mesa	10	3.56
Northeast	6	1.76
Otero-Crowley	3	0.55
Pueblo	6	4.97
San Juan Basin	4	1.48
Tri County	14	9.60
Weld	12	3.82
Totals	104	50.43

The 41 smaller Colorado LPHAs are also required to align their work with MCH priorities and their community health improvement plans, increasing consistency of efforts across agencies and the state.

Colorado meets the requirement to serve blind and disabled individuals under age 16 receiving benefits under

Title XVI, to the extent medical assistance for such services is not provided under Title XIX, by using Title V funds to link blind and disabled individuals under 16 to community based care and support as a component of our efforts to support the CYSHCN population. The current service delivery system (HCP, Family Healthline) provides individuals with information, resources and referral to services based on their need.

Colorado's MCH program takes steps to assure that a statewide system of services exist which reflect the principles of comprehensive, community-based, coordinated, family-centered care. State program collaborations with other state agencies and private organizations (e.g., Child Fatality Prevention System, Project Launch, MIECHV, ECCS, Healthy Start, Child Abuse and Neglect Prevention, interface with the Departments of Health Care Policy and Financing (Medicaid) and Human Services, state support for communities (local public health collaborations), coordination with health components of community-based systems and coordination of health services with other services at the community level (Early Childhood and Youth Advisory Councils, State Innovation Model (SIM) project funded by the CMMI and the Colorado Association of Local Public Health Officials (CALPHO) will be addressed in the Partnerships and Collaborations section of the application. All partnerships and collaborations involve the efforts of Title V funded staff.

II.B.2.b.iii. MCH Workforce Development and Capacity

MCH and CYSHCN Workforce

See Table II.b.2.ii for details on MCH senior level management employees and program staff who contribute to the state's planning, evaluation and data analysis capabilities.

This table demonstrates the state team's strong credentialing and public health experience. Variability in tenure has been achieved in order to buffer the impact of staffing transitions over time. Succession planning and strategic hiring decisions are made as transitions occur and roles are shifted or created to reflect priority area needs. An example is the recent creation of a performance management specialist position, which will establish performance tracking and quality improvement initiatives in accordance with recently updated national public health accreditation standards and MCHB expectations.

Table II.b.2.ii.b. (above) provides data on local public health MCH staff.

Parent and Family Member Staff

The Children, Youth and Families Branch's Family and Community Engagement Specialist (1.0 FTE) and the two FLTI Family Advisors (each 0.5 FTE, for a combined 1.0 FTE) are all mothers of a youth or adult with special health care needs.

HCP also employs four full time family leaders who are located in LPHAs and have received training through the Family Leadership Training Institute.

There is currently one 0.5 FTE Youth Advisor who is a paid member of the CYFB. He will continue in his position through February, 2016 with plans to re-hire by late-2015. Denver Health will hire three youth advisors in July to work on the CO 9-25 Denver Regional Council, HEAL (health eating active living) activities, and tobacco work.

Culturally Competent Approaches to Service Delivery

Local MCH contractors are guided to assess MCH data and conduct program planning with a goal of reducing health inequities. Contractors are provided technical assistance in using the Colorado Health Indicators website, which provides county, regional and state level data on a variety of health, environmental and social topics. Data are organized based on the CDPHE Health Equity Model

(http://www.chd.dphe.state.co.us/CHAPS/Documents/Health%20Equity%20Model%20and%20Summary.pdf). This model groups the social determinants of health into four categories: life course perspective, determinants of health, health factors, and population health outcomes.

CDPHE has adopted the *National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care* (the *National CLAS Standards*). By December 31, 2015, all employees were required to participate in a language services on-line training to effectively address limited English proficiency. Department efforts in this area are supported by a dedicated CLAS Coordinator and support services in interpretation, translation, and quality assurance. In addition, work conducted by all MCH contractors aligns with the CLAS Standards.

HCP consultants developed standards and guidelines for HCP pediatric specialty clinics, requiring that clients be provided with culturally appropriate services such as in-person translation services, delivery of information utilizing the families' primary language and consideration of cultural preferences and beliefs when providing care.

In 2014, the Health Equity and Environmental Justice (HE/EJ) Collaborative formed with representation from every division within CDPHE. The HE/EJ Collaborative focuses on populations who experienced disproportionate disease, illness and environmental burden such as racial and ethnic minorities; lesbian, gay, bisexual and transgender persons; persons experiencing disabilities; place of residence; and socio-economic status. The strategic goals of the collaborative include data, workforce development, meaningful community involvement, resource alignment, policy development and communication. Workgroups formed for each strategic goal area. The MCH Unit Manager and a MCH Generalist Consultant are participating on the resource alignment and meaningful community involvement work groups, respectively.

As part of the FY2016-2020 MCH Needs Assessment, a series of 12 MCH issue briefs were created; each including a section on healthy disparities and social determinants of health. For a more detailed description of the issue briefs, see Section II.B.1. All the briefs can be downloaded from www.mchcolorado.org.

Staff from the Children, Youth and Families Branch organizes learning circles for all MCH funded staff every other month. See Section II.F.2. for more information.

Collaboration with community leaders/groups and families

Colorado has a long history of strong collaboration with community and family organizations. For over twenty years, Colorado's MCH/CYSHCN program has employed a family leader to embed family engagement in programmatic design, implementation and evaluation. The Family and Community Engagement (FACE) team is comprised of a team Supervisor and two Family Advisors, all three are parents of CSHCN and paid state employees. Like many states, the CYSHCN program began mastering the principles of family engagement as part of its work to improve results on the six national MCH performance measures for CYSHCN. In recent years, however, family engagement strategies include all MCH populations, such as early childhood obesity prevention, maternal wellness and youth systems development. In addition, family leaders were actively involved with the recent MCH Needs Assessment process, through a partnership with Family Voices of Colorado.

As a result, the perspective of families and the community as a whole is highly valued and consistently embedded into MCH programs. Partnerships with local family organizations are prevalent throughout the state, including:

- **Family Voices Colorado**
- **The ARC -** advocacy and education to people with disabilities.

- **El Grupo VIDA -** empower those experiencing disabilities among the Spanish-Speaking population.
- **Children's Hospital Colorado -** prioritizes the integration of trained family leaders (via FLTI) into advisory councils and task forces.
- **Early Childhood Councils -** provide leadership through their network of 30 local councils with family engagement and support as a priority area.
- **The National Fatherhood Initiative**
- **Family Resource Centers -** provide local family support activities statewide.
- **Healthy Community Colorado -** network of communities dedicated to empowering families in 24 local communities across the state.
- **The Eagle River Youth Coalition (ERYC)** assesses prevention needs and programs and policies for Eagle County youth.
- **The Colorado Respite Coalition (CRC) -** families and community partners who facilitate safe, affordable, and stimulating respite care choices.
- **Community Enterprise** engages community members in Adams County to build healthy, inclusive neighborhoods.

For more on family collaboration and partnerships see Section II.F.3.

Colorado also has an extensive history of engaging young people as partners. For the last 15 years, CDPHE has supported the Youth Partnership for Health (YPH) – a statewide youth advisory council composed of 13-19 year olds, who meet monthly to inform youth-focused programs, practices and policies. Some recent collaborations have resulted in a synthetic marijuana prevention campaign, informing an agency on their outreach for health insurance targeted to young adults, participating in the MCH needs assessment, shaping the retail marijuana youth prevention campaign, creating tobacco prevention ads, crafting messaging for the promotion of sexual health and the prevention of teen dating violence, and ideas on addressing mental health stigma.

Using its own Youth Advisor Model, the state hired youth as state employees to partner and share their expertise around youth needs/culture. Youth Advisors complete project specific work, currently related to Colorado 9to25, in addition to providing feedback on state programs/initiatives by engaging youth from across the state, and hosting weekly office hours as a mechanism to increase the accessibility of youth feedback for staff. An evaluation of the CDPHE model has linked successful outcomes to hiring youth as employees, as well as demonstrating viability and recommendations for replication and improvement. For more on youth leaders and partnerships see Section II.F.3.

II.B.2.c. Partnerships, Collaboration, and Coordination

Other MCHB investments

Colorado receives a State Systems Development Initiative (SSDI) grant from MCHB to build data capacity to quantify and evaluate MCH priority efforts. CDPHE was awarded an MCHB-funded CYSHCN Systems Integration Grant to develop/implement a state plan to increase CYSHCN who receive integrated care through a patient/family-centered medical home. The State Leadership Team for this effort includes representatives from Family Voices, University Physicians, Inc., the Colorado Departments of Health Care Policy and Financing (Medicaid) and Human Services, Southwestern Colorado Area Health Education Center, the Center of Excellence in Care Coordination, the Colorado Department of Education and CDPHE. Input is also garnered from Family-to-Family and Medical Home Coalitions as well as multiple physician groups.

Families Forward Resource Center serves as Colorado's Healthy Start grantee. Healthy Start, CDPHE, and metro area local public health agencies along with a broad range of stakeholders continue to collaborate on both

state and local infant mortality CoIIN initiatives as well as Healthy Start-required efforts to reduce the African American Infant Mortality Rate. Two CDPHE team members serve as active participants on the Healthy Start Community Action Network (CAN) and multiple participants of the CAN, including its coordinator, serve on CDPHE's African American Infant Mortality CoIIN. Denver Public Health, a Block Grant sub-recipient, leads evaluation efforts for the Colorado Healthy Start initiative.

The CO Early Childhood Systems grant (MCHB-funded ECCS) is housed at the Civic Canopy, focusing on mitigating the effects of toxic stress and trauma for infants and toddlers, advised by the Early Childhood Colorado Partnership (ECCP) – a large group of public and private stakeholders. This work is closely aligned with efforts statewide to improve identification of pregnancy-related depression and early identification systems for developmental screening & referral. MCH staff is partially funded by the ECCS grant to support some of the grant deliverables. The Maternal Wellness & Early Childhood Unit Supervisor serves as a co-chair of the ECCP Steering Committee.

Colorado receives $22 million under the MCHB-funded Maternal-Infant and Early Childhood Home Visiting Program (MIECHV) to support expansions of evidence-based home visiting programs in 10 counties (Pueblo, Adams, Alamosa, Costilla, Saguache, Crowley, Otero, Denver, Morgan and Mesa) and to support state and local systems building activities to strengthen the early childhood system in CO. Models currently funded in CO include Healthy Steps for Young Children, the Nurse Family Partnership (NFP), Home Instruction for Parents of Preschool Youngsters, Parents as Teachers and Safe Care Augmented. This program compliments historical funding for dissemination of the NFP across the state.

The MCH Program partners with the MCH-funded technical assistance grantee, through the Colorado School of Public Health (CSPH), to implement the rural MCH education initiative. A variety of other educational opportunities are also accessed through a partnership with the CSPH and the Center for Public Health Practice. MCH-Link provides online public health education and skills development in injury and violence prevention, adolescent health, nutrition, and reproductive health.

Other Federal investments

The Colorado Child Fatality Prevention System (CFPS) is a statewide, multidisciplinary, multiagency effort to prevent child deaths. Using a public health approach, the CFPS aggregates data from individual deaths, describes trends and patterns of child deaths, and identifies prevention strategies. Local child fatality review teams review the individual deaths as well as implement prevention strategies, coordinating with MCH partners at the local level in order to leverage funding and improve MCH outcomes.

The USDA-funded Colorado Supplemental Nutrition Program for Women, Infants and Children (WIC) and MCH Programs coordinate whenever program goals are mutually shared. For example, because both programs require local agencies to undergo an annual planning process, both programs collaborate in the development of this deliverable. Also, WIC participant data is available for MCH Block Grant progress reporting purposes.

Colorado's CDC-funded Essentials for Childhood (EfC) project includes a variety of stakeholders, including MCH-funded partners at the state and local level, working to create safe, stable, nurturing relationships and environments (SSNREs) to reduce child maltreatment. The Common Agenda includes advancing policy and community approaches to: increase family-friendly business practices across Colorado, increase access to childcare and afterschool care, increase access to preschool and full-day kindergarten, improve social and emotional health of mothers, fathers, caregivers and children.

The newborn hearing program functions under a CDC collaborative agreement, the Development, Maintenance and Enhancement of Early Hearing Detection and Intervention Information System (EHDI-IS) Surveillance Programs. The funding is being used to assist EHDI programs in developing/maintaining a centralized newborn

hearing screening tracking and surveillance system.

Colorado received funding from SAMHSA to implement Project LAUNCH from 2014-2019, with a focus on services in Adams County. The purpose is to improve child wellness from birth to age eight through systems coordination and integration of behavioral and physical health services. This effort is coordinated between CDPHE and CDHS, the grantee. The Young Child Wellness Specialist sits within the MCH program at CDPHE with time split equally between Project LAUNCH and other MCH-funded projects. Part of the role of this position is ensure alignment between the MCH priorities focused on pregnancy-related depression and developmental screening efforts. The local level effort is coordinated through the Early Childhood Partnership of Adams County with involvement from MCH staff at Tri-County Health Department addressing these same two MCH priority areas.

Other governmental agencies

In 2013, the Office of Early Childhood (OEC) was created in statute at the Colorado Department of Human Services (CDHS). The MIECHV and child abuse programs were transferred from CDPHE to CDHS. The MCH program collaborates extensively with OEC staff around issues pertinent to MCH. The Title V Director represents CDPHE on the Early Childhood Leadership Commission and has been involved in revising the state's early childhood framework. Staff involved in Project Launch is co-located at CDPHE and CDHS. Representatives from the Children, Youth and Families Division at CDHS not only serve on the Youth Sexual Health Team, but helped develop CO9to25 and serve on the CO9to25 Leadership and Steering teams. This partnership was especially useful in ensuring that CO9to25 was used as the foundation to develop the statutorily mandated statewide youth development plan.

The MCH program has a long-standing collaboration with the Department of Health Care Policy and Financing/Medicaid (HCPF). MCH leadership and staff interact with HCPF at multiple levels. MCH staff provides ongoing content expertise and support to the Medicaid Accountable Care Collaborative (ACC) Program, to maximize access to a medical home approach that meets the needs of the MCH population in Colorado. MCH staff provided input into the Enhanced Primary Care incentive model that was implemented July 2014. MCH staff participates in the ACC Program Improvement Advisory Council, as well as the Payment Reform, Quality, and Provider and Community Relations sub-committees. MCH staff is advocating for a family representative to be included as a voting member of the Program Improvement Advisory Council. MCH and HCP staff is working collaboratively with HCPF to help inform the Regional Care Collaborative Organization (RCCO) re-bid process to help assure that the needs of the CYSHCN population enrolled in Medicaid are addressed through the RCCO model. HCPF staff actively participated in the AMCHP Action Learning Collaborative and the MCH Workforce Development Center TA projects. Staff also partner in implementing Colorado's State Innovation Model grant (SIM). Colorado received a $65 million federal SIM cooperative agreement from CMMI to implement a health care delivery system that integrates primary care and behavioral health care services. The goal is to bring this model of care to 80 percent of the state's population within a 4-year time frame. In addition, to creating systems that can offer patients integrated care, SIM will initiate payment reform. The Title V and CYSHCN Directors currently serve on a pediatric sub-committee that will guide practice transformations among children and youth in alignment with the SIM model.

Staff from the CDHS OEC, CDPHE MCH and the HCPF has completed an implementation plan for Help Me Grow in Colorado.

MCH staff has an ongoing, productive partnership with the Colorado Department of Education. Strong partnerships with the Health and Wellness and Dropout Prevention Units have resulted in collaborative grants and initiatives supporting youth sexual health, CO9to25 and most recently a Project AWARE grant from SAMSHA focused on improving behavioral health of students across the state. CDE staff serves on the MCH Youth Sexual

Health Implementation Team, CO9to25 Leadership Team and Healthy Kids Colorado Survey Steering Committee.

State and local MCH programs
Each of Colorado's 54 local public health agencies (LPHAs) is appropriated Block Grant funding to support the implementation of strategies to serve the MCH and CYSCHN populations. See *Section 2b. Title V Program Capacity, Agency Capacity* for more information about local MCH work. The Colorado Association of Local Public Health Officials (CALPHO) is the statewide organization representing local public health agencies (LPHAs) in Colorado. Its purpose is to foster an effective and efficient public health system in Colorado and to encourage improvement in the quality, capacity and leadership of LPHAs. The Colorado MCH program works collaboratively with CALPHO and all LPHAs to advance MCH statewide, as all 54 LPHAs in Colorado receive some MCH funding.
There are currently 31 Early Childhood Councils in Colorado representing 58 of the 64 counties. The role of the councils is to improve and sustain the availability, accessibility, capacity and quality of early childhood services for children and families throughout the state. They work to bring together local partners, including MCH staff in LPHAs to advance programs, resources and support around early learning, family support and parent education, and social, emotional, and mental health for young children.

Other programs within CDPHE
Immunization funding provided to LPHAs encourages partnerships within each agency with MCH, FP, HCP and WIC programs. Helping parents understand the immunization schedules and making sure they know how to access immunizations for their children is critical in the Immunization-MCH partnership. In addition, pregnant women are now a focus given the emphasis on T-dap and influenza vaccinations.

The CDPHE Injury Prevention Section partners with MCH to provide technical assistance at the state and local levels on a variety of childhood injury prevention issues, including: child passenger safety, teen driving safety, infant safe sleep, bullying, suicide, and poisoning. The Injury Prevention Section is responsible for conducting surveillance on childhood injuries using emergency department, hospital discharge, and death certificate data. Additionally, the Injury Prevention Section coordinates several multidisciplinary coalitions that work on injury prevention issues, including the Colorado Teen Driving Alliance, a multidisciplinary, statewide coalition concerned that work to reduce motor vehicle injuries and fatalities.

The MCH program partners with the Healthy Living and Chronic Disease Prevention Branch within the Prevention Services Division on a variety of prevention efforts, most specifically the early childhood obesity prevention priority which is a collaborative effort between the MCH, WIC and Health Eating and Active Living Unit in PSD. Colorado's new tobacco NPM will be operationalized through a partnership between MCH and the Branch's tobacco control program.

Tribes, Tribal Organizations and Urban Indian Organizations
Colorado is home to two federally-recognized tribal nations in the southwest corner of the state that operate as their own jurisdictions: The Ute Mountain Ute and the Southern Ute. The two tribes have a total of 3,468 enrolled members residing both on and off the reservations. American Indian/Native Alaskans make up less than one percent of the state's population, with a total of 46,395 American Indian/Native Alaskans living in urban areas and 9,615 living in rural parts of the state. Tribal leaders partner with both state and local health department staff in the implementation of public health interventions that align with current and emerging needs.

Family/consumer partnership and leadership programs
The cornerstone of Colorado's family engagement initiative is the Colorado Family Leadership Training Institute

(FLTI), a leadership course designed to increase civic engagement in local communities. For more on FLTI see Section II.F.3.

Youth Partnerships

In addition to the youth work described above, more details about youth partnerships can be found in Section II.F.3.

II.C. State Selected Priorities

No.	Priority Need
1	Women's mental health, including pregnancy-related depression
2	Reduction of infant mortality among African Americans
3	Early childhood obesity prevention
4	Developmental screening and referrals
5	Bullying and youth suicide prevention
6	Medical home for children and youth with special health care needs
7	Substance misuse reduction (tobacco, marijuana and prescription drugs) among pregnant and postpartum women

As a result of Colorado's 2016-2020 needs assessment process, the Advisory Group chose seven priorities. The seven 2016-2020 state selected priorities include:
-Women's mental health, including pregnancy-related depression
-Reduction of infant mortality among African Americans
-Early childhood obesity prevention
-Developmental screening and referrals
-Bullying and youth suicide prevention
-Medical home for children and youth with special health care needs
-Substance misuse reduction (tobacco, marijuana and prescription drugs) among pregnant and postpartum women

Women's mental health, including pregnancy-related depression
Mental health issues such as depression and anxiety, can diminish a woman's physical health and quality of life, while also negatively impacting pregnancy. In 2012, 18.7 percent of Colorado women of reproductive age experienced eight or more days of poor mental health in the past 30 days. In 2012, 10.4 percent of Colorado women of reproductive age were currently depressed. Forty-three percent ever diagnosed with a depressive disorder had also been diagnosed with an anxiety disorder. Overall, 18.9 percent of women of reproductive age in Colorado reported an anxiety disorder. The department is preparing updates to these data from the 2014/2015 Behavioral Risk Factor Surveillance Survey (BRFSS), which should be available in late fall.

Pregnancy-related depression (PRD) is a mood disorder that occurs during pregnancy or up to one year postpartum. Children of depressed mothers are more likely to exhibit social/emotional problems; poor self-control; aggression; and difficulty in school. More than one in every 10 (11.0 percent) Colorado women, who gave birth in 2013, experienced postpartum depressive symptoms . This makes depression the most common complication of pregnancy.

Reduction of infant mortality among African Americans
The infant mortality rate is defined as the number of deaths to infants less than one year of age among all live births in one year, per 1,000 live births. In 2014, Colorado had 315 infant deaths out of 65,816 births for a rate of 4.8; the U.S. rate was 6.0 in 2013. Over the past 10 years, Colorado's infant mortality rate has been close to the Healthy People 2020 goal of 6.0 deaths per 1,000 births.

Infant mortality rates vary by race/ethnicity in Colorado. Infants of color, with the exception of Asian American/Pacific Islander infants, have higher infant mortality rates than White non-Hispanic infants. African-American infants have a rate that is more than double the White non-Hispanic infants. The selection of this priority aligns with the federal infant mortality priority and Colorado's CoIIN efforts.

Early childhood obesity prevention

Overweight and obese young children often become overweight and obese youth and adults, increasing their risk of chronic disease over time. The risk of early childhood obesity begins during pregnancy and early childhood. Maternal overweight and obesity prior to and during pregnancy is associated with obesity in the next generation. In addition, early patterns of eating, physical activity and sleep greatly influence child health and weight, permanently altering neurological and metabolic systems.

One in five (21.2 percent) children, who participate in WIC, ages two to four years, were overweight or obese in 2015. About 14 percent were overweight and seven percent were obese. Reliable Colorado data are limited to the WIC population at this time.

Increasing breastfeeding among infants is an evidence-based strategy for preventing early childhood obesity. Among infants born in 2012, 30.3 percent were exclusively breastfed at six months. Sixty percent received some breast milk at that age and 36.2 percent of all infants continued breastfeeding for twelve months.

Developmental screening and referrals

Developmental screening utilizing standardized tools has been shown to correctly identify 70-80 percent of developmental disabilities among children, and 80-90 percent of mental health problems. Screening may indicate the need for further evaluation. Health care providers play a unique role in developmental screening because they interact frequently with children and their families between birth and three years old. The American Academy of Pediatrics (AAP) advises primary care providers to conduct developmental screening at age nine, 18, and 30 months and before starting preschool or kindergarten.

In Colorado, 93 percent of pediatric providers are using a standardized developmental screening tool as a routine component of well child-care. Colorado Early Intervention data indicates that primary care physicians accounted for 49 percent of all referrals in 2015, an increase of 400 percent since 2006. In 2012, Colorado ranked 2nd in the number of children receiving screens. When parents of Colorado children, ages 10 months to five years, were asked about developmental screening, 47 percent indicated they received a developmental screening compared with 30.8 percent of parents nationally. Data will be updated upon completion of the National Survey of Children's Health.

Bullying and youth suicide prevention

Adolescence brings with it a unique set of developmental changes. Youth and young adults face health issues related to self-regulation of behaviors and emotions, such as bullying, suicide, injury, substance use, and risky sexual behaviors which put them at greater risk for morbidity and mortality. Colorado's current youth systems-building initiative, Colorado 9to25, has made significant progress and is recognized as a best practice by the National Institute of Health.

Bullying

Bullying is intentional, aggressive behavior that involves an imbalance of power or strength. Current estimates suggest nearly 30 percent of American adolescents reported at least moderate bullying experiences as the bully, the victim, or both. The 2015 Healthy Kids Colorado Survey (HKCS) found that 20.1 percent of high school students were bullied on school property within the past 12 months. The HKCS collects data on sexual orientation, specifically asking young people whether they identified as gay, lesbian or bisexual (GLB), and gender identity. Similar national

data on sexual orientation and gender identity is not available. Almost one out of 10 (8.9 percent) of Colorado high school students report being bullied because someone thought they were gay, lesbian or bisexual (GLB) in 2015.

Youth Suicide
Adverse childhood experiences, depression, gender, access to lethal means, behaviors considered “high-risk”—such as smoking, drinking, and fighting—and absence of school connectedness are associated with suicidal ideation, suicide attempts, or death.

Among Colorado’s high school youth, the 2015 HKCS found that 29.5 percent felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities. One in six (17.4 percent) high school youth seriously considered attempting suicide in the past year, 14.1 percent made a plan about how they would attempt suicide, 7.8 percent actually attempted suicide one or more times, and 3.0 percent reported that their suicide attempt resulted in an injury, poisoning, or overdose that needed medical treatment. The Colorado teen suicide rate in 2014 (12.4 per 100,000) did not meet the Healthy People 2020 target of 10.2 per 100,000.

Medical home for children and youth with special health care needs
Because the children and youth with special health care needs population requires care beyond that of a typical child/youth, the components of a medical home approach are essential in order to fully meet the needs of the child/youth and their family. The medical home approach refers to health care that is patient/family-centered, comprehensive, coordinated, accessible, continuous, and culturally effective.

Based on Colorado Child Health Survey data from 2014, 51.3 percent of CYSHCN ages 1-14 in Colorado received coordinated, ongoing, comprehensive care within a medical home. This is significantly different from the 67.9 percent of non-CYSHCN in Colorado who received care in a medical home.

Substance misuse reduction (tobacco, marijuana and prescription drugs) among pregnant and postpartum women
Substance abuse poses significant health risks to women of reproductive age (18-44). The abuse and misuse of substances is associated with health risks like addiction, mental health disorders, overdose, and death. For women who become pregnant, substance abuse is associated with preterm birth, stillbirth, infant death, and long-lasting childhood developmental problems. Women who abuse substances are also at higher risk for a range of social problems including domestic violence, unintended pregnancy, and child abuse.

An estimated 16.5 percent of women ages 18-44 in Colorado smoke tobacco regularly and 15.3 percent use illicit drugs, which includes the misuse of prescription drugs. Colorado ranks among the top states with the highest rates of illicit drug use among adults and has the second-highest rate of opiod abuse in the U.S. according to the 2013-2014 National Survey on Drug Use and Health Women who are pregnant often reduce their use of tobacco and illicit drugs below their pre-pregnancy consumption levels. However, 7.4 percent of pregnant women reported smoking in the last trimester of pregnancy in 2013. Preliminary unweighted estimates from the Pregnancy Risk Assessment Survey (PRAMS) indicate that 6.5 percent of Colorado women used marijuana at any time during pregnancy in 2014.

In 2015, 84.4 percent of Colorado children ages 1-14 were not exposed to secondhand smoke even if a smoker lives in the house. This is lower than the HP2020 goal of 87 percent. Colorado decriminalized marijuana use for medicinal purposes in 2000 and, in November of 2012, became one of the first two states to legalize recreational marijuana for adults age 21 and over.

Substance use is a Winnable Battle for CDPHE.

MCH Impact – Performance Management

Since hiring a Performance Improvement (PI) Specialist in February 2015, Colorado's MCH Program has developed and implemented a performance management system focused mostly on the state MCH priorities. The PI Specialist formed a MCH Impact Advisory Group to inform system development; and implemented a robust communication and education plan to foster staff support, awareness and knowledge about performance improvement. As part of the communication effort, MCH leaders and supervisors provided information and inspiration to staff about the value and importance of MCH Impact.

MCH Impact implementation began in November 2015. The MCH performance management system involves the integration of monitoring and reporting fields in the state and local action plan templates; monthly reporting requirements using the action plan format and the four-square tool (a qualitative reporting tool); monthly supervisory and MLT meetings to review and discuss data; and the identification of cross-cutting quality improvement themes such as the provider interventions, working with Medicaid, and staff vacancies.

In July 2016, an assessment of the current system will be conducted. Feedback will inform phase two of the initiative which will likely involve improvements. A similar approach will also be applied to the monitoring and support of the MLT's strategic goal and related activities. Overall, MCH Impact has benefited Colorado's work by increasing staff knowledge of progress on MCH efforts as well as providing the opportunity to respond with real-time support and course corrections ultimately to assure that the state "moves the needle" on the NPMs/SPMs.

II.D. Linkage of State Selected Priorities with National Performance and Outcome Measures

- NPM 2 - Percent of cesarean deliveries among low-risk first births
- NPM 4 - A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months
- NPM 6 - Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool
- NPM 7 - Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19
- NPM 8 - Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day
- NPM 9 - Percent of adolescents, ages 12 through 17, who are bullied or who bully others
- NPM 11 - Percent of children with and without special health care needs having a medical home
- NPM 14 - A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes

Logic models and action plans were created for each priority during this planning year. Both the logic models and action plans outline goals, strategies, and short, medium and long-term outcomes with associated action plans that detail specific activities designed to impact NPMs, ESMs, and OMs. ESMs chosen for each NPM/domain relate to one of the strategies identified in the state's logic model and relate to the strategy highlighted in the state's action plans. Performance objectives for each ESM are highlighted in Form 10a.

Priority: Women's mental health, including pregnancy-related depression
NPM 2: Percent of cesarean deliveries among low-risk (NTSV) first births
-ESM 2.1: Completion of a report identifying NTSV data/rates for all delivering hospitals to identify facilities for C/S reduction/QI interventions

In the fall of 2015, partners from the Colorado Department of Health Care Policy and Financing (HCPF) provided CDPHE staff with quality improvement data for hospitals, looking at the percentage of cesarean deliveries (C/S) among low-risk, first births. Although Colorado's overall rate for NTSV C/S is below the Healthy People 2020 goal of 23.9 percent (20.5), findings revealed wide variation in rates across Colorado hospitals, ultimately motivating CDPHE staff to pursue this as a priority area. CDPHE chose to work on NPM 2 related to C/S acknowledging that surgical delivery can impact mental health status postpartum.

Given that pregnancy-related depression (PRD) is a continuing MCH priority, strategies and interventions are well underway. These efforts will continue and a state performance measure was developed to assess progress and impact. See section II.E and II.F.1 for more on PRD.

Priority: Reduction of infant mortality among African Americans
There is no national performance measure for this priority. See Section IIE. for information on the infant mortality SPM.

Priority: Early childhood obesity prevention
NPM 4: A. Percent of infants who are ever breastfed and B. Percent of infants breastfed exclusively through 6 months
-ESM 4.1: The number of delivering hospitals in Colorado that are certified as Baby-Friendly
NPM 8: Physical activity (Percent of children ages 6 through 11 and adolescents ages 12 through 17 who

are physically active at least 60 minutes per day)
-ESM 8.1: The number of licensed child care centers in Colorado that have physical activity as part of the daily curriculum

Given the strong association in the literature between breastfeeding and obesity prevention, breastfeeding strategies and interventions will be employed to prevent and reduce early childhood obesity. Evidence suggests that breastfeeding strategies and interventions employed by the state should directly impact the national performance measures: percent of infants who ever breastfed and percent of infants breastfed exclusively through six months. Strategies and interventions focused on improving physical activity have also been shown to prevent and reduce obesity. Early development of basic motor skills in ECE settings are linked to later levels of physical activity. Likewise, lifelong habits which influence physical activity and food preferences are formed during this time of rapid development. To assure children ages six through eleven years are accustomed to being physically active, the CDPHE ECOP team continues to promote and implement physical activity and nutrition programs during the early childhood period to improve the likelihood that as children age they have the skills, inclination and abilities to stay physically active. It is expected that strategies that increase physical activity within child care centers serving three- to five year old children should, over the long term, impact the national performance measure: percent of children ages six through 11 who are physically active at least 60 minutes per day. Impacting long-term indicators such as this generally takes between four to six years.

Priority: Developmental screening and referrals
NPM 6: Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool
-ESM 6.1: The number of LPHAs, community and/or health care partners in Colorado that have implemented ABCD quality standards that support early childhood screening, referral and treatment services for developmental needs

Evidence suggests that the strategies and interventions to improve developmental screening and referral systems and services should directly impact the national performance measure: percent of children ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool.

Activities will focus on community efforts to overcome barriers to increase the number of children that receive developmental screening, referral and services. Local and state action plans also include a focus on engaging families in the development and implementation of activities to increase screening rates. If successful, these strategies and activities will increase the number of LPHAs, community and/or health care partners that have implemented ABCD quality standards that support early childhood screening, referral and treatment services for developmental needs (the ESM) which will then impact NPM 6.

Priority: Bullying and youth suicide prevention
NPM 7: Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents ages 10 through 19
-ESM 7.1: The number of local partners reporting use of the Positive School Environment Toolkit in prioritized communities
NPM 9: Percent of adolescents, 12 through 17, who are bullied or who bully others
-ESM 9.1: The number of local partners reporting use of the Positive School Environment Toolkit in prioritized communities.

Colorado is taking a shared risk and protective factor approach to the new bullying prevention priority and the continuing youth suicide prevention priority. The application of a shared protective factor approach has resulted in a

focus on strategies at the individual level of the social ecology to build life skills. According to research in ***Connecting the Dots: An Overview of the Links Among Multiple Forms of Violence***, building life skills is protective for suicide, youth violence, teen dating violence and child maltreatment. MCH staff anticipates showing impact on bullying as well through a strategy focus on building life skills. MCH staff has a second strategy focus at the relationship and community levels of the social ecology on the shared protective factor school connectedness. According to Connecting the Dots, school connectedness is protective for bullying, suicide, youth violence, sexual violence and teen dating violence. In FY17, the ESM will focus on the use of the Positive School Environment Toolkit in prioritized communities, as it is unlikely that school connectedness will be impacted without building capacity within schools and communities to change school climate. The measure will be applicable to the LPHA communities/counties that select the bullying and youth suicide priority. There are multiple school districts and schools within each of those counties, so the potential users of the toolkit will depend on the number of schools engaged by LPHAs and the number of community partners that LPHAs identify as champions for this work.

Priority: Medical home for children and youth with special health care needs
NPM 11: Percent of children with and without special health care needs having a medical home
-ESM 11.1: The percentage of CYSHCN who receive HCP Care Coordination services who have an inter-agency shared plan of care.

Evidence suggests that the strategies and interventions promoting coordinated care for children and youth with special health care needs should directly impact the national performance measure: percent of children with special health care needs having a medical home. This continuing priority will identify and implement policy/systems changes that support communication and collaboration between programs that provide care coordination, enhance statewide access to pediatric specialty care, strengthen transitions for youth and their families, and expand access to information and resources for children, youth and their families. To support communication and collaboration between programs that provide care coordination for children and youth, MCH staff continues to coordinate the Colorado Care Coordination Collaborative (Team 4C). Team 4C is focused on CYSHCN enrolled in Medicaid and, to that end, is targeting systems change opportunities for local public health agencies and Medicaid's Regional Care Collaborative Organizations. These strategies and activities should positively impact the ESM and NPM 11.

Priority: Substance misuse reduction (tobacco, marijuana and prescription drugs) among pregnant and postpartum women
NPM 14: A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes
-ESM 14.1 - Percent of women who report that a doctor, nurse, or other health care worker talked with them about how smoking during pregnancy could affect their baby
-ESM 14.2 - Percent of women who report that a doctor, nurse, or other health care worker advised them during pregnancy and postpartum about the harms of their child's exposure to secondhand smoke
-ESM 14.3 - Percent of children whose parents report that their child's' health care provider talked to them about their child's exposure to secondhand smoke

See Section II.E. for information on the substance misuse SPMs.

The goal of the Tobacco priority within MCH is to reduce the percent of women who smoke during pregnancy and the percent of children who live in households where someone smokes. Two main strategies are being employed in order to reach this goal. The first strategy, is promoting the dangers of smoking and secondhand smoke to pregnant and postpartum women through OB/GYNs and other primary care providers. The second strategy, is working with pediatricians to counsel every parent about the harms of secondhand smoke to their children, and promote smoke-

free homes and cars. Staff is educating providers to screen for tobacco use at every visit during pregnancy and postpartum, and encouraging them to refer women to the Colorado QuitLine's specialized Pregnancy Protocol. Colorado's State Tobacco Education and Prevention Partnership (STEPP) administers the Colorado QuitLine Pregnancy Protocol which provides a dedicated, personal coach to pregnant and postpartum women and helps them develop an individualized quit plan. Women in this program are also eligible to earn rewards after every call that can be used to buy items for their baby. Additionally, staff is working with providers to refer women to Baby and Me Tobacco Free, a smoking cessation program created to reduce the burden of tobacco use on the pregnant and post-partum population. In July 2015, the Baby and Me Tobacco Free program expanded to 32 sites, reaching women in 33 additional counties, and Colorado is the first state to offer Baby and Me Tobacco Free services statewide. Finally, the STEPP program is promoting tobacco cessation benefits for pregnant women on Medicaid through a digital and a promotional campaign in Federally Qualified Health Centers in high tobacco prevalence counties. These promotional campaigns are geo-targeted to women on Medicaid in these counties, advertising the free benefits available to them and urging them to ask their doctor about quitting smoking. In addition to the consumer-promotion, the program provides quarterly training webinars to Medicaid providers, detailing how to bill Medicaid and how to treat tobacco dependence in special populations, such as low-income and pregnant women. The chosen ESMs serve as logical measures of Colorado's main goals to impact the NPM.

II.E. Linkage of State Selected Priorities with State Performance and Outcome Measures

- SPM 1 - Percent of mothers that report a doctor, nurse or other health care worker talked with them about what to do if they felt depressed during pregnancy or after delivery
- SPM 2 - Infant mortality rate among African Americans in Denver and Arapahoe counties
- SPM 3 - Percent of women who report using marijuana at any time during their pregnancy
- SPM 4 - Rate of emergency department visits for women for prescription drug use poisoning per 100,000 women ages 15 through 44
- SPM 5 - Rate of hospitalizations for prescription drug poisoning per 100,000 women ages 15 thought 44

Logic models and action plans were created for each priority during this planning year. Both the logic models and action plans outline goals, strategies, and short, medium and long-term outcomes with associated action plans that detail specific activities designed to impact the newly identified SPMs. The Colorado MCH program chose five SPMs, which serve as logical measures for the strategies chosen.

1. Priority – Women's mental health, including pregnancy-related depression

SPM 1: Percent of mothers that report a doctor, nurse or other health care worker talked with them about what to do if they felt depressed during pregnancy or after delivery

Since CDPHE adopted this priority area in 2011, marked progress has been made in the number of mothers reporting their providers spoke to them about what to do when experiencing depressive symptoms, from 73.8 percent in 2010 to most current data showing 78.0 percent of Colorado women participated in a conversation in 2013 (Colorado PRAMS). Efforts to increase the number of providers talking to mothers about depression will continue along with efforts to decrease stigma, increase help-seeking behavior, and enable more women to receive help.

2. Priority – Reduction of infant mortality among African Americans
SPM 2: The infant mortality rate among African Americans in Denver and Arapahoe counties

Given the significant health disparity in birth outcomes among Colorado's African American population, the MCH program will continue to focus on reducing infant mortality among African Americans, aiming for a rate of 4.0 for all Coloradans. This work will be focused in the two counties with the largest African American populations: Denver and Arapahoe.

3. Priority – Substance misuse reduction (tobacco, marijuana and prescription drugs) among pregnant and postpartum women
SPM 3: Percent of women who report using marijuana at any time during their pregnancy
SPM 4: Rate of emergency department visits for prescription drug poisoning per 100,000 women ages 15 through 44
SPM 5: Rate of hospitalization for prescription drug poisoning per 100,000 women ages 15 through 44

Colorado decriminalized marijuana use for medicinal purposes in 2000 and, in November of 2012, became one of the first two states to legalize recreational marijuana for adults ages 21 and over. Colorado's efforts to systematically review the somewhat limited literature regarding the effects of marijuana use during pregnancy and postpartum has indicated levels of risk for both prenatal and postpartum use. Pregnancy Risk Assessment Monitoring System (PRAMS) data regarding marijuana use during pregnancy and postpartum is not yet available from the CDC, which is one of the many reasons why the state will be piloting the use of internet panels for data collection. (See Emerging Issues section, Health eMoms Project).

An estimated 15.3 percent of childbearing-age women ages 15-44 in Colorado use illicit drugs, which includes the misuse of prescription drugs. Colorado ranks among the top states with the highest rates of illicit drug use among adults and has the second-highest rate of opioid abuse in the U.S. according to the 2013-2014 National Survey on Drug Use and Health. Given the potential for neonatal abstinence syndrome among pregnant opioid users and the other data points listed above, decreasing marijuana and prescription drug use among pregnant and postpartum women is therefore a major part of the new substance misuse priority.

See Section IID. for information on the tobacco NPM and ESMs.

For more about Colorado's priority work and the corresponding SPMs see Section II.F.1.

II.F. Five Year State Action Plan

II.F.1 State Action Plan and Strategies by MCH Population Domain

Women/Maternal Health

State Action Plan Table

State Action Plan Table - Women/Maternal Health - Entry 1

Priority Need

Women's mental health, including pregnancy-related depression

NPM

Percent of cesarean deliveries among low-risk first births

Objectives

By 6/30/2017, identify delivering hospitals in CO, with NTSV Cesarean Section rates above 23.9 percent and/or a Colorado-identified benchmark.

Strategies

Develop a C/S reduction/QI collaborative among hospitals with high (23.9 percent or above) NTSV C/S rates.

ESMs

ESM 2.1 - Completion of a report identifying NTSV data/rates for all Colorado delivering hospitals to identify facilities for C/S reduction/QI interventions

NOMs

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

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

State Action Plan Table - Women/Maternal Health - Entry 2

Priority Need

Women's mental health, including pregnancy-related depression

SPM

Percent of mothers that report a doctor, nurse or other health care worker talked with them about what to do if they felt depressed during pregnancy or after delivery

Objectives

By 2017, increase the number of Medicaid providers who screen pregnant or postpartum women for PRD from 16.1 percent to 20.1 percent as measured by Regional Care Collaborative Organization (RCCO) Medicaid claims data.

Strategies

Strengthen referral networks for providers to address PRD.

Measures

NPM 2 - Percent of cesarean deliveries among low-risk first births

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	20.2	19.8	19.4	19	18.5	18.1

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	20.4 %	0.3 %	4,625	22,687
2013	20.6 %	0.3 %	4,686	22,806
2012	21.2 %	0.3 %	4,838	22,840
2011	20.0 %	0.3 %	4,664	23,311
2010	21.1 %	0.3 %	4,973	23,596
2009	21.7 %	0.3 %	5,236	24,147

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

ESM 2.1 - Completion of a report identifying NTSV data/rates for all Colorado delivering hospitals to identify facilities for C/S reduction/QI interventions

Annual Objectives

	2017	2018	2019	2020	2021
Annual Objective	Yes	Yes	Yes	Yes	Yes

Women/Maternal Health - Plan for the Application Year

Priority: Women's Mental Health, including Pregnancy Related Depression (PRD)

New NPM 2: Percent of cesarean deliveries among low-risk first (NTSV) births

ESM 2.1: Completion of a report identifying NTSV data/rates for all Colorado delivering hospitals to identify targets for reduction/QI

The NPM 2 target for 2016 is 20.2 percent. The target for 2017 is 19.8 percent.
The ESM 2.1 target for 2017 is to complete the comprehensive data report to identify hospitals with higher than expected rates. A new ESM will be established for 2018 and targets established.

In the Fall of 2015, partners from the Colorado Department of Health Care Policy and Financing (HCPF) provided CDPHE staff with quality improvement data for hospitals, looking at the percentage of cesarean deliveries among low-risk, first births. Findings were provocative as they uncovered wide variation in practices across Colorado hospitals, ultimately motivating CDPHE staff to pursue this as a priority area. Experts from multiple sectors have expressed interest in working together to address this; therefore CDPHE staff established a collaborative planning group with representation from HCPF, CDPHE, the Colorado Perinatal Care Quality Collaborative (CPCQC), and

Maternal-Fetal Medicine specialists to identify a path forward.

Preliminary research from this planning group identified five key strategies to address this issue at a systems level: 1) leverage data for quality improvement, 2) implement consumer education and decision support, 3) redesign payment methods, 4) review benefits design, and 5) enhance patient care through standardized clinical practices. Each strategy features a distinct tactic for reducing the Nulliparous Term Singleton Vertex (NTSV) C-Section rate. To determine the applicability of each strategy to the Colorado context, CDPHE staff will continue to consult with national experts involved in the development and implementation of the California Maternal Quality Care Collaborative's *Supporting Vaginal Birth Toolkit*, the Pacific Business Group on Health's resources for decreasing the C-Section rate and reducing hospital C-Section variation in California, and the American College of Obstetricians and Gynecologists (ACOG) Council on Patient Safety in Women's Health Care *Safe Reduction of Primary Cesarean Birth Patient Safety Bundle*. The planning group will use lessons learned from these partners as well as the corresponding resources to inform and support the efforts in Colorado. In particular, given the successful decrease of the NTSV C-Section rate in California among select hospitals, the planning group has determined that the California Maternal Quality Care Collaborative's Supporting Vaginal Birth Toolkit will help to provide the foundation for Colorado's future efforts.

Planning group members have reviewed guidelines, committee opinions, and special reports released by ACOG and Society for Maternal-Fetal Medicine (SMFM). The February 2016 SMFM Special Report *Comparing variation in hospital rates of cesarean delivery among low-risk women using three different measures* (Armstrong et al.) encouraged the planning group to adopt the SMFM recommended measures for NTSV and pursue collecting these data in Colorado through the All-Payers Claims Database and Vital Statistics records. This methodology will enable Colorado to establish more reflective and appropriate baseline NTSV rates and measure the effect of implementing interventions by hospital. During 2017, the planning group will develop a comprehensive data report detailing C/S rates among NTSV. Concurrently, a project will be undertaken by the group's maternal-fetal medicine specialist to match NTSV C/ S cases from 2015 with the All Payer Claims Database to assess this rate more broadly, including sequelae, among those experiencing C/S births. These data will then be used to identify hospitals/providers with NTSV C/ S rates exceeding 23.9%, the Healthy People 2020 goal. Hospitals will be encouraged to join a quality improvement collaborative, utilizing strategies piloted in California, to lower these rates.

Pregnancy-related depression

New SPM 1: Percent of mothers that report 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 2017 is 80.0 percent. The target for 2018 is 81.9 percent.

The pregnant and postpartum period is a critical time to identify and address maternal mental health problems, for both mother and child. Since CDPHE adopted this priority area in 2011, marked progress has been made in the number of mothers reporting their providers spoke to them about what to do when experiencing depressive symptoms, from 73.8 percent in 2010 to most current 2013 data showing 78.0 percent of Colorado women had this conversation (Colorado PRAMS). However, even when women are screened and referred for treatment, stigma continues to act as a major barrier to women seeking out needed mental health treatment. This impacts public health primary prevention efforts designed to minimize the onset of PRD, as well as the secondary prevention efforts aimed at promoting early treatment to prevent worsening of symptoms over time.

Therefore, state and local plans crafted by CDPHE staff ultimately aim to decrease stigma, increase help-seeking behavior, and enable more women to receive assistance in addressing symptoms. To accomplish this goal, CDPHE staff identified three key strategies: 1) develop and implement a public awareness campaign to reduce stigma; 2)

strengthen referral networks; and 3) increase provider competencies to address maternal mental health.

Formative market research (see below) for a public awareness campaign has been conducted and CDPHE staff is in the contracting process to identify a marketing firm to develop the creative materials and evaluation plan to determine the campaign's impact. Community partners statewide have asked for messaging and creative materials to be developed so they can disseminate them through their networks. Similarly, CDPHE will work with the marketing firm to implement a targeted digital campaign via commonly used media platforms for mothers, like BabyCenter, based on the mother's Colorado zip code. In the coming year, CDPHE staff will also work with non-traditional partners like children's consignment shops and prenatal yoga locations to broaden the reach of the campaign. This campaign will aim to increase awareness that pregnancy-related depression is common and it is okay to ask for help.

However, stigma is not the only obstacle to receiving needed mental health care – gaps in services, referral inconsistencies, limited access (especially in rural areas), and limited training for providers all are endemic challenges to accessing treatment. As campaign resources aim to encourage women to feel 'okay' seeking help, CDPHE staff will also work to build up the referral network to ensure that appropriate referral mechanisms are identified so women who are feeling more confident asking for help will know where to get help. CDPHE staff will continue working with the Colorado chapter of Postpartum Support International to link women who call their 'warm line' to community level resources. Similarly, CDPHE will re-administer its screening and referral survey to get mid-point data on current practices among Colorado providers. This will enable staff to better understand the impact of efforts from 2011 to 2015, adjust activities based on the data collected and identify hot-spots for targeted efforts moving forward. Staff will also review additional mechanisms for referral like the Crisis Hotline to determine what protocols are in place for pregnant and postpartum women and identify how they can be strengthened moving forward.

CDPHE staff involved in the concurrent Substance Abuse and Mental Health Services Administration (SAMHSA)-funded Colorado Project LAUNCH (Linking Actions for Unmet Needs in Children's Health) will also be implementing a comprehensive screening-referral-follow up process for pregnant and postpartum women through integrated behavioral health and comprehensive care navigation approaches in selected partner clinics and school districts. As part of this project, a pregnancy-related depression (PRD) public awareness video and materials will be developed and used by providers in clinics to talk to women experiencing depression.

CDPHE will continue to enhance existing collaborations and define new partnerships among those serving pregnant and postpartum women, with a specific focus on underserved populations. One example of this is the newly enhanced relationship between the Colorado Department of Health Care Policy and Financing staff and CDPHE staff through an interagency agreement to provide more real-time depression data.

Efforts continue to be guided by professional expertise from over 60 Colorado health professionals on the CDPHE Pregnancy-Related Depression State Advisory Committee. Moving forward, advisory committee members have decided to pursue the development of 'Maternal Mental Health Competencies' for providers. It was determined that Colorado is not yet ready for Maternal Mental Health Credentialing, given the pre-existing shortage of providers and challenges with network adequacy. However, many providers in Colorado do not feel competent or confident addressing mental health issues. Therefore, CDPHE staff will convene a group of expert stakeholders to develop a set of core 'competencies' for providers (specific provider type to be identified). A system of incentives will be identified and these will be piloted in target communities to refine and adjust before statewide scale-up.

Additional activities to strengthen provider competencies include efforts in conjunction with the Colorado State

Innovation Model (SIM) project. SIM is a statewide initiative funded by the Centers for Medicare and Medicaid Innovation (CMMI), that seeks to improve the health of Coloradans by providing access to physical and behavioral health care services in integrated systems, with value-based payment structures. In year one, 100 practices were selected across the state to carry out the mission of SIM by integrating behavioral health services into existing primary care settings. SIM practices will collect and report on six clinical quality measures (CQMs) intended to track patient and process outcomes, one of these measures being maternal depression screening (NQF1401). As a component of the SIM Provider Education Plan, CDPHE staff partnered with The University of Colorado School of Public Health to create and pilot a provider education module on Perinatal Mood and Anxiety Disorders. Findings from the pilot study will be reviewed so the module can be refined and implementation can be scaled up in the future.

CDPHE staff have also partnered with Assuring Better Childhood and Development (ABCD) teams to integrate pregnancy-related depression screening and referral initiatives into practice-based quality improvement efforts already occurring for developmental screening. Early identification and treatment of PRD and connection to additional supports for those at risk for PRD, can enhance protective factors and minimize the detrimental impact of PRD on a mother's attachment and relationship with her children. To facilitate this, ABCD received approval from the American Board of Pediatrics, the American Board of Family Practice and the American Board of OB-GYN for a quality improvement initiative within medical practices to support PRD screening and referral processes. Local public health agency personnel from Denver, Tri-County, and Northeast Colorado Health Departments have agreed to help facilitate and support these efforts at the local level as well.

From 2016 to 2020, local public health agencies who select this priority area will be asked to work towards 1) implementing a public awareness campaign and 2) strengthening local referral networks. CDPHE staff will continue to provide technical assistance to local public health agency staff moving forward.

Legislative requirements outlined in 501 (a)(1) and 505

Colorado's approach to choosing priorities aligns with the public health assurance role outlined in 501 (a)(1). Also, by virtue of MCH program policy and procedures, Colorado is fully compliant with the requirements outlined in section 505. Specific information in reference to 501 and 505 is included throughout the block grant application and report.

Critical partnerships with other MCHB-supported programs

MCH program partnerships with other MCHB-supported programs are discussed in section B.2.c. and throughout the population-domain program updates.

Women/Maternal Health - Annual Report

Old 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.

For reporting year 2015, 78.0 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 2015 was 79.0 percent and the target was not met.

CDPHE staff continued to disseminate the PRD guidance documents developed in collaboration with *HealthTeamWorks* to meet the needs of both clinical and non-clinical professionals who work with pregnant and/or postpartum women. These Colorado-specific guidance documents address screening and referral protocols for PRD. Opportunities for dissemination included presentations to the Colorado Public Health Nurse Leaders, Colorado NICU Consortium, 2020 Mom California Maternal Mental Health Task Force, and at the City Match

Conference. These guidance documents serve as helpful tools for providers of all levels to feel more equipped to 'start the conversation' with women.

During 2014 and 2015, CDPHE staff continued to facilitate educational opportunities for providers around the state. This includes the provision of scholarships to ten rural providers to enroll in the 2020 Mom/Postpartum Support International Maternal Mental Health Certificate Program. Part of this education included the dissemination of up-to-date professional organization guidelines on when to screen women and how to bill for screening.

In 2015, CDPHE staff convened a group of 30 providers from around the state to develop Colorado-specific recommendations to reduce preterm birth. An ever growing body of research shows an association between depression and preterm birth, therefore, addressing depression in the pregnancy and postpartum periods was identified as a key recommendation to reducing preterm birth.

Between 2004 and 2012, 30 percent of maternal deaths in Colorado were due to suicide and accidental drug overdose. To better understand the impact pregnancy-related depression has on Colorado women, CDPHE staff worked with the Colorado Maternal Mortality Review Committee on a descriptive study to determine prevalence of depression, mood and anxiety disorders, and distinguish what drugs (recreational and prescription) were most commonly associated with overdose deaths. Findings were presented at the annual American Congress of Obstetricians and Gynecologists (ACOG) conference and the Colorado Maternal Mortality & Morbidity Symposium. Committee members were invited to submit for publication in the American Journal of Obstetrics & Gynecology, where the formal manuscript is currently in the peer-review process.

To better understand the interplay of stigma and help-seeking behaviors, CDPHE staff worked with the Colorado Health Institute to utilize 2015 Colorado Health Access Survey data to look at reasons women of reproductive age forego needed mental health treatment. These additional analyses revealed that over the past 12 months, 13.3 percent of Colorado women of reproductive age said there was a time when they needed mental health care or counseling services but did not get it. Of these women, nearly half (48 percent) reported they did not get services because they did not feel comfortable talking with a health professional about their personal problems; and more than a third (35 percent) said they were concerned about what would happen if someone found out they had a problem.

Results reinforced the need for a public awareness campaign aimed at decreasing stigma around maternal mental health. Given the limited resources available to do this, it was a priority to reach women with the highest burden of disease – those with low socio-economic status – and women of color. Therefore, CDPHE collaborated with a marketing firm and epidemiologist to conduct research with affected moms of low socio-economic status in Denver, Larimer, Tri-County, and Logan counties and their identified support networks (e.g. friend, partner, parent) to inform future campaign development. Additional community discussions were conducted with African American women throughout the Denver-metro area to learn from them and allow for the creation of culturally appropriate messages. Finally, healthcare professionals were consulted through pre-existing networks (PRD State Advisory Committee, Maternal Mortality Review Committee, local public health agency staff, etc.) and by means of a provider survey (206 respondents). Messages and images were also tested with these communities and formal recommendations were issued. These will be used as CDPHE staff move forward to engage in work to develop and implement the creative campaign materials.

Through Colorado Project Launch, CDPHE staff collaborated with state and local community partners to identify the intersections of maternal and child mental health with entities such as the PRD Action Team (part of the Early Childhood Partnership of Adams County), the Maternal, Infant, and Early Childhood Home Visitation (MIECHV) state program, Strengthening Families/Two-Generation initiatives, and others. During this time, the group released a

statewide and Adams County-specific environmental scan of services and programs serving prenatal, pregnant, and postpartum women. Findings were used to inform activities moving forward.

Technical assistance was provided to local public health agencies addressing pregnancy-related depression throughout the state. This included assistance with the development and implementation of local action plans, local surveys, presentation of educational materials at locally held training events, development of resource tools, facilitation of cross-agency collaboration, and participation in local public health advisory committees. Remarkable progress has been made by local partners, including the development of a standard for pregnancy-related depression screening for providers at Denver Health; roll out of PRD screening at seven clinics within the Denver-metro area; and the development of community-specific referral resources in Chaffee and Northeast Counties.

Table for Women/Maternal Health Priorities and PMs that will not Continue

Performance Measure and/or Priority	Last Year's Accomplishments and Current Activities
SPM 1: Percentage of sexually active women and men ages 18-44 using an effective method of birth control to prevent pregnancy	The annual indicator for reporting year 2015 was 65.5 percent. The target for reporting year 2015 was 69.0 percent. The target was not met. Colorado continues to work to increase access to long-acting reversible contraceptives by reducing cost barriers, training providers and other clinic staff on best practices, and supporting education and outreach to men and women of reproductive age in Colorado.

Perinatal/Infant Health

State Action Plan Table

State Action Plan Table - Perinatal/Infant Health - Entry 1

Priority Need

Early childhood obesity prevention

NPM

A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months

Objectives

Increase the number of Colorado hospitals designated Baby-Friendly from three in 2015 to nine by 2017 as reported by Baby-Friendly USA.

Strategies

Provide technical assistance and networking to promote breastfeeding-friendly practices in hospitals with maternity services.

ESMs

ESM 4.1 - Number of delivering hospitals in Colorado that are certified as Baby-Friendly

NOMs

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

State Action Plan Table - Perinatal/Infant Health - Entry 2

Priority Need

Reduction of infant mortality among African Americans

SPM

Infant mortality rate among African Americans in Denver and Arapahoe counties

Objectives

By 2017, increase the number of healthcare systems (from 0 to 1) and providers (from 0 to 15) actively implementing the Colorado preterm birth clinical recommendations.

Strategies

Develop and disseminate statewide preterm birth prevention recommendations.

Measures

NPM-4 A) Percent of infants who are ever breastfed

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	81.5	82.3	83.0	83.8	84.5	85.3

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	86.3 %	2.7 %	56,553	65,529
2011	81.0 %	3.2 %		
2010	79.5 %	4.1 %		
2009	86.0 %	2.9 %		
2008	81.4 %	2.7 %		
2007	87.7 %	2.3 %		

Legends:

Indicator has an unweighted denominator <50 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

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

Annual Objectives

	2016	2017	2018	2019	2020	2021
Annual Objective	26.0	26.5	27.0	27.5	28.0	29.5

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	30.3 %	3.3 %	19,394	64,063
2011	25.8 %	3.2 %		
2010	21.2 %	3.7 %		
2009	21.9 %	3.6 %		
2008	22.3 %	2.4 %		
2007	21.5 %	2.8 %		

Legends:

Indicator has an unweighted denominator <50 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 4.1 - Number of delivering hospitals in Colorado that are certified as Baby-Friendly

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	9.0	12.0	12.0	18.0	19.0

Perinatal/Infant Health - Plan for the Application Year

Priority: Reduction of Infant Mortality among African Americans

New SPM 2: Infant mortality rate among African Americans in Arapahoe and Denver counties.

SPM 2: The target for reporting year 2017 is 11.0. The target for 2018 is 9.0.

Related activities, accomplishments, challenges and revisions for this time period:
Given the significant health disparity in birth outcomes among Colorado's African American population, CDPHE's plan continues to focus on reducing infant mortality among African Americans, aiming for a rate of 4.0 for all Coloradans. Between October 2015 and April 2016, state and local logic models and action plans were created to prioritize and guide evidence-based strategies, supported by Title V funding, in the target areas.

A significant milestone was the 2015 creation of the Colorado Preterm Birth Recommendations. This set of recommendations followed a thorough review and analysis of existing preterm birth guidelines and a collaborative planning process among a 30-member workgroup of clinicians as well as public health and other system partners. CDPHE received the 2015 Statewide Mission Impact Partner Award from the March of Dimes in recognition of this accomplishment.

As part of our focus on monitoring and communicating disparities and inequality in birth outcomes, Colorado participates in the national CoIIN infant mortality and preterm birth data tracking system. This information, including deaths related to maternal mortality, is then reformatted and disseminated quarterly via an online Infant Mortality Data Dashboard for use by state and local partners in grant applications, burden reports, and public-facing communications. Recent modifications include the addition of ICD-10 codes used to identify SUID deaths and clarification that the data represent resident births and deaths. A collaboratively developed public television documentary *Precious Loss* was created and aired, along with companion pieces such as a panel discussion entitled *Race in Colorado: Infant Mortality* in which a Rocky Mountain PBS News investigation explored the disparities in infant deaths by race; why the US lags behind other Western nations in infant mortality; and why babies born to Colorado minority families, blacks in particular, have a greater chance of dying before their first birthdays than whites. The panel discussion included Dr. Larry Wolk, Executive Director of the Colorado Department of Public Health and other system partners. Additional presentations were provided to the Safe Deliveries conference hosted by Colorado Hospital Association and the Colorado Perinatal Care Quality Collaborative and to faculty, students, and staff at the Colorado School of Public Health (100 participants) to promote infant mortality efforts, Colorado Preterm Birth Recommendations, and family friendly employment opportunities as well as the data dashboard as resource.

A state-level strategy assessment was completed and submitted to the federal infant mortality national technical assistance provider. It was noted that in most cases policy work is occurring but not representative of a broad, statewide effort. Passage and implementation of state-level policies is impacted by Colorado's "Taxpayer's Bill of Rights," a tax and spending limitation in the state. The state infant mortality lead met with a member of the state paid leave policy advocates to discuss identified data needs. This resulted in the investigation of adding employment questions to the Colorado PRAMS survey.

A key infant mortality staff member participated in the March of Dimes Prematurity Prevention Conference and networked with other states to better understand their experiences with what has/has not worked in their settings (e.g. in Virginia group prenatal care for women who were medically high risk for preterm birth was much more successful than traditional forms of group care).

Milestones anticipated in 2016 include targeted dissemination of the Colorado Preterm Birth Recommendations; working with employers to adopt family-friendly workplace policies shown to improve perinatal outcomes, such as breastfeeding accommodations, flex-place, and paid or unpaid maternity/paternity leave; and cross-jurisdictional planning to increase mutually-reinforcing activities among partner groups. Through September 2017, state-level CoIIN efforts will specifically include:

Strategies
Disseminate statewide preterm birth prevention recommendations
Work with health plans to incentivize adoption of preterm birth recommendations
In jurisdictions with high infant mortality rates, increase business-sector implementation of policies shown to improve perinatal outcomes
Engage in strategic partnerships with infant mortality-focused initiatives
Develop mechanisms to share data and performance metrics across initiatives
Short Term Outcome Targets (1 year)
Initiatives with similar goals begin co-promotion of preterm birth recommendations
Providers, hospitals & community members have access to evidence-based recommendations for addressing preterm birth
Employers located in jurisdictions of high infant mortality are engaged in conversations about family friendly employer practices
Increased awareness of shared strategies among existing efforts
Increased connectivity and shared measurement among existing efforts
Long Term Outcome Targets (3-5 years)
Increased adoption of PTB prevention strategies in clinical and non clinical settings

Percent of pregnant women on Medicaid with a prior preterm birth who receive progesterone is increased 10 percent over baseline
Increased number of businesses implementing FFE practices over baseline
Increased engagement in infant mortality reduction strategies
Increased achievement of shared outcomes

Local level strategies will include assuring that African American women and their families in Denver and Arapahoe counties are enrolled in all eligible benefit programs, including a better connection with the Regional Care Collaborative Organization serving Denver and Arapahoe counties; increasing participation among African American women in group prenatal care; assuring the provision of culturally-informed care; increasing lactation support and peer counseling for African American women; promotion of family-friendly employer policies; and linking systems of care for better coordination of services to child-bearing aged African American women and their families.

Partnerships that will continue to be leveraged in support of these efforts include: MCH resources and staff; other federal grants (e.g., Essentials for Childhood, Healthy Start); Metro Infant Mortality Community Action Network; investment among the African American community; state agency partnerships (e.g., Colorado Departments of Health Care Policy and Financing and Human Services); Denver metro area local public health agencies; CDPHE and local data collection and analysis; Colorado Opportunity Project; Colorado March of Dimes; Federal (NICHQ) CoIIN technical assistance; Colorado Infant Safe Sleep Partnership; Child Fatality Prevention System State Review Team; Colorado School of Public Health; and the Colorado Black Health Collaborative.

Priority: Early Childhood Obesity Prevention (ECOP) – Breastfeeding

New NPM 4: a) Percent of infants who are ever breastfed b) Percent of infants breastfed exclusively through 6 months

ESM 4.1: Number of delivering hospitals in Colorado (out of 56) that will be certified as Baby-Friendly

The target for the percent of infants who are ever breastfed for reporting year 2016 is 81.5. The target for 2017 is 82.3. The target for the percent of infants breastfed exclusively through six months for reporting year 2016 is 26. The target for 2017 is 26.5.
The target for ESM 4.1 for reporting year 2017 is 9. The target for 2018 is 12.

The Colorado Baby-Friendly Hospital Collaborative (CBFHC) was created in 2013 to address the CDPHE priority to reduce obesity during early childhood through hospital support of exclusive breastfeeding. Implementing Baby-Friendly Hospital Initiative's *Ten Steps to Successful Breastfeeding* improves breastfeeding prevalence and increases breastfeeding support throughout local communities statewide. October 2015 marked the beginning of the third year of the Collaborative. CDPHE will continue to provide technical assistance to staff from the 17 participating hospitals in the Collaborative through three webinars and a full-day annual networking workshop. CDPHE will contract with one of the two remaining CBFHC hospitals eligible to receive one-time funding to fulfill activities associated with the Baby-Friendly designation by the end of the reporting year 2016. CDPHE will continue to collect and track hospital data to monitor quality improvements in Collaborative hospitals and the overall impact of the Collaborative on breastfeeding rates.

In late 2015, Boulder Community Health and Aspen Valley Hospital became the Collaborative's first hospitals to become designated Baby-Friendly. As of July 2016, three additional Collaborative member hospitals are now designated, Valley View Hospital, Saint Anthony North Health, and the largest birthing facility in the state, Saint Joseph's Hospital, raising Colorado to eight officially designated facilities. Three other Collaborative hospitals have site visits with Baby-Friendly USA auditors, the final step to becoming designated, scheduled in 2016. Colorado anticipates having 11 Baby-Friendly hospitals by September 2017.

CDPHE assessed non-participating hospitals for interest in becoming Baby-Friendly designated and joining a second cohort of the Collaborative. Nine hospitals, many in Colorado's rural areas, have expressed interest in joining the Collaborative. Due to this interest, a second cohort of CBFHC is being created. CDPHE will draft a charter and host a second cohort Baby-Friendly informational and networking kickoff workshop during the summer of 2016. New member hospitals will be invited to join the Collaborative following the workshop. The second cohort will join the first cohort during technical assistance webinars for the later part of 2016 and 2017, and the annual networking workshop in September 2016. Combining the first and second cohorts will allow the veterans of the group to share their knowledge, best practices, lessons learned and expertise to help staffs from hospitals beginning the Baby-Friendly journey successfully complete the steps.

CDPHE continues to convene the Baby-Friendly Hospital Collaborative Advisory Committee to inform and provide technical assistance to hospitals participating in the CBFHC, both first and second cohorts.

CDPHE provides technical assistance and supports local public health agencies (LPHAs), the Colorado Breastfeeding Coalition and statewide partners in workplace lactation accommodation. The majority of employed mothers return to work during their infant's first year of life. Workplaces play a critical role in supporting breastfeeding mothers to initiate and sustain breastfeeding, thus impacting breastfeeding duration and exclusivity rates. Technical assistance and support includes quarterly learning circle networking conference calls and one-on-one calls, lactation policy templates, toolkits, resource sharing, and statewide webinars on lactation accommodation laws, policies, implementation tips and best practices. Newer partners include four Cancer, Cardiovascular and Pulmonary Disease (CCPD) grantees, in which lactation accommodation work began July 2015. LPHAs and partners are working to increase workplace lactation accommodation policies and implementation of the Colorado statute in local businesses, including, but not limited to, a focus on employers of low income women/hourly workers, child care settings, retail establishments, and school districts. Since July 2015, grantees have worked with over 30 workplaces and child cares throughout the state to establish lactation policies, create lactation rooms and recognize workplaces for their breastfeeding supportive practices. For 2017, CCPD grantees are targeting 88 workplaces and child cares in 14 counties. CDPHE will investigate the development of a Colorado resource toolkit and business recognition program.

Increasing breastfeeding support in child care is important to have a positive impact on breastfeeding duration and exclusivity. Through the Breastfeeding in Child Care Advisory Committee, CDPHE will implement its plan to address the gaps in breastfeeding knowledge, skills, attitudes and practices of Colorado child care directors and providers identified in a 2014 assessment survey. CDPHE, in partnership with Committee members, will review currently available state and national breastfeeding in child care resources and create a statewide resource toolkit, identify technical assistance and training opportunities, and potentially develop a recognition program for early care and education providers. Breastfeeding in Child Care toolkits will be disseminated to all licensed child care providers participating in the Child and Adult Care Food Program (CACFP) and CDPHE will work closely with LPHAs and other partners (such as the Family, Friends and Neighbor care network) to distribute to additional providers throughout Colorado communities. Additionally, a small number of LPHAs have elected to work in their communities to disseminate the toolkit, provide technical assistance to child care providers, offer breastfeeding training, and form committees to further this priority at the local level.

Two local agencies within the Colorado WIC Program, Boulder and Tri-County, applied for the 2016 Loving Support Award of Excellence Gold Award for their strong breastfeeding support and successful peer counselor programs. Colorado will again host Lactation Management Specialist (LMS) training June of 2016 to all WIC staff to provide increased breastfeeding knowledge and support throughout Colorado WIC agencies. The training was developed specifically for Colorado WIC and provided by a physician lactation expert biennially. The LMS training, space

permitting, is also offered to LPHAs, community health workers, or other interested individuals looking to receive breastfeeding education. The training is a three-day workshop that includes a comprehensive exam and required observation hours, and upon completing permits individuals to be considered Lactation Management Specialists and provide more advanced breastfeeding support to clients.

Legislative requirements outlined in 501 (a)(1) and 505

Colorado's approach to choosing priorities aligns with the public health assurance role outlined in 501 (a)(1). Also, by virtue of MCH program policy and procedures, Colorado is fully compliant with the requirements outlined in section 505. Specific information in reference to 501 and 505 is included throughout the block grant application and report.

Critical partnerships with other MCHB-supported programs

MCH program partnerships with other MCHB-supported programs are discussed in section B.2.c. and throughout the population-domain program updates.

Perinatal/Infant Health - Annual Report

Priority: Reduction of Infant Mortality among African Americans

The reduction of infant mortality among Colorado's African American population was identified as an emerging priority through the 2014-15 needs assessment and prioritization process. Colorado's overall infant mortality rate falls below the Healthy People 2020 goal for the U.S., however, rates for African Americans far exceed the rate for other racial and ethnic groups in Colorado. Because of this, Colorado elected to participate in the national Infant Mortality Collaborative Innovation and Improvement Network (CO CoIIN). A delegation of Colorado's CoIIN team attended the 2014 and 2015 National Infant Mortality Summits and drafted the following vision and aim statements.

Identified Priorities:
1. Expand the content and increase the quality of preconception/prenatal/ postpartum interventions.
2. Address the impact of social determinants of health.
3. Improve the capacity of women and families to protect and promote their health.

Given that the African American population is highest in Arapahoe (10.8 percent) and Denver (10.2 percent) counties, local strategies were developed to focus cross-jurisdictionally in these two areas of the state. Perinatal Periods of Risk (PPOR) analyses completed in both counties indicated the existence of excess fetal-infant death in the maternal health/prematurity and infant health categories. State and local level strategies associated with each of these areas were researched and analyzed for potential adoption and the following vision and aim were identified.

Vision: Colorado 4.0 - Each and every baby celebrates a first birthday.
Aim: Reduce Colorado's African American infant mortality rate to the current White, non-Hispanic rate (4.0/1,000) or below by employing complementary strategies at both the state and local level.

The Colorado Infant Mortality CoIIN Team met regularly since its inception in July of 2014. In October 2015, the team voted to officially join with the Healthy Start Infant Mortality Community Action Network in order to increase alignment of efforts and ability to achieve outcomes. As part of the national CoIIN movement, the team participated as active, contributing members of the Social Determinants of Health National Learning Collaborative and engaged in ongoing webinars, national discussions, and requested assessments.

State level strategies explored included developing a statewide set of preterm birth prevention guidelines for providers, including efforts to assure that only medically indicated inductions and C-Sections occur within the hospital

setting; development of a perinatal quality collaborative to guide data collection and perinatal quality improvement within the hospital setting; promote the use and acceptability of long-acting reversible contraceptives (LARC); increase the number of Baby Friendly Hospitals in the state; ensure that safe sleep recommendations are employed and support family-friendly policy development, particularly within the Supplemental Nutrition Program for Women, Infants and Children program (WIC), Tobacco QuitLine, etc. This initial list of potential strategies was prioritized according to feasibility, momentum, and impact. While each of the strategies considered will be supported by current partners, the Colorado CoIIN Team elected to focus its multi-year action plan on a) the development and implementation of preterm birth recommendations, b) family-friendly employer policies, and c) analysis and communication of data to better demonstrate and target efforts to reduce African American infant mortality.

Ongoing technical assistance was provided to local health departments in the target area. Beginning 1/1/16, Colorado's Boulder County extended paid leave for new birth or adoptive parents. The policy change was guided by public health and Boulder County early childhood advocates. The new policy extends paid parental leave for county employees from one week to four weeks, which can be followed by available paid leave and/or utilized as part of Family Medical Leave Act (FMLA) leave for a maximum of 12 weeks off. The county's parental leave extension follows growing recognition across the country about the importance of early childhood development. In order to support outcomes among the local public health agencies in our target jurisdictions, state staff monitored this effort to document steps for potential replication.

Additional state and local efforts included:

- CoIIN team members actively contributed to the work of Colorado's Perinatal Quality Care Collaborative, NICU Consortium, and Healthy Start Infant Mortality Community Action Network.
- CDPHE, along with funded local public health agencies, partnered with Families Forward Resource Center (FFRC) to explore the establishment of referral systems among service delivery programs; FFRC implements the Healthy Start federal program for infant mortality health disparities, with 250 newly enrolled participants.
- Denver Public Health worked with its Montebello Health Center to initiate a new, culturally specific, Group Prenatal Care model that recruits for black participants, beginning February 2016. Group Prenatal Care is one of the only RCT tested interventions shown to reduce pre-term birth and low birth weight in African Americans. To improve the site's capacity to offer culturally relevant care and retain African American enrollees, Denver Health assisted the center in recruiting an African American provider to support the Centering Pregnancy program, which was highlighted in a biographical article and advertisement for group care in the local paper, The Urban Spectrum, in April 2016. Denver Health also assisted in the recruitment of a local African American group care facilitator who is also a Family Advocate with Healthy Start. Group care is now slated for expansion into several Denver Health clinics.
- Funded local public health agencies performed outreach to the African American community on infant safe sleep. Activities included teaching displays at events, dissemination of a video emphasizing the father's role, and the adoption of a focus on safe sleep by legislatively mandated Child Fatality Review Committees.
- Denver Public Health worked internally to advocate for the availability of 17P, a hormone injection that staves off preterm labor, at all Denver Health Community Health Centers.

Priority: Early Childhood Obesity Prevention (ECOP) – Breastfeeding

Old NPM 11: The percent of infants who breastfed at 6 months of age

The annual indicator for reporting year 2015 was 60 percent of infants who breastfed at 6 months of age (CDC *National Immunization Survey* data, infants born in 2012). The target for reporting year 2015 was 57 percent.

The target was met.

September 2015 marked the completion of the second year of the Colorado Baby-Friendly Hospital Collaborative (CBFHC). CDPHE provided technical assistance to staff from 17 hospitals in the Collaborative through three webinars and a full-day annual networking workshop. CDPHE contracted with six Collaborative hospitals in 2015 to receive one-time funding to fulfill activities associated with the Baby-Friendly designation process. Hospitals utilized funds to provide staff training, develop continuity of lactation support in their community, and pay Baby-Friendly fees. There are currently eight Baby-Friendly designates hospitals and two more waiting to hear from Baby-Friendly.

Between February and October 2015, CDPHE and the March of Dimes worked together to plan and implement a process to develop a set of recommendations around preventing and reducing preterm birth (PTB) in the state. Efforts focused specifically on creating recommendations addressing 1) preterm birth prevention & screening; 2) behavioral, psychosocial, & socio-demographic contributors; 3) biological contributors; and 4) diagnosis & treatment – before and during pregnancy.

CDPHE tracked hospital data from year one of the Collaborative to monitor quality improvement in participating hospitals and the overall impact of the Collaborative on breastfeeding rates. Data indicates hospitals participating in the Collaborative have the potential for widespread impact on improving breastfeeding support in maternity practices. Collaborative hospitals reported an average breastfeeding initiation rate of 88 percent in 2014. According to 2014 birth certificate data, 49 percent of live births in Colorado occurred in CBFHC hospitals. Additionally, participating hospitals represent greater ethnic diversity (larger proportions of infants born to Hispanic and African American mothers), greater economic diversity (larger proportions of infants born to low and very low income mothers) and greater payer diversity (a large proportion of Medicaid paid births) compared to all other Colorado hospitals with maternity services.

The Baby-Friendly Hospital Collaborative Advisory Committee convened quarterly to provide essential information and technical assistance to hospitals participating in the CBFHC and guide the overall direction of the Collaborative. A total of eight hospitals in Colorado have been designated Baby-Friendly; 5 during FY16 (Aspen Valley, Boulder Community, St. Anthony's North, St. Joseph's (largest number of births in the state) and Valley View Medical Center).

CDPHE supported LPHAs, the Colorado Breastfeeding Coalition and newly engaged partners statewide in quarterly workplace lactation accommodation conference calls and one-on-one technical assistance. On average 14 LPHAs, representing roughly 24 counties, participated in the calls. Additionally, technical assistance was provided to four Cancer, Cardiovascular and Pulmonary Disease (CCPD) grantees, who work on employer and child care lactation accommodation in 14 counties. CCPD grantees initially targeted 36 worksites and child cares throughout FY16. CCPD grantees just beginning this work focused on county buildings, developing and implementing policies, lactation spaces and best practices.

In 2014, CDPHE developed and disseminated a survey through email and by paper to understand Colorado child care directors' and providers' breastfeeding supportive knowledge, practices, attitudes and skills. A total of 437 individuals responded to the survey; 75 percent were child care providers and 25 percent identified themselves as directors or assistant directors; and 72 percent represented home child care and the remaining 28 percent worked in centers. Respondents were in child care settings located in 39 (out of 64) Colorado counties. Overall survey responses indicated a positive attitude towards breastfeeding and breast milk in child care, however, the majority of respondents indicated a belief that they could not influence a parent's feeding decision. Knowledge, attitude and belief gaps identified in the survey included: handling and preparing of breast milk, breast milk health benefits for infants, and infant feeding cues and practices. An action plan was developed to address the gaps using professional development, tools and resources. CDPHE will create a Colorado-specific "Breastfeeding in Child Care" toolkit for

child care providers and investigate the development of trainings and recognition/designation program for early care and education providers.

Two agencies within the Colorado WIC Program, Denver and Tri-County, received the 2015 Loving Support Award of Excellence Gold Award for their strong breastfeeding support and successful peer counselor programs. In 2015, the Breastfeeding Peer Counselor (BFPC) Texting Pilot program, in which one local agency, Pueblo City-County Health Department WIC Program, provides peer counselor text/phone support to 14 additional Colorado WIC agencies, proved to be successful and has since moved from pilot to being a permanent, important part of the Colorado BFPC model. Additionally, through special permission from the USDA, each local WIC agency in Colorado now has at least one higher performing multiple user hospital-grade electric pump (Medela Symphony pump) to better serve WIC participants.

Table for Perinatal/Infant Health Priorities and PMs that will not Continue

Performance Measure and/or Priority	Last Year's Accomplishments and Current Activities
NPM #1: 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	The annual indicator for reporting year FY2015 was 100 percent. The target for reporting for FY2015 was 100 percent. The target was met. Newborn screening for Critical Congenital Heart Disease was implemented statewide for hospitals located at <7,000 feet of altitude. Efforts are underway to strengthen horizontal collaboration across CDPHE for newborn hearing, metabolic and pulse ox screening.
NPM #17: Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates	The annual indicator for reporting year 2015 was 88.9 percent. The target for reporting year 2015 was 90.0 percent. The target was essentially met. The Colorado Perinatal Care Quality Collaborative (CPCQC) is a volunteer, non-profit advisory group whose members represent the majority of birthing hospitals in Colorado. The CPCQC's primary role is the coordination and improvement of perinatal care services in the state of Colorado. In this role, the Council conducts self-assessments related to hospital designation of obstetric and neonatal care levels. They are in the process of transitioning from a perinatal care council to a full perinatal quality collaborative. Their primary quality improvement activity in 2015-16 is aimed at prevention of preterm birth through the Colorado Safe Deliveries Project, led by the Colorado Hospital Association. There are currently 19 hospitals and their OB providers enrolled in this initiative. The group is also planning to adopt the CDC's LOCATe tool to assessment the level of maternal and neonatal services provided by Colorado's birthing hospitals.
NPM #18: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	The annual indicator for reporting year 2015 was 80.3 percent. The target for reporting year 2015 was 81.0 percent. The target was not met. Colorado continues to implement the full requirements of the Affordable Care Act, including support for the expansion of Medicaid and implementation of a state-run health exchange, Connect for Health Colorado. The Medicaid expansion provides access to benefits for all individuals below 138 percent of the federal poverty level and up to 195 percent of the federal poverty level for pregnant women. The Medicaid expansion is estimated to add anywhere from 240,000 – 300,000 new enrollees in the program by 2025, most of whom are currently uninsured or underinsured. Connect for Health Colorado enrolled an estimated 211,000 individuals for 2016, which is an increase of 70,000 over 2015 numbers. Much of this increase

	occurred in rural and mountainous regions of the state. This will likely continue to improve access to early prenatal care in the years to come. As of 2015, only 6.7 percent of Coloradans remained uninsured.
SPM #6: Percentage of live births where mothers gained an appropriate amount of weight during pregnancy according to pre-pregnancy BMI	The annual indicator for reporting year 2015 was 34.1 percent. The target for reporting year 2015 was 35.0 percent. The target was not met. In 2015, materials were created to support public health, health care, and early care and education providers in sharing messages associated with early childhood obesity. The messages focus on eating healthy, replacing sugar sweetened beverages with water, staying active and gaining the appropriate weight during pregnancy for a healthy pregnancy/infant. The messages were disseminated to over 125 public health clinics, over 1000 early care and education providers and several primary care providers with a link to an online toolkit of resources to download. The Early Childhood Obesity Prevention team continues to refer WIC and primary and public health care providers to resources to support women in achieving a healthy weight, such as Colorado's Diabetes Prevention Program and Weigh and Win.
SPM #7: Percent of parents reporting that their child (age 1 through 3) first went to the dentist by 12 months of age	The annual indicator for reporting year 2015 was 6.6 percent. The target for reporting year 2015 was 12.0 percent. The target was not met. Cavity-Free at Three is continuing to expand trainings throughout the state with upcoming trainings in Rio Blanco, Moffat, Routt and southeast (Cheyenne, Kiowa, Prowers, Bent, Otero, Crowley) counties. From Oct 2014-Sep 2015, a total of 43 CF3 trainings to 580 individuals took place. Of those, five of the target counties hosted eight trainings with a total of 132 individuals. In a 30-60 day post-test of 114 participants in the training, 73.7 percent responded that they had partially, somewhat or completely implemented CF3 into their practice setting.

Child Health

State Action Plan Table

State Action Plan Table - Child Health - Entry 1

Priority Need

Early childhood obesity prevention

NPM

Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day

Objectives

By September 2017, at least 10 child care centers in select counties* will integrate structured physical activity into center lesson plans, curriculum and/or policy (*counties include Boulder, El Paso, Jefferson, Mesa, Pueblo, and Summit).

Strategies

Implement evidence-based physical activity interventions in select child care centers through a network of state and local partners.

ESMs

ESM 8.1 - Number of licensed child care centers in select counties in Colorado that have physical activity as a part of daily curriculum

NOMs

NOM 19 - Percent of children in excellent or very good health

NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)

State Action Plan Table - Child Health - Entry 2

Priority Need

Developmental screening and referrals

NPM

Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Objectives

By 2018, increase the number of local public health agencies, community, and/or health care partners in Colorado that have implemented ABCD quality standards that support early childhood screening, referral and treatment services from 20 to 60.

Strategies

Support individualized technical assistance to LPHAs, community and health care partners on best practices in early childhood developmental screening, referral and intervention services.

ESMs

ESM 6.1 - Number of LPHAs, community and/or health care partners in Colorado that have implemented ABCD quality standards that support early childhood screening, referral and treatment services for developmental needs

NOMs

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

NOM 19 - Percent of children in excellent or very good health

Measures

NPM 6 - Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	48	49	50	51	52	53

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	47.0 %	3.5 %	146,800	312,132
2007	25.9 %	3.4 %	84,174	324,716

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 6.1 - Number of LPHAs, community and/or health care partners in Colorado that have implemented ABCD quality standards that support early childhood screening, referral and treatment services for developmental needs

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	40.0	60.0	80.0	100.0	120.0

NPM 8 - Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day (Child Health)

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	34.2	34.9	35.6	36.3	37	37.7

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	33.5 %	2.9 %	139,594	416,439
2007	36.5 %	3.2 %	139,463	381,685
2003	32.5 %	2.3 %	116,479	358,897

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 8.1 - Number of licensed child care centers in select counties in Colorado that have physical activity as a part of daily curriculum

Annual Objectives

	2017	2018	2019	2020	2021
Annual Objective	10.0	25.0	35.0	55.0	75.0

Child Health - Plan for the Application Year

Priority: Early Childhood Obesity Prevention (ECOP)

New NPM 8: Percent of children ages 6 through 11 years and adolescents ages 12 through 17 years who are physically active at least 60 minutes per day

ESM 8.1: Number of licensed child care centers in select counties in Colorado (out of a total of 1,190) that will have physical activity as a part of the daily curriculum

The targets for the percentage of children ages 6 through 11 years who are physically active at least 60 minutes per day for reporting years 2016 and 2017 are 34.2 percent and 34.9 percent, respectively.
The target for ESM 8.1 for reporting year 2017 is 10. The target for 2018 is 25.

Early development of basic motor skills in early care and education (ECE) settings are linked to later levels of physical activity. Likewise, lifelong habits which influence physical activity and food preferences are formed during this time of rapid development. To assure children ages six through eleven years are accustomed to being physically active, the CDPHE ECOP team continues to promote and implement physical activity and nutrition programs during the early childhood period to improve the likelihood that as children age they have the skills, inclination and abilities to stay physically active.

The CDPHE Early Childhood Obesity Prevention (ECOP) team continues to promote practices and policies that early care and education, primary care and public health providers, parents and caregivers can implement to support young children in establishing healthy preferences. These practices and policies impact physical activity, healthy eating and other healthy weight behaviors in a variety of settings, including ECE, WIC, primary care and local public

health clinics.

Colorado health advocates welcomed revised child care center licensing regulations in January 2016 which require no less that 60 minutes of daily gross motor physical activity for children in full day care (more than five hours) and 30 minutes for children in care for three to five hours; prohibit television and video viewing for children less than two years and allow viewing for up to 30 minutes a week for children over two years of age; disallow media during meal times; limit 100 percent fruit juice to no more than twice a week; require meals meet current USDA meal patterns; and prohibit sugar-sweetened beverages (e.g., flavored milk). The ECOP team will continue to provide guidance to ECEs as a means to achieving compliance with these regulations.

The team promotes physical activity through the *I am Moving, I am Learning* (a Head Start project) ECE training and coaching project, the consistent ECOP messaging initiative, the Colorado Healthier Meals Initiative and the WIC Wellness Coordinator system.

The ECOP team in coordination with six local public health agencies (LPHAs); a CDPHE contractor, Healthy Child Care Colorado (HCCC); and the Denver Children's Museum continued to provide adapted versions of the *I am Moving, I am Learning* (IMIL) training to over 60 ECEs along Colorado's Front Range, mountain, and northwestern communities. LPHAs who choose ECOP can provide this training and Healthy Child Care Colorado is offering additional training statewide with Colorado Health Foundation supportive funding. LPHAs, CDPHE and HCCC also began providing technical assistance, such as on-site physical activity modeling, to over 20 large ECE centers. CDPHE will partner with the University of Colorado's Culture of Wellness in Preschool (CWOP) program to train community-based coaches, such as LPHA staffs, Early Childhood Council members, child care health consultants, and ECE wellness champions in the AIM-P (assess, identify, make it happen in preschools) strategic planning process to facilitate sustainable environmental and policy changes that promote structured (teacher-led) physical activity in ECE centers.

CDPHE began facilitating a Physical Activity in ECE Work Group to promote collaboration and coordination with the other ten organizations (e.g., LPHAs, HCCC, CWOP, Head Start, Colorado Department of Human Services Office of Early Childhood, American Heart Association's Healthy Way to Grow) implementing programs to increase structured physical activity in ECE settings in Colorado. The Work Group strives to fill gaps, reduce duplication, unify messages, improve communication and coordination, enhance policies and systems, and collectively evaluate the members' impact on increasing physical activity in ECEs. The results of a CDPHE 2016 survey of Colorado Head Start providers found that over 50 percent of centers would like IMIL training; and a 2016 survey of 68 community-based individuals who consult to or support ECE providers revealed 75 percent would like training to receive skills to facilitate integration of physical activity practice and policy in ECE settings. The Work Group devised and began implementing a plan to address these requests which will build the capacity throughout Colorado to support ECE providers in integrating structured physical activity.

The ECOP team refresh-released *9 Ways to Grow Healthy Colorado Kids*, Colorado's consistent healthy weight messaging initiative, in October 2015, with transcreated Spanish language messaging, new images and a portfolio of materials in English and Spanish. First released in 2013, the Colorado audience-tested messages promote preconception, prenatal and early childhood healthy behaviors found most promising in preventing overweight and obesity before it begins in young children. *There's no power like parent power! Eat well and move more to care for yourself and your family* and *Give your child nutritious food and active play for a healthy future* are two of the messages. The Colorado WIC Program, MCH, public health, ECE, and primary care providers *speak with one voice* using the materials offered in an online toolkit on the One Stop ECOP Shop messaging website. The online toolkit contains downloadable posters, consumer handouts, provider newsletter templates, and talking points. The website also contains links to provider and consumer messaging topic-related websites and recorded webinars on individual

messaging topics (e.g. healthy sleep).

Over 60 individuals statewide representing these targeted providers participated in the release webinar. The team disseminated over 125 introductory kits of printed materials to all Colorado LPHA programs and WIC clinics. The messages were integrated into applicable WIC nutrition education brochures and into the Bright by Three program's materials and Bright by Text program.

The team created and facilitated a nine-month message roll-out campaign. From February 2016 through October 2016, individuals who signed up to participate receive a monthly newsletter with information, resources and ideas for that month's message. During the first four months of the campaign the team filled over 50 orders for materials from organizations, not including the WIC Program. As Colorado WIC Program data describes the rate of overweight and obesity in it program participants ages two through four years as trending downward, the ECOP team continues to promote and improve the consistency and frequency in *speaking with one voice* with families on achieving healthy weights.

The team continues to promote the CDPHE Healthier Meals Initiative (HMI) in ECE settings which include menus reflecting whole grains served at least once a day, juice served no more than twice a day (which aligns with new aforementioned regulations) and processed meats no more than once a week. LPHA and partner organization staffs provided over 300 toolkits (depleting CDPHE's stock) and technical assistance to support these changes. The team will continue to promote the HMI online tool kit and continue to seek funding to disseminate the CDPHE Culinary Training Program (CTP) as a pilot in 1-3 Colorado communities. The CTP consists of a series of workshop modules, each focusing on a different core concept, and introduces specific knowledge and skills necessary for supporting the transition to healthier meal preparation and service. The CTP also includes a coaching component for center-based consultation. The culinary curriculum is designed to develop the culinary skills of childcare center cooks gradually, over an extended period of time.

The ECOP team continues to build and support the WIC Wellness Coordinator (WC) system; a strategy to bring state and local WIC agencies together in addressing early childhood obesity through WIC services in Colorado. Fifteen of Colorado's 38 WIC agencies operate a WC system. Seven out of 21 Wellness Coordinators supported statewide ECOP initiatives with 18 actions including building community partnerships, implementing staff wellness activities, and training staff on the *9 Ways to Grow Healthy Colorado Kids* and disseminating the messages to WIC participants, community partners and the public. Primarily working through WIC, the team will continue to identify methods to enhance support to post partum women to achieve a healthy weight and physically active lifestyle prior to their next pregnancy.

The team hosted four webinars to support staff and Wellness Coordinators in guiding WIC families to aim for active living and healthy habits such as limiting screen time, drinking water, avoiding sugar sweetened beverages, and getting the appropriate amount of sleep. Two webinars were offered on worksite wellness. The first webinar targeted WIC Program and LPHA directors and program managers to gain buy-in through addressing potential barriers and challenges, describing the health and wellness benefits for the employer and employees, and enabling them to practice the behaviors they promote. Over 60 people participated representing at least 26 Colorado public health agencies. The second webinar was offered only to WIC agencies in order to focus on implementation in a WIC setting.

The team continues to provide support to LPHAs, mainly in the areas of physical activity and breastfeeding (see NPM #4) in ECE settings and community healthy weight messaging through the WIC webinars, learning circle and networking webinars, and individual technical assistance. The team will provide training opportunities to LPHAs to

address the challenges ECE providers face in creating physical activity policies and integrating the curriculum into daily practice.

In partnership with state and local programs and agencies, and CDPHE's evaluation staff, the team will continue to collect evaluation data on these and other ECOP strategies to assess the overall impact of the ECOP efforts. One product of this work is a statewide inventory of ECOP efforts and a Community-based Initiative map to support LPHA partner collaboration. The map will be updated each fall. These partners continue to share best practices and lessons learned about ways to support ECEs and the networks of family, friends and neighbor care in providing structured physical activity, healthy and safe meals, and engaging parents in these health promoting behaviors.

The team will leverage MCH funding to ensure continued collaboration with programs, such as WIC and CACFP and will continue to explore alignment between CDPHE ECOP and Health Systems Unit work in order to promote ECOP strategies at the system and policy levels and in communities through direct service provision.

Priority: Developmental Screening and Referrals

New NPM 6: Percent of children, ages 9 through 71 months, receiving a developmental screening using a parent-completed screening tool

ESM 6.1: Number of LPHAs, community and/or health care partners in Colorado that have implemented ABCD quality standards that support early childhood screening, referral and treatment services for developmental needs

The target for NPM 6 for 2016 is 48 percent. The target for 2017 is 49 percent.
The target for ESM 6.1 for 2017 is 40. The target for 2018 is 60.

Historically, CDPHE had limited state-level staff time to support this work at the state and local levels. Therefore, Assuring Better Child Health and Development (ABCD), a statewide nonprofit organization, contracted by CDPHE to provide support to local public health staff, represented the MCH priority at local and state partnerships. With the expansion of staff on the Maternal Wellness and Early Childhood team, the role of CDPHE to support this priority has increased. The development of the state logic model helped define the role of CDPHE in identifying and addressing state-level systems barriers. ABCD's role with the MCH priority work will focus on promoting best practices through coordination and consultation within local communities, while also serving as a conduit for communities to identify barriers along the screening to services continuum that require a state-level solution. This realignment of roles improves the state's capacity to integrate developmental screening and referral efforts with pregnancy-related depression (PRD) screening and referral efforts. This also improves coordination of the priority work with other state level screening and referral efforts, such as the federally-funded Project LAUNCH (Linking Actions for Unmet Needs in Children's Health); the privately-funded expansion of Project LAUNCH, known as LAUNCH Together; and the State Innovation Model (SIM) - each of which is described in further detail below. This will help the state better identify and advocate for key recommendations to improve state-level policies that support seamless screening, referral and intervention.

Final state logic model and action plans have been completed and are reflective of the new role CDPHE staff will have in supporting this priority. As the statewide experts on implementing best practices in screening and referral system building efforts, ABCD will continue to play an essential role in supporting local public health staff to implement this priority. Clarification around roles between ABCD and CDPHE has maximized coordination at the local and state levels.

Local logic model and action plans were also finalized. Both are based on local public health agencies continuing with this priority from the previous block grant cycle and not starting this as a new priority. Strategies and activities

focus on community efforts to overcome barriers to increase the number of children who receive developmental screening, referral and services. Local and state action plans also include a focus on engaging families in the development and implementation of activities to increase screening rates.

Despite community variations, team engagement in working towards a system to better serve children and families is a constant across all communities working on this priority. Each community has created a community-level workgroup that drives the implementation activities. In focus groups conducted with a few of these groups during the previous year, participants discussed how they are better able to serve families and children. Participants reported that they have increased their knowledge about the quality standards (evidenced based and/or best practices needed to support screening and referral quality improvement activities in their communities. This results in LPHA staff having better tools to provide technical assistance to community partners specific to their role in the screening to services continuum. Workgroup members also discussed wishing to continue to help families reduce frustrations, confusion, and fear around systems and services navigation and to help families feel empowered. Ideas that members identified for parent/family empowerment included the use of Care Navigators when possible and creating opportunities for families to come together to provide peer support, such as support groups or involvement in workgroups or action teams. Based on findings from the local evaluation last year, the following recommended activities will be continued or implemented for the next plan year:
1. develop a locally-coordinated surveillance-to-services system using strong facilitators who can guide, but also "step back," so communities drive the work forward;
2. increase family representation in workgroups with the goal of increasing family knowledge about the systems and services around developmental delays and disorders and assure that the strategies are usable and meaningful to families;
3. engage organizations in a manner that promotes organizational stability, despite staff turnover, so that organizational involvement is maintained and learning is not lost;
4. further support communities by grounding ABCD community processes in implementation- and impact-oriented work to increase understanding on how resources can be implemented and tracked in the community; and
5. promote better understanding of ABCD's processes through ABCD presentations to workgroups on its work and services to the community.

As the work moves forward, ABCD will continue to provide guidance to local public health staff to increase their community-level competency and capacity to provide technical assistance to internal and external partners. The goal of this is to expand the reach to more partners who can implement the quality standards across the surveillance to services continuum.

As mentioned earlier, the ABCD and CDPHE teams continue to explore opportunities to integrate pregnancy-related depression (PRD) screening and referral initiatives into quality improvement efforts already happening in clinics around developmental screening. Early identification and treatment of PRD, and connection to additional supports for those at risk for PRD, can enhance protective factors and minimize the detrimental impact of PRD on a mother's attachment and relationship with her children. To facilitate this, ABCD received approval from the American Board of Pediatrics, the American Board of Family Practice and the American Board of OB-GYN for a quality improvement initiative within medical practices to support PRD screening and referral processes. More about this effort is described under the priority update for women's mental health.

The MCH priority work on developmental screening will also align closely with other state level initiatives such as the Colorado State Innovation Model (SIM), Project LAUNCH (Linking Actions for Unmet Needs in Children's Health) and LAUNCH Together, each of which have a developmental screening and referral component.

The work of the Colorado State Innovation Model (SIM) as it relates to developmental screening is informed by best

practices developed by ABCD and community input provided through ABCD's work at the local level. SIM is a statewide initiative funded by the Centers for Medicare and Medicaid Innovation (CMMI), that, as a direct response to community identified priorities, seeks to improve the health of Coloradans by providing access to physical and behavioral health care services in integrated systems, with value-based payment structures. Of the cohort one SIM practices, thirty-three serve children and include pediatric practices, family practices and school-based health centers. SIM practices will collect and report on six clinical quality measures (CQMs) intended to track patient and process outcomes. Three of these CQMs are directly related to the developmental and social-emotional wellbeing of children, including developmental screening (NQF1448), adolescent depression screening (NQF0418), and maternal depression screening (NQF1401). Conversations have taken place about how to expand the data collection for future SIM practice cohorts around developmental screening beyond the number of screens conducted, to include data from screening through the receipt of services. This expanded data collection will be used to help inform state policy recommendations. In addition, an implementation guide and toolkit were completed in January 2016 to assist the practice transformation coaches working with these practices to implement evidence-based, quality standards. The content of the implementation guide and toolkit are aligned with the ABCD quality standards for standard developmental screening practices.

Colorado Project LAUNCH is a federal initiative funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). This initiative focuses on providing Colorado children from birth to age eight with the skills needed to successfully enter school with appropriate social, emotional, cognitive and physical skills. One of the primary strategies for achieving this goal is improved screening and assessment in a range of child-serving settings. Staff members in the Maternal Wellness & Early Childhood Unit partner with the Colorado Department of Human Services - Office of Early Childhood on this effort. ABCD also participates as a member of the state-level Young Child Wellness Council to help inform this work. The pilot community for Colorado's Project LAUNCH is southern Adams County, and local implementation is lead by staff at the Early Childhood Partnership of Adams County (ECPAC). ECPAC staffs have strong relationships with the MCH staff at Tri-County Health Department (which serves Adams County) and both work together to align the local community efforts on developmental screening. Colorado Project LAUNCH began its first year of full implementation in October 2016. Opportunities and lessons learned through the effort will be shared with state MCH staff to ensure coordination of efforts.

LAUNCH Together is an $11.5 million first-in-the-nation initiative inspired by the experiences and outcomes of Project LAUNCH partners, and the national project funded by SAMHSA. It is similarly designed to improve social, emotional, behavioral, physical and cognitive outcomes for young children (prenatal through age eight) and their families in Colorado. Created through a unique collaboration of eight Colorado-based foundations representing diverse foci (early childhood, health care, mental health, public health, economic self-sufficiency), LAUNCH Together will support four additional communities across the state to enhance existing evidence-based prevention and health promotion practices, including a focus on developmental screening, and build more coordinated community systems. As LAUNCH Together local implementation begins in September 2016, there will be expanded opportunities to hear from local partners on challenges or barriers encountered with developmental screening and referral systems. This will further enhance the support behind addressing state-level systems barriers.

Colorado looks forward to leveraging the increased number of partners and opportunities to more fully address developmental screening and referral statewide to ensure all Colorado children reach their developmental potential.

Legislative requirements outlined in 501 (a)(1) and 505

Colorado's approach to choosing priorities aligns with the public health assurance role outlined in 501 (a)(1). Also, by virtue of MCH program policy and procedures, Colorado is fully compliant with the requirements outlined in section 505. Specific information in reference to 501 and 505 is included throughout the block grant application and

report.

Critical partnerships with other MCHB-supported programs
MCH program partnerships with other MCHB-supported programs are discussed in section B.2.c. and throughout the population-domain program updates.

Child Health - Annual Report

Priority: Early Childhood Obesity Prevention (ECOP)
Old NPM 14: Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85 percentile

The annual indicator for reporting year 2015 was 21.2 percent. The target for reporting year 2015 was 21.6 percent. The target was met. Since 2012 the indicator has decreased by 7.4 percent or by 1.7 percentage points depicting a downward trend in early childhood overweight and obesity.

The CDPHE Early Childhood Obesity Prevention (ECOP) team continued implementation of the state action plan, which included strategies related to public health, health care, and early care and education (ECE) sectors with a focus on primary prevention during the preconception, prenatal and early childhood periods.

The team rebranded the ECOP consistent messaging strategy as *9 Ways to Grow Healthy Colorado Kids*. These are CDPHE's Colorado audience-tested, evidence-based messages about behaviors which are most promising in preventing overweight and obesity in early childhood. This strategy crosses all sectors. While the messages have been available since 2013, there was not widespread use in local public agencies and in the WIC Program due to the lack of supporting materials. The team contracted with Neocom Promo, LLC to transcreate the messages into Spanish and to make them culturally relevant by testing and adapting them with input from predominantly mono-lingual Spanish-speaking focus groups. CDPHE's communications and the ECOP team prepared print materials including posters, handouts and a child growth chart as well as an online messaging toolkit comprised of supporting materials to download, recorded topic-specific webinars , links to informative websites, and a campaign newsletter and roll-out calendar.

Colorado WIC formally adopted a Wellness Coordinator System after the system pilot revealed successes. The system brings state and local WIC agencies together to address early childhood obesity. Wellness Coordinators (WC) from 14 WIC agencies participated on quarterly conference calls and led activities to advance early childhood obesity prevention and wellness in WIC. At least four WCs integrated responsive infant feeding training for staff in their agencies. Other WCs provided information to staff and participants about sugar sweetened beverages, appropriate weight gain during pregnancy, healthy eating and physical activity to achieve a healthy weight postpartum, and healthy sleep routines for young children. Several WCs hosted Cooking Matters classes for participants.

All Colorado WIC staff participated in a training on implementing Baby Behavior, a program of the University of California, Davis, to coach parents how to better read their infant's cues. All WIC agencies implemented aspects of Baby Behavior practices in their annual nutrition education planning and performance. The evidence is promising

that parental responsiveness to infant feeding cues is protective against childhood obesity. The ECOP healthy weight message provides guidance to caregivers on responsive feeding: *Trust your baby to know how much she needs to eat. Your baby will show you cues of hunger and fullness and will trust you to respond.*

Beginning mid-2015 LPHA staff and other ECOP partners participated in WIC hosted webinars on ECOP-related topics, including maternal wellness and healthy sleep. Additionally, the ECOP team offered tools, training, and networking to LPHA staff through eight learning circles, webinars and conference calls on the topics of workplace lactation accommodation, child care policy development, and child care nutrition and physical activity strategies.

During this period LPHA MCH staffs employed a variety of strategies to influence practice and policy changes to promote healthy weight behaviors. At least six LPHAs engaged local ECE settings in 5.2.1.0 messaging which promotes daily consumption of five servings of fruits and vegetables, viewing less than two hours of screen time, engaging in one hour of physical activity, and completely avoiding sugar sweetened beverages. For example, Boulder County LPHA staff worked with 50 child care programs to adopt 5.2.1.0 policy and practices. All programs received county recognition. Boulder trained health inspectors to provide technical assistance on these messages to ECEs during their visits. Jefferson County LPHA staff formed a Health in Early Care county collaborative with strong partner support and one staff member became the Health Representative for the Early Childhood Council. Pueblo County LPHA staff trained and offered technical assistance to four ECEs as they completed the *Let's Move* Child Care program and received *Let's Move* national recognition certificates. Weld County LPHA staff promoted and provided technical assistance to four ECE centers and 12 homes with 5.2.1.0 messages resulting in the development of food, beverages, physical activity and screen time policies.

The Colorado Child and Adult Care Food Program (CACFP), the ECOP team and LPHAs continued implementation activities for the Healthier Meals Initiative (HMI) (i.e., limit 100 percent fruit juice to no more than twice a week; limit highly processed meats to once a week; and at least one whole grain product a day). This effort, which began October 2013, aims to support child care providers in serving meals to meet higher standards by reducing barriers and by offering culinary training and menu planning tools. Since the HMI's rollout in late 2013, CACFP staffs have monitored menus in 639 sites representing roughly two-thirds of participating CACFP sites. A menu analysis found 95.2 percent sites are compliant with whole grains; 98.5 percent are compliant with juice; and 94.7 percent are compliant with processed meat. Colorado CACFP providers are well prepared for the release of USDA's new CACFP meal patterns in 2016.

CDPHE developed and disseminated healthy and safe meals guidance for child care health inspectors to inform them about Colorado's HMI standards and how child care providers can overcome the barriers to serving healthy meals while meeting the health and safety requirements.

The ECOP team continued physical activity efforts in ECE settings by co-facilitating nine *I am Moving, I am Learning* (IMIL) project trainings with Healthy Child Care Colorado. Over 340 participants representing 121 ECE centers and other community partners, such LPHA staff and Early Childhood Councils participated in an IMIL training. A follow up survey of center providers (with a 23 percent response rate) identified that 90 percent of respondents indicated they have made changes to physical activity in their centers since their participation in IMIL training. Over 50 percent report physical activity is written into their curriculum and/or daily lesson plans. Twenty-nine percent report they have a written policy requiring physical activity. The ECOP team held four learning circles for IMIL trainers to network, share best practices, and offer lessons learned.

The ECOP team continued to convene stakeholders to inform CDPHE and partner strategic directions.

Priority: Developmental Screening and Referrals

Old SPM 4: Percent of parents asked by a primary care provider to fill out a questionnaire about development, communication, or social behavior of their child ages 1 through 5.

The annual indicator for reporting year 2015 showed that 56.3 percent of parents were asked by a primary care provider to fill out a questionnaire about development, communication, or social behavior of their child ages 1 through 5. The target for reporting year 2015 was 68 percent and the target was not met.

Assuring Better Child Health and Development (ABCD) staff continued to support local public health staff to align and mobilize primary care providers and community partners to address screening and referral in a consistent way to ensure that families are supported through the developmental screening to services continuum. Local public health agencies have worked towards this goal in multiple ways: 1) all communities have completed partner spotlights in order to understand what the screening and referral process looks like in their communities; 2) all communities (eight total) in which this priority is identified have partners that agreed to a common agenda (work plan) with agreed upon measurable goals; 3) all communities have developed protocols based on best practices in order to streamline the current screening and referral process so children and families can be best served; 4) six communities have begun dissemination of materials to primary care providers and community partners; and 5) all communities have begun to review available local data and make course corrections as needed. El Paso County has created a screening and referral toolkit for their local department of human services CAPTA/CASA teams, early learning providers, home visitation and primary care and private service providers.

During this last period, ABCD contracted with an outside evaluator to evaluate the community work. There were four objectives of the evaluation; each is listed below with the resulting conclusion.

Objective 1: Document the ongoing ABCD Model Community Framework (MCF) process and current implementation in three counties. **Conclusion:** Consistent partner participation (especially as it relates to staff turnover), workgroup resource development due to grant opportunities, and the strong facilitation of workgroups can all influence workgroup processes and progress.

Objective 2: Understand the extent to which ABCD processes are perceived as having helped (and are continuing to help) community partners better coordinate their Surveillance to Services efforts. **Conclusion:** In focus groups, participants discussed benefitting from ABCD's support, data, outreach, and training. A few focus group participants also discussed that they would benefit from grounding processes in more implementation-oriented work.

Objective 3: Understand the extent to which community processes are moving the needle on the number of screenings that occur in all three counties and the referral-to-evaluation percentage. **Conclusion:** Adams County, which is further along in their coordinated screening and referral system efforts, also showed further progress in moving the needle on the number of screenings in the community according to the Provider Survey. Workgroup partners' perception regarding progress towards the development of a coordinated screening and referral system is generally positive. However, evidence of change in their own agency is lower.

Objective 4: Understand the extent to which community processes are helping connect families to needed services. **Conclusion:** In all workgroup focus groups, participants discussed how they are better able to serve families and children because of their participation in the workgroup. A few participants also discussed that by working with primary care providers more closely the long-term positive outcome will be that more families will be connected to needed services. Furthermore, all communities have experienced an increase in the total number of referrals from 2014 Q1-2 to 2015 Q1-2.

Old SPM 5: Percent of Early Intervention Colorado referrals coming from targeted screening sources

The annual indicator for reporting year 2015 showed that 48.8 percent of referrals came from targeted screening sources. The target for reporting year 2015 was 49 percent and the target was not met.

ABCD received funding to offer developmental screening, autism screening and/or referral support to 20 pediatric or family practices. Using an academic detailing approach, ABCD provided hands on technical assistance through individualized practice visits, formal continuing medical education (CME) and/or participation in a quality improvement (QI) project. Over 60 primary care providers at 20 different practices have participated in ABCD's QI projects. When the developmental referral QI project was being developed, only 53 percent of patients referred to Early Intervention (EI) were connected to services. After three PDSA cycles, this increased to 74 percent of patients being connected to EI. One of the initial discoveries was that in the QI practices, only 57 percent of the referrals sent to EI were recorded as received on the other end. Most practices worked on changes to standardize their referral process, which resulted in an increase in referral receipt to 99 percent and a positive impact on the ability of families to connect to services. This is confirmed by evaluation data stating that 97 percent of providers agreed or strongly agreed to the statement: "building relationships with Early Intervention and/or Child Find benefited me and the developmental referrals I make".

ABCD continued to provide technical assistance to LPHAs to improve referral systems at the community level. There continues to be a number of challenges related to increasing the percentage of referrals that result in services. Through a cross agency process that includes community partners participating in QI initiatives with primary care providers, partners agree to be accountable for implementing an effective referral process. El Paso County has a high density of private providers and therefore a local resource directory was created so that primary care providers and community partners know what the referral options are for children and families. Boulder County used their materials to train the local home visitation coalition to help increase their commitment to the ABCD Quality Standards relative to conducting developmental screening and referral of young children.

Table for Child Health Priorities and PMs that will not Continue

Performance Measure and/or Priority	Last Year's Accomplishments and Current Activities
NPM #7: 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	The annual indicator for reporting year 2015 was 76.1 percent. The target for reporting year 2015 was 80.0 percent. The target was not met. In 2015, the Colorado VFC program distributed nearly 989,000 doses of vaccine valued at more than $50,000,000 to ensure that children who are uninsured and children covered under the Colorado Medicaid program had access to vaccines. The Immunization Branch (CIB) continues to fund LPHAs to provide clinics and to improve immunization rates in their areas. CIB also funds special projects in several areas of the state aimed at assessing and improving immunization rates in child care centers.
NPM #9: Percent of third grade children who have received protective sealants on at least one permanent molar tooth	The annual indicator for reporting year 2015 was 44.9 percent. The target for reporting year 2015 was 49.0 percent. It is unknown whether the target was met since updated data are not available. The Oral Health Program is working closely with the Center for Health and Environmental Data (CHED) who is working with the Colorado Department of Education EDAC (Education Data Advisory Committee) for approval to conduct the Basic Screening Survey (BSS). CHED is also in the process of randomly selecting schools statewide. As of 2015, schools have been selected but due to

	staffing limitations, the project is delayed until the 2016-17 school year.
NPM #10: The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children	The annual indicator for reporting year 2015 was 1.3 per 100,000. The target for reporting year 2015 was 2.0 per 100,000. The target was met. Child Fatality Prevention System (CFPS) staff conducted 15 in-person child fatality review trainings with local public health departments. These trainings stressed the need to use data to inform local level prevention strategies for child passenger safety activities and other issues. In May 2015, the CFPS held a 1.5 day CFPS Local Coordinator Training for 48 local team coordinators that included an introduction to injury prevention. The CFPS State Review Team's Motor Vehicle Subcommittee identified motor vehicle policy strategies for the CFPS 2015 Legislative Report, as well as local prevention strategies to include in 48 local data summaries for each local review team.
NPM #13: Children without Health Insurance: Percent of children without health insurance	The annual indicator for reporting year 2015 was 2.7. The target for reporting year 2015 was 3.0 percent. The target was met. HCPF and Connect for Health Colorado have implemented system improvements with PEAK, the online public benefits system, and the exchange to enhance user experience in obtaining health insurance and minimize the percent of children without health insurance. During the 2015-16 open enrollment period more Coloradans enrolled in coverage through the exchange compared to last year. More Coloradans received financial help. And, more customers saved more money through federal premium tax credits and cost-sharing reductions. Enrollments increased in nearly every county in the state, with strong increases in enrollments in rural and mountain counties. Annual enrollment reports available here: http://connectforhealthco.com/resources/stay-informed/metrics/

Adolescent Health

State Action Plan Table

State Action Plan Table - Adolescent Health - Entry 1

Priority Need

Bullying and youth suicide prevention

NPM

Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19

Objectives

By September 2017, increase utilization of the state-created Positive School Environment Toolbox by local partners in prioritized communities (e.g., local MCH and child fatality review team partners, school professionals, community-based organizations) from 0-8.

Strategies

Provide training and technical assistance for implementation of evidence-based/evidence-informed policies and practices that increase school connectedness.

ESMs

ESM 7.1 - Number of local partners reporting use of the Positive School Environment Toolkit in prioritized communities

NOMs

NOM 15 - Child Mortality rate, ages 1 through 9 per 100,000

NOM 16.1 - Adolescent mortality rate ages 10 through 19 per 100,000

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000

NOM 16.3 - Adolescent suicide rate, ages 15 through 19 per 100,000

State Action Plan Table - Adolescent Health - Entry 2

Priority Need

Bullying and youth suicide prevention

NPM

Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Objectives

By September 2017, increase utilization of the state-created Positive School Environment Toolbox by local partners in prioritized communities (e.g., local MCH and child fatality review team partners, school professionals, community-based organizations) from 0-8.

Strategies

Provide training and technical assistance for implementation of evidence-based/evidence-informed policies and practices that increase school connectedness.

ESMs

ESM 9.1 - Number of local partners reporting use of the Positive School Environment Toolkit in prioritized community

NOMs

NOM 16.1 - Adolescent mortality rate ages 10 through 19 per 100,000

NOM 16.3 - Adolescent suicide rate, ages 15 through 19 per 100,000

Measures

NPM 7 - Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19 (Adolescent Health)

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	247.1	242	237	231.9	226.9	221.8

Data Source: State Inpatient Databases (SID) - ADOLESCENT

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	226.8	5.7 %	1,580	696,631
2012	268.8	6.2 %	1,866	694,226
2011	275.8	6.4 %	1,881	682,112
2010	281.2	6.5 %	1,883	669,758
2009	304.4	6.8 %	2,018	663,007
2008	319.7	7.0 %	2,097	655,903

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

ESM 7.1 - Number of local partners reporting use of the Positive School Environment Toolkit in prioritized communities

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	8.0	12.0	16.0	20.0	24.0

NPM 9 - Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	24	23.5	23	22.5	22	21.5

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	13.5 %	2.2 %	52,980	393,543
2007	12.0 %	2.3 %	46,911	390,501

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011	24.5 %	1.4 %	51,104	208,297

Legends:

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 9.1 - Number of local partners reporting use of the Positive School Environment Toolkit in prioritized community

Annual Objectives

	2017	2018	2019	2020	2021
Annual Objective	8.0	12.0	16.0	20.0	24.0

Adolescent Health - Plan for the Application Year

Priority: Bullying and Youth Suicide Prevention

New NPM 7: Rate of injury-related hospital admissions per population ages 0 through 19 years

ESM 7.1: Number of local partners reporting use of the Positive School Environment Toolkit

New NPM 9: Percent of adolescents, ages 12 through 17 years, who are bullied

ESM 9.1: Number of local partners reporting use of the Positive School Environment Toolkit

The target for NPM 7 for reporting year 2016 is 247.1. The target for 2017 is 242.
The target for NPM 9 for reporting year 2016 is 24.0 percent. The target for 2017 is 23.5 percent.
The target for ESMs 7.1 and 9.1 for reporting year 2017 is 8. The target for 2018 is 12.

According to the Centers for Disease Control and Prevention (CDC), violence is interconnected and often shares the same root causes.[i] An effective approach identified by the CDC is to utilize a shared risk and protective factor strategy that recognizes the overlapping causes of violence as well as the factors that protect against the experience of violence. According to the CDC, “understanding shared risk and protective factors of violence can help us plan how to prevent multiple forms of violence at once.” [ii] It also affords an opportunity to leverage existing funding streams by understanding how different forms of violence are linked to one another. Thus, an effective strategy examines the research, understands the connections between different types of violence, focuses on shared risk or protective factors rather than specific types of violence and evaluates for impact.

Colorado is taking a shared risk and protective factor approach to the new bullying prevention and the youth suicide prevention priority focus for NPM 7. The application of a shared protective factor approach has resulted in a focus on strategies at the individual level of the social ecology to build life skills. According to research in *Connecting the Dots: An Overview of the Links Among Multiple Forms of Violence*, building life skills is protective for suicide, youth violence, teen dating violence and child maltreatment. Staff anticipates showing impact on bullying as well through a strategy focus on building life skills. A second strategy targets the relationship and community levels of the social ecology by choosing an evidence-based strategy measure focusing on school connectedness. According to *Connecting the Dots*, school connectedness is protective for bullying, suicide, youth violence, sexual violence and teen dating violence.

MCH staff will support this work through the development of technical assistance tools and training for local partners. To support communities, MCH staff will conduct a review of evidence-based and research-informed programs and map across the prioritized shared protective factors: life skills and school connectedness. Additionally, MCH staff will develop, in collaboration with partners and stakeholders, a comprehensive positive school climate toolbox. This toolbox will identify best practices such as using a positive youth development approach, “hot spot” mapping and policy development to enable bullying prevention or specific populations at risk, e.g., lesbian, gay, bisexual and transgender youth. Applying a health equity lens will be a critical focus of this project through the development of the toolbox.

In partnership with local communities, MCH staff will create local action plans for bullying and suicide prevention, guided by the MCH Implementation Team for this priority, CDPHE’s Healthy Youth Team (HYT). HYT members will engage local partners to align technical assistance and training, leveraging funding for greater impact at the local level.

MCH staff will continue to partner with the Violence and Injury Prevention - Mental Health Promotion Branch, who is responsible for managing the Child Fatality Prevention System (CFPS) and the Office of Suicide Prevention (OSP). Together they will leverage resources, partnerships and staff to ensure coordination of efforts at the local level. One example of this is the work being done by MCH staff and CFPS staff to connect local public health staff working on MCH and Child Fatality Review to leverage data and prevention recommendations generated by the child fatality review to support bullying and suicide prevention. This has resulted in several local public health agencies partnering across MCH and Child Fatality Review.

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[i] Wilkins, N., Tsao, B., Hertz, M., Davis, R., Klevens, J. (2014). Connecting the Dots: An Overview of the Links Among Multiple Forms of Violence. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention Oakland, CA: Prevention Institute.

[ii] Ibid.

Legislative requirements outlined in 501 (a)(1) and 505

Colorado’s approach to choosing priorities aligns with the public health assurance role outlined in 501 (a)(1). Also,

by virtue of MCH program policy and procedures, Colorado is fully compliant with the requirements outlined in section 505. Specific information in reference to 501 and 505 is included throughout the block grant application and report.

Critical partnerships with other MCHB-supported programs
MCH program partnerships with other MCHB-supported programs are discussed in section B.2.c. and throughout the population-domain program updates.

Adolescent Health - Annual Report

Priority: Bullying and Youth Suicide Prevention
Old PM: The rate per 100,000 of suicide deaths among youths aged 15-19.

The annual indicator for reporting year 2015 showed that there were 12.4 youth suicide deaths per 100,000 youth ages 15 to 19. The target for reporting year 2015 was 13.0. The target was met.

State funding was allocated to the Office of Suicide Prevention (OSP) for programs statewide and across the lifespan. Several activities targeted youth between the ages of 15 to 19. Currently, the OSP does not have federal funding for youth suicide prevention efforts.

Community grants were provided to organizations working with youth. Lesbian, Gay, Bisexual, Transgender, and Questioning/Queer, and Latina youth were identified in 2013 as priority populations to target with statewide suicide prevention efforts.

Another priority for the OSP is a school-based, positive youth development suicide prevention program called Sources of Strength. The evidence-based program builds resiliency, increases youth attachment to school and caring adults, and increases help-seeking behavior. In the 2014-2015 school year, the program was implemented in three communities and ten schools across the state. In addition, collaboration within CDPHE allowed for the development of a program utilizing a shared risk and protective factor framework in implementing Sources of Strength to maximize limited resources across health fields (child fatality prevention, sexual violence prevention, and suicide prevention funding streams). The opportunity allowed implementation of the positive youth development within Sources of Strength with evaluation of outcomes across suicide specific measures and also sexual violence indicators. The pilot implementation began in seven schools in Colorado in fall 2015.

Other activities accomplished include sponsoring symposia and conferences; coordinating the Suicide Prevention Commission of Colorado; providing educational materials statewide; disseminating community grants; partnering with the Suicide Prevention Coalition of Colorado to raise awareness about suicide and mental health; providing resource materials to emergency departments across the state; and participating on key advisory boards like the Colorado School Safety Resource Center and the Denver Youth Violence Prevention Partnership.

Table for Adolescent Health Priorities and PMs that will not Continue

Performance Measure and/or Priority	Last Year's Accomplishments and Current Activities
NPM #8: The rate of birth (per 1,000) for teenagers aged 15 through 17 years	The annual indicator for reporting year 2015 was 8.7 per 1,000. The target for reporting year 2015 was 11.0 per 1,000. The target was met. The birth rate and abortion rate for women ages 15-19 fell 48

	percent from 2009 through 2014. The Colorado Family Planning Initiative has been recognized by state and national health organizations and has positioned Colorado as a leader in family planning. However, the initiative has ongoing funding challenges, specific to services and devices not covered by insurance and available public funding sources. When private funding ran out in June 2015, several of Colorado's leading foundations stepped in to provide $2.2 million in bridge funding to support the program. An additional $2.5 million in state general fund was appropriated by the state legislature to continue this successful effort as of 7/1/16. CDPHE submitted a legislative update on progress related to HB13-1081 - Comprehensive Human Sexuality K-12 Education, specifically the lack of funding for these efforts. The summary included considerations for legislators to strengthen youth sexual health efforts.
SPM #8: Percentage of sexually active high school students using an effective method of birth control to prevent pregnancy	The annual indicator for reporting year 2015 was 31.7 percent. The target for reporting year 2015 was 31.5 percent. The target was met. CDPHE hosted a brown bag for parents and other trusted adults on how to talk with youth about sex and sexual health. The Youth Friendly Clinic Makeover report was shared with state and national partners and project staff was invited, and will attend, a family planning conference in Tennessee to share results. See NPM #8 for information about declines in the birth and abortion rates.
SPM #9: Motor vehicle death rate for teens ages 15-19 yrs old	The annual indicator for reporting year 2015 was 9.8 per 100,000. The target for reporting year 2015 was 10.8 per 100,000. The target was met. During reporting year 2015, the Violence and Injury Prevention, Mental Health Promotion (VIP-MHP) Branch continued to convene the Colorado Teen Driving Alliance (CTDA) to implement key activities in the Motor Vehicle Action Plan. The CTDA provided technical assistance to local health departments and other community-based agencies implementing local motor vehicle safety activities. The VIP-MHP Branch and its partners hosted a statewide motor vehicle conference in June 2015. The VIP-MHP Branch analyzed county- and statewide data and produced the Colorado Department of Transportation (CDOT) 2015 Problem Identification Reports. The VIP-MHP Branch also partnered with the Colorado Department of transportation (CDOT) to improve its 2016-2018 local grant application. Since teen motor vehicle safety will not continue as a MCH priority for the next five years, the VIP-MHP Branch worked with local health departments to apply for CDOT funding and provided technical assistance to applicants on grant writing and evaluation. The Weld County Department of Public Health and Environment and the Montezuma County Public Health Department were awarded three-year grants from CDOT to continue their motor vehicle work for $85,758 per year and $60,000 per year, respectively.
SPM #10: The percentage of group members that invest the right amount of time in the collaboration effort to build a youth system of services and supports.	The annual indicator for reporting year 2015 was 88.5 percent. The target for reporting year 2015 was 78.0 percent. The target was met. Colorado 9to25 continued to be recognized as Colorado's youth system, as well as a mechanism for leveraging current and future funding, such as marijuana tax dollars used to fund the Communities That Care model in 43 local communities statewide. The Statewide Youth Development Plan's steering committee has been merged with the Colorado 9to25 steering committee (HB13-1239) to best promote alignment and long-term sustainability of

	Colorado 9to25 activities. In addition, the Colorado 9to25 Action Plan served as the foundation in the development of the recommendations included in the Statewide Youth Development Plan for HB12-1239. MCH staff led the revision of backbone agency scope of work details to ensure that funding resulted in a strong, sustainable youth-system infrastructure. MCH staff provided ongoing regional positive youth development trainings across the state in addition to numerous ad hoc trainings to state, local and community organizations. Staff worked to complete an updated positive youth development literature review, a positive youth development in Action Tool to capture how organizations are operationalizing the positive youth development approach. MCH staff has created Communities of Practice with local public health agency staff and partners to support supervisors of Youth Advisors, as well as the Youth Advisors themselves.

Children with Special Health Care Needs

State Action Plan Table

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

Priority Need

Medical home for children and youth with special health care needs

NPM

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

Objectives

By October 2017, increase the percentage of CYSHCN who receive HCP Care Coordination services who have an inter-agency shared plan of care from a baseline of 33.1 to 50 percent.

Strategies

Identify and implement policy/systems changes that support communication and collaboration between programs that provide care coordination for children and youth.

ESMs

ESM 11.1 - Percent of children and youth with special health care needs (CYSHCN) who receive HCP Care Coordination services and have an interagency shared plan of care

NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system

NOM 19 - Percent of children in excellent or very good health

NOM 22.1 - Percent of children ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3*:3:1:4)

NOM 22.2 - Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

Measures

NPM 11 - Percent of children with and without special health care needs having a medical home

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	50	52	53	54	55	56

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	48.3 %	4.2 %	97,225	201,227
2007	43.1 %	4.3 %	83,071	192,623

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	56.7 %	2.0 %	561,642	990,029
2007	62.6 %	2.1 %	589,502	941,904

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 11.1 - Percent of children and youth with special health care needs (CYSHCN) who receive HCP Care Coordination services and have an interagency shared plan of care

Annual Objectives

	2017	2018	2019	2020	2021
Annual Objective	50.0	52.0	54.0	56.0	58.0

Children with Special Health Care Needs - Plan for the Application Year

Priority: Medical Home

New NPM 11: Percent of children with and without special health care needs having a medical home

ESM 11.1: The percentage of CYSHCN who receive HCP Care Coordination services who have an inter-agency shared plan of care

The NPM 11 target for reporting year 2016 is 50 percent. The target for 2017 is 52 percent.
The ESM 11.1 target for reporting year 2017 is 37 percent. The target for 2018 is 41 percent.

The MCH priority of supporting Medical Homes for Children and Youth with Special Health Care Needs (CYSHCN) was continued in 2016 under the new NPM 11. New state and local logic models and action plans have been developed to guide implementation of MCH medical home strategies for 2016-2020. These strategies are focused on identifying and implementing policy/systems changes that:
-support communication and collaboration between programs that provide care coordination for children and youth
-enhance statewide access to pediatric specialty care
-strengthen transitions for youth and their families
-expand access to information and resources for children, youth and their families

To support communication and collaboration between programs that provide care coordination for children and youth, MCH staff continues to coordinate the Colorado Care Coordination Collaborative (Team 4C). Team 4C is focused on increasing efficiency and reducing duplication of care coordination services for CYSHCN that are provided through Medicaid's Accountable Care Collaborative Program, Healthy Communities (EPSDT Outreach Program) and Title V's HCP program. State MCH staff is using lessons learned from the Team 4C pilot (see annual report section) to provide input to the state Medicaid agency, as they craft phase II of the Accountable Care

Collaborative Program that will be launched in July 2018. MCH staff is also using the Team 4C process to develop local planning and technical assistance materials to guide replication with additional local public health agencies.

In addition, MCH staff established a workgroup with the Children's Hospital Colorado (CHCO) called Team 5C (CDPHE/CHCO Care Coordination Collaborative). While CHCO is based in metro Denver, their patient panel represents CYSHCN from every county in the state. Likewise, HCP programs provide community-based information and resources and/or care coordination services for CYSHCN statewide. Team 5C's purpose is to align CHCO's clinical care management with community-based HCP care coordination services throughout Colorado. An initial focus of this group has been to enhance the HCP referral form within CHCO's electronic medical record to be more accessible and user-friendly for CHCO staff. A longer term activity is to explore opportunities to pilot shared plans of care between CHCO clinics and HCP. To further support this effort, the group is leveraging the successes, challenges and opportunities identified through CHCO's CMMI-CARE Award and the CYSHCN Systems Integration Grant.

MCH staff are also partnering with CHCO to enhance statewide access to pediatric specialty care for CYSHCN. HCP currently partners with CHCO and University Physicians, Inc. to increase access to specialty care in rural areas of Colorado. Through this partnership, a number of systems level challenges have been identified that pose barriers to families accessing care. During the first part of 2016 the work group has expanded the discussion to include the Regional Care Collaborative Organizations (RCCOs), with a focus on the western slope where HCP is doing the largest amount of specialty care gap-filling. In addition to the systems level work, HCP has streamlined the triaging of CYSHCN accessing specialty care by setting up policies and processes to ensure that children who need follow up care are referred back to their primary care provider while the PCMP is able to access to the specialist for consultation. This streamlined process in increasing efficiency and promotes a medical home approach.

Strengthening transitions for youth and their families has been incorporated into the current medical home logic model and action plan. Because this is a new component of the medical home priority, staff have been conducting a series of transition scoping meetings to identify existing youth to adult transition efforts across the state and evidence based strategies that will be used to craft action plan activities beginning in FFY17.

The fourth strategy included in the state medical home logic model and action plan is expanding access to information and resources for children, youth and their families through the development and implementation of a Help Me Grow Hybrid system. Leadership from CDPHE, the Department of Health Care Policy and Financing and the Department of Human Services are aligned in support of the effort and are currently developing a plan, in partnership with private foundations, to braid funding for a HMG-H pilot. The MCH Director and CYSHCN Systems Integration Grant Coordinator are both involved in supporting this collaborative effort. During FFY16 MCH staff took an active role in participating on committees to shape the development of the Help Me Grow Hybrid in Colorado as part of the CYSHCN Systems Integration work. This ongoing effort ensures that the CYSHCN population will be considered in the design of the Help Me Grow and will benefit from the information and resources provided through the Help Me Grow Hybrid program.

The MCH implementation team lead for the medical home priority continues to coordinate and facilitate the Medical Home Coalition and the Medical Home Community Forum to support and sustain a statewide medical home infrastructure for children and youth. These groups are used to further the activities outlined in the medical home state action plan. Examples of topics discussed in these forums include: leveraging Colorado's State Innovation Model Grant; improving communication across providers through the development of shared plans of care for children and youth receiving care coordination services; coordinating with the Regional Care Collaborative Organizations to align supports and services for CYSHCN enrolled in Medicaid; and developing recommendations for ACC 2.0 around standards for the delivery of care coordination for CYSHCN. The Medical Home Coalition also serves as the

advisory group for Colorado's CYSHCN Systems Integration Grant and provides valuable input into the development and implementation of the CYSHCN SIG state plan.

Local MCH strategies for FFY17 are focused on the first two bullets (care coordination and specialty care), with the potential of expansion of effort to include the second two bullets (transition and Help Me Grow Hybrid) in the future.

To support the implementation of local medical home action plans, MCH staff continue to provide technical assistance and training to four local public health agencies (LPHAs) including: Tri County, Weld, San Juan Basin and Mesa County Health Departments. State funded MCH staff worked most closely with Tri-County Health Department in their role as a key implementation partner in the Team 4C, or Colorado Care Coordination Collaborative. A tangible outcome from Team 4C has been the execution of a data sharing agreement that is facilitating communication between the local health department and their RCCO about their respective caseloads. During the implementation of the Team 4C pilot, a subgroup was formed to focus on interagency care conferencing for CYSHCN receiving services from both the health department and the RCCO. The case conferencing workgroup has identified tangible policy and process changes that are being implemented within and between agencies. The lessons learned through the Team 4C process has shaped the design of the state medical home action plan, as well as the local medical home action plan template that is being used for the FFY17 local planning process.

Legislative requirements outlined in 501 (a)(1) and 505

Colorado's approach to choosing priorities aligns with the public health assurance role outlined in 501 (a)(1). Also, by virtue of MCH program policy and procedures, Colorado is fully compliant with the requirements outlined in section 505. Specific information in reference to 501 and 505 is included throughout the block grant application and report.

Critical partnerships with other MCHB-supported programs

MCH program partnerships with other MCHB-supported programs are discussed in section B.2.c. and throughout the population-domain program updates.

Children with Special Health Care Needs - Annual Report

Priority: Medical Home

Old NPM 3: Percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home

The annual indicator for reporting year 2015 was 43.7 percent. The target for reporting year 2015 was 47 percent and it is unknown whether the target was met because updated data were not available for reporting year 2015.

As outlined in the MCH Implementation Team's Medical Home state action plan, there were four strategy areas for reducing barriers to a medical home approach during this reporting period: mobilizing partnerships, policy development, supporting consumer voice and supporting local communities to promote a medical home approach.

Mobilizing partnerships: MCH-funded staff continued to lead the work of two key medical home stakeholder groups, in collaboration with the Colorado Department of Health Care Policy and Financing (HCPF). The first is the Colorado Medical Home Coalition, which is focused on strategically aligning existing statewide medical home projects, grants and initiatives to avoid duplication of effort. The coalition consists of representatives from the following Colorado programs and/or organizations: the Children's Hospital Colorado, the Coalition for the Medically Underserved, the Association of Family Physicians, the Rural Health Center Association, the Behavioral Health Care Council, the

Children's Healthcare Access Program, Family Voices Colorado, ClinicNET, JFK Partners, the School-Based Health Center Program, Title V's Health Care Program (HCP) for Children with Special Needs and the Community Health Network. Examples of topics discussed by the coalition include: leveraging Colorado's State Innovation Model Grant; Coordinating with the Regional Care Collaborative Organizations and Developing recommendations for ACC 2.0. The Medical Home Coalition also serves as the advisory group to Colorado's CYSHCN Systems Integration Grant.

The second CMHI-supported group is the Colorado Medical Home Community Forum. These bi-monthly, evening meetings provide an opportunity to support bi-directional communication related to supporting a medical home approach within Colorado's evolving health care reform efforts. Presenters share information with and solicit input from a diverse array of medical home stakeholders that includes state and local government agencies, non-profit organizations, families, and providers from primary, specialty, oral and behavioral health care systems. Examples of topics addressed include integration of Colorado's insurance exchange; youth to adult care transitions; promoting access to pediatric specialty care in rural communities; and community-based collaboration with the Regional Care Collaborative Organizations (RCCOs).

Policy development: Specific to the policy objective included in the state action plan, MCH prioritized two areas of policy development that support family-centered care within a medical home: 1) increase families' access to needed information and resources to support navigation within and across systems; 2) maximize state and federal resources to efficiently provide care coordination for children and youth without duplication. To support the first area of focus, MCH partnered with HCPF and the Office of Early Childhood at the Colorado Department of Human Services to develop an implementation plan to launch a Help Me Grow Hybrid model in Colorado. In alignment with the second areas of focus, Colorado continued the work initiated under the MCH Workforce Development Technical Assistance Center's Cohort 1 Colorado's project, coined the Colorado Care Coordination Collaborative or Team 4C, focused on maximizing the effectiveness and efficiency of care coordination for the CYSHCN population by identifying more than 40 policy change opportunities and prioritizing the work for FFY2015. Achievements included the development of a data sharing agreement between a local public health agency and their RCCO to better understand the degree of potential duplication and the implementation of case conferencing to identify and implement interagency policy and process changes. The primary Team 4C partners include Health Care Policy and Financing; Colorado Access (the Regional Care Collaborative Organization for the pilot area); and Tri-County Health Department.

To further support medical home systems change, Colorado was one of 12 states to receive a Children and Youth with Special Health Care Needs Systems Integration Grant. The CYSHCN SIG Leadership Team integrated both the Help Me Grow Hybrid model and Team 4C efforts into the state plan that was developed in 2015, with implementation continuing through August 2017.

Supporting consumer voice: Three family leaders, funded as state employees, continued to provide statewide coordination for the Family Leadership Training Institute (FLTI) to support family leaders in communities throughout Colorado. During this period the online platform for the Family Leadership Registry was developed and tested, with the ultimate goal of linking family leaders with opportunities to to positively influence programs and policies. Additionally, an MCH-funded family leader participated in Colorado's Family-to-Family (F2F) Coalition coordinated by Family Voices Colorado to assure alignment of effort with other family organizations in Colorado. For more on family leadership see section F.3.

Supporting local communities: MCH-funded staff provided technical assistance and training to four local public health agencies (LPHAs) to support implementation of their local medical home action plans to strengthen coordinated care for children and youth within their community. Technical assistance was based upon the policy and systems change process piloted through Team 4C (mentioned above).

Table for CSHCN Priorities and PMs that will not Continue

Performance Measure and/or Priority	Last Year's Accomplishments and Current Activities
NPM #2: The percent of children with special health care needs (CSHCN) age 0 to 18 whose families partner in decision-making at all levels and are satisfied with the services they receive	The annual indicator for reporting year 2015 was 66.5 percent. The target for reporting year 2015 was 70.0 percent. It is unknown whether the target was met since updated data are not available. The Family Leadership Training Institute (FLTI) continues to be the primary strategy to address the capacity of families as decision makers and to impact satisfaction rates related to services. The FLTI course is offered in 12 communities across the state, including urban and rural locations. Currently there are approximately 625 graduates of the program since 2009. Three of the locations offer the course for mono-lingual Spanish speaking families. Evaluation highlights include how often the participants developed programs to address community needs and how they used data to understand program quality. Family leaders reported their engagement with these activities from "never" or rarely to nearly "monthly." The percent of participants checking "yes" to participating in civil activities in the past six months more than doubled. They also showed the greatest increase of knowledge for how community systems are organized. Before the FLTI training, 35 percent of these family leaders spoke or presented at a community meeting and 34 percent contacted a public official. After completing the training, over 90 percent reported participating in a community meeting and contacting an elected official. In addition to the FLTI course, families are also supported to attend the annual Family Leadership Summit and have access to a myriad of trainings offered by partners statewide. Graduates of FLTI now serve on boards and advisories as other state agencies, assuring the family perspective in embedded in policy. Examples include one FLTI graduate who was elected to the Larimer County Health Commission/District, two that serve on the CDE Statewide Council (known as the Special education Advisory Council (SEAC), and two grads that work for Representative Rhonda Fields. The Family Leadership Registry is a tool to help agencies connect with a Family Leader who is trained and equipped to offer the parent/family perspective. The database contains over 500 family leader profiles and 15 partner organization profiles. Partner agencies can complete an organizational profile, then post a leadership opportunity whereby families can partner with agencies on councils, work groups, review committees, etc. The registry was officially launched March 1, 2016. For more on family leadership see section F.3.
NPM #4: 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	The annual indicator for reporting year 2015 was 49.9 percent. The target for reporting year 2015 was 53.0 percent. It is unknown whether the target was met since updated data are not available. MCH-supported staff co-led the Colorado Medical Home Initiative, which addressed issues related to access to adequate insurance (see NPM 3). In addition, MCH funded staff participated in the Children's Services Steering Committee (the EPSDT/Healthy Communities policy advisory) and the Children's Disability Advisory Committee, which are both led by HCPF, and the Covering Kids and Families Coalition to share information, simplify the public insurance application process and identify concerns for families using public insurance. In addition to the CMHI, MCH-supported staff participated in a cross systems care coordination pilot called Team 4C. The Colorado Care

	Coordination Collaborative's objective is to minimize the gaps, avoid duplication and maximize the value of care coordination services. This work effort is being implemented through partnerships between CDPHE, HCPF, local public health agencies and the RCCOs. During the pilot, agencies have developed data sharing agreements, clarified roles and developed policies and systems that ensure that CYSHCN are insured and receive access to appropriate and timely care.
NPM #5: The percent of children with special health care needs age 0 to 18 whose families report community-based service systems are organized so they can use them easily	The annual indicator for reporting year 2015 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 2015 was 62.0 percent. It is unknown whether the target was met since updated data are not available. The HCP consultants at CDPHE held four coordinating meetings and one training with the Brain Injury program located in the Colorado Department of Human Services (CDHS), the Colorado Department of Education (CDE) and HCP care coordinators to evaluate and strengthen the referral systems for children with traumatic brain injuries. The outcome of the training was improved referral systems and resulted in children and youth with brain injuries to receiving more timely care coordination and follow up. In addition, the CYSHCN section manager participated on the TBI Trust Fund Board which contributes to improving statewide systems that support individuals with brain injuries. MCH-supported staff participated in the formation of the Colorado Care Coordination Collaborative (Team 4C) which focuses on improving coordination among three state wide programs serving children and youth enrolled in Medicaid including: Regional Care Collaborative Organizations (RCCOs) and Health Communities (EPSDT) from HCPF and HCP from CDPHE with the goal of maximizing care coordination resources to minimize gaps and avoid duplication of services for the CYSHCN population. This project has resulted in aligning care coordination efforts across multiple programs through effective policy and system changes. For example, a system was developed to identify shared client's, case conference the clients to identify areas for improvement and develop shared plans of care. This project has increased the communication across providers and improved coordinated care for families of CYSHCN.
NPM #6: 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)	The annual indicator for reporting year 2015 was 42.1 percent. The target for reporting year 2015 was 46.0 percent. It is unknown whether the target was met since updated data are not available. MCH-supported staff has continued disseminating the resources from GotTransition.org, the National Center for Health Care Transition and providing related technical assistance to local partners. In addition, the MCH-supported staff has worked closely with the Family Voices Colorado staff and Family-to-Family coalition to assure alignment in supporting families and sharing resources. Staff has also partnered with Parent to Parent to connect families to peer-to-peer support, based on shared experience. Transition guidance, technical assistance and age-related reminders within the data system are being included to support care coordinators and ensure that more LPHA staff are implementing strategies that support smooth transitions of care. MCH-supported staff is participating in a federal inter-agency transition community of practice to assess existing transition efforts and identify opportunity to implement policy/systems changes that strengthen transitions for CYSHCN and their families. An internal work group comprised of staff focused on CYSHCN and Colorado 9 to 25 has been formed to assess the transition needs of youth across programs and how to implement

	evidenced based strategies at a state and local level.

Cross-Cutting/Life Course

State Action Plan Table

State Action Plan Table - Cross-Cutting/Life Course - Entry 1

Priority Need

Substance misuse reduction (tobacco, marijuana and prescription drugs) among pregnant and postpartum women

NPM

A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes

Objectives

By September 2017, increase the percent of pregnant women who report their health care provider asked or advised them about smoking, and/or referred them to cessation services from 30 percent to 33 percent.

By September 2017, increase the percentage of pregnant and postpartum women who report that their health care provider advised them during pregnancy and postpartum about the harms of their child's exposure to secondhand smoke from 34.6 percent to 35.9 percent and the percent of parents who report their health care provider talked to them about their child's exposure to secondhand smoke will increase from 28.8 percent to 29.5 percent.

Strategies

Educate health care providers (pediatricians) to screen infants for exposure to secondhand smoke at every visit.

ESMs

ESM 14.1 - Percent of women who report that a doctor, nurse, or other health care worker talked with them about how smoking during pregnancy could affect their baby

ESM 14.2 - Percent of women who report that a doctor, nurse, or other health care worker advised them during pregnancy and postpartum about the harms of their child’s exposure to secondhand smoke

ESM 14.3 - Percent of children whose parents report that their child’s’ health care provider talked to them about their child’s exposure to secondhand smoke

NOMs

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

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

NOM 4.1 - Percent of low birth weight deliveries (<2,500 grams)

NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)

NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)

NOM 5.1 - Percent of preterm births (<37 weeks)

NOM 5.2 - Percent of early preterm births (<34 weeks)

NOM 5.3 - Percent of late preterm births (34-36 weeks)

NOM 6 - Percent of early term births (37, 38 weeks)

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.2 - Neonatal mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

NOM 19 - Percent of children in excellent or very good health

State Action Plan Table - Cross-Cutting/Life Course - Entry 2

Priority Need

Substance misuse reduction (tobacco, marijuana and prescription drugs) among pregnant and postpartum women

SPM

Percent of women who report using marijuana at any time during their pregnancy

Objectives

By September 2017, increase the number of health care providers who provide care to pregnant, postpartum or women of reproductive age who complete prescription drug continuing medical education training or who receive marijuana education from 0 to 100.

Strategies

Provide provider education and training on health effects and risks of substance use specifically prescription drug misuse and marijuana use among pregnant, postpartum and women of reproductive age 15-44.

State Action Plan Table - Cross-Cutting/Life Course - Entry 3

Priority Need

Substance misuse reduction (tobacco, marijuana and prescription drugs) among pregnant and postpartum women

SPM

Rate of emergency department visits for women for prescription drug use poisoning per 100,000 women ages 15 through 44

Objectives

By September 2017, increase the number of health care providers who provide care to pregnant, postpartum or women of reproductive age 15-44 who complete prescription drug continuing medical education training or who receive marijuana education from xx to xx.

Strategies

Provide provider education and training on health effects and risks of substance use specifically prescription drug misuse and marijuana use among pregnant, postpartum and women of reproductive age 15-44.

State Action Plan Table - Cross-Cutting/Life Course - Entry 4

Priority Need

Substance misuse reduction (tobacco, marijuana and prescription drugs) among pregnant and postpartum women

SPM

Rate of hospitalizations for prescription drug poisoning per 100,000 women ages 15 thought 44

Objectives

By September 2017, increase the number of health care providers who provide care to pregnant, postpartum or women of reproductive age who complete prescription drug continuing medical education training or who receive marijuana education from 0 to 100.

Strategies

Provide provider education and training on health effects and risks of substance use specifically prescription drug misuse and marijuana use among pregnant, postpartum and women of reproductive age 15-44.

Measures

NPM-14 A) Percent of women who smoke during pregnancy

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	6.9	6.7	6.5	6.3	6.1	5.9

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	6.7 %	0.1 %	4,399	65,615
2013	7.1 %	0.1 %	4,611	64,547
2012	7.4 %	0.1 %	4,798	64,753
2011	7.4 %	0.1 %	4,817	64,936
2010	8.1 %	0.1 %	5,381	66,249
2009	8.4 %	0.1 %	5,750	68,485

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NPM-14 B) Percent of children who live in households where someone smokes

Annual Objectives

	2016	2017	2018	2019	2020	2021
Annual Objective	20.2	19.8	19.4	19.0	18.5	18.0

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	20.6 %	1.5 %	249,950	1,214,588
2007	22.2 %	1.7 %	259,471	1,169,690
2003	24.6 %	1.3 %	243,711	992,273

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 14.1 - Percent of women who report that a doctor, nurse, or other health care worker talked with them about how smoking during pregnancy could affect their baby

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	70.2	71.8	73.4	75.0	76.6

ESM 14.2 - Percent of women who report that a doctor, nurse, or other health care worker advised them during pregnancy and postpartum about the harms of their child's exposure to secondhand smoke

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	35.9	37.3	38.7	40.0	41.4

ESM 14.3 - Percent of children whose parents report that their child's' health care provider talked to them about their child's exposure to secondhand smoke

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	29.5	30.3	31.0	31.7	32.5

Cross-Cutting/Life Course - Plan for the Application Year

Priority: Substance misuse reduction (tobacco, marijuana and prescription drugs) among pregnant and postpartum women

1) Tobacco

New NPM 14: a) Percent of women who smoke during pregnancy b) Percent of children who live in households where someone smokes

ESM 14.1: Percent of pregnant women who report their provider talked to them about how tobacco use could affect their baby

ESM 14.2: Percent of pregnant and postpartum women who report that their health care provider advised them during pregnancy and postpartum about the harms of their child's exposure to SHS

ESM 14.3: Percent of children whose parents report that their child's health care provider talked to them about their child's exposure to secondhand smoke.

The target for NPM 14a for year 2016 is 6.9 percent. The target for 2017 is 6.7 percent.
The target for NPM 14b for reporting year 2016 is 20.2 percent. The target for 2017 is 19.8 percent.
The target for ESM 14.1 for reporting year 2017 is 70.2 percent. The target for 2018 is 71.8 percent.
The target for ESM 14.2 for reporting year 2017 is 35.9 percent. The target for 2018 is 37.3 percent.
The target for ESM 14.3 for reporting year 2017 is 29.5 percent. The target for 2018 is 30.3 percent.

Activities to prevent tobacco use among pregnant women include:
-Maintain and operate a smoking cessation pregnancy program within the Colorado QuitLine.

-Maintain the Baby and Me Tobacco Free (BMTF) smoking cessation program in 32 health agency partners across Colorado (see annual report for background information about BMTF).
-BMTF to at least four new health agencies.
-Increase awareness and promote utilization of the Colorado Medicaid tobacco cessation counseling benefit and pharmacotherapy benefits among health care providers and pregnant and postpartum women.
-Provide quarterly web-based training for OB/GYNs about tobacco cessation during pregnancy.
-Work with local partners to cross-promote and integrate treatment and referrals to the QuitLine.
-Coordinate messaging and outreach efforts with state-wide partner organizations to promote the QuitLine (see the annual report for more information on the Quitline).
-Work with State Medicaid office to incorporate BMTF curriculum into their pregnancy payment bundle.
-Work with State Medicaid office to expand the provider types who can provide cessation counseling to pregnant women.

Activities to reduce the percent of children who live in households where someone smokes (tobacco) include:
-Promote clinical prevention guidelines to health care providers to screen all newborns for exposure to secondhand smoke, to advise parents and caregivers to never allow smoking in the home or car, and to advise parents to quit smoking.
-Promote non-smoking (tobacco and marijuana) policies in multi-unit housing to prevent infant secondhand smoke exposure.
-Develop and promote resources for parents on adopting a smoke-free home and car rule.
-Develop training and toolkit resources for public housing providers on the benefits of adopting a smoke-free policy and resources for implementation and enforcement.
-Create and distribute print media materials about the harms of exposure to secondhand smoke (tobacco and marijuana) to children aimed at a multiunit housing setting.
-Promote and encourage resident involvement in smoke-free policy development, implementation, and enforcement in a multiunit housing setting.

2) Other Substance Use:
New SPM 3: Percent of women who report using marijuana at any time during their pregnancy
New SPM 4: Rate of emergency department visits for prescription drug poisoning per 100,000 women ages 15 through 44
New SPM 5: Rate of hospitalization for prescription drug poisoning per 100,000 women ages 15 through 44

The target for SPM 3 for reporting year 2017 is 6.2 percent. The target for 2018 is 6.1 percent.
The target for SPM 4 for reporting year 2017 is 216.7. The target for 2018 is 212.9.
The target for SPM 5 reporting year 2017 is 92.8. The target for 2018 is 91.2.

As a new priority area for the MCH Block Grant, substantial foundational work is underway to support this priority.

By 2017, CDPHE will decrease the perception of "no risk" of harm from daily or near daily use of marijuana among women ages 18-44, specifically for pregnant and postpartum women as data becomes available, by five percent from baseline data available Summer 2016 from the Behavioral Risk Factor Surveillance Survey. To this end, CDPHE will work with partners to inform and disseminate mass reach health education campaigns that target pregnant and postpartum women with substance abuse prevention messages. Since October 2015, CDPHE has contracted with a media agency to do focus groups with pregnant and postpartum female marijuana users to inform the development and implementation of a marijuana public education campaign that aims to raise awareness about the risks of marijuana use during pregnancy and while breast feeding. Creative assets are currently in development

and the statewide campaign is scheduled to be launched in the Summer of 2016. Following the campaign launch, CDPHE will coordinate messaging and outreach efforts with statewide partner organizations and local public health agencies to promote mass reach health education campaign materials with substance abuse (marijuana and nonmedical use of prescription drugs) messaging.

By 2017, CDPHE will increase the number of counties with permanent prescription drug take-back sites in Colorado from 17 to all 64 in an effort to increase access to safe disposal of substances to limit availability for misuse via coordination with the CDPHE Medication Take-Back Program. CDPHE has partnered with Environmental Health to recruit law enforcement, pharmacies or hospitals to host permanent prescription drug take-back receptacles. Five new take-back locations have come online since October 2015 and Environmental Health has selected a vendor to safely collect and dispose of medication acquired at the receptacle and locally-hosted drug take back events. The vendor will also provide receptacles to all remaining counties that do not currently host a take-back location, and will engage with communities that are more populous or geographically isolated to ensure that Coloradans across the state have easy access to safe disposal by 2017. In partnership with Colorado School of Pharmacy, CDPHE plans to assist a minimum of ten identified local communities to develop plans to establish safe permanent disposal sites for unused prescription medications and will create safe disposal local community communication tool kits about the importance of safe disposal and the location of medication disposal boxes by July 2016.

By 2017, CDPHE will increase the number of health care providers who provide care to pregnant, postpartum, or women of reproductive age who complete prescription drug continuing medical education training or who receive marijuana education through the provision of health care provider education and training materials. CDPHE currently provides online trainings, clinical guidance documents, and webinars to healthcare providers on health effects, and risks of marijuana use for pregnant or postpartum women. One hundred eighty-two (182) providers have been trained from October 2015 - February 2016, with a goal of 200 by 2017. In January 2016, CDPHE hired a temporary employee to develop online Continuing Medical Education (CME) training on marijuana use and pregnancy. The CME training has been approved and will be launched June 2016. By 2017, CDPHE will engage partners to develop and promote similar resources to healthcare providers on health effects and risks of prescription drug misuse.

By 2017, the Colorado State Board of Health, Board of Medicine, Department of Regulatory Affairs, or other statewide organizations will issue statements to physicians who recommend medical marijuana, relative to use during pregnancy or post-partum. CDPHE met with regulatory board(s) to advocate for information sharing focused on common misconceptions about marijuana use during pregnancy or postpartum, supporting the development of a statement to ensure evidence-based prescribing practices. CDPHE staff compiled comments on the “Policy Regarding Recommendations for Marijuana as a Therapeutic Option” and provided them to the Colorado Medical Board. In October 2015, the Colorado Medical Board issued the following guidance "For women of childbearing age, the recommending physician should also take into consideration the possibilities of pregnancy and breast-feeding and perform further evaluation and/or counseling as appropriate."

By 2017, CDPHE will increase the ratio of queries to Prescription Drug Monitoring Program (PDMP) for high-dose opioid prescriptions dispensed to women age 18-44 by 5 percent, from baseline to be established. As of February 2016, CDPHE hired a Prescription Drug Epidemiologist to conduct public health surveillance via the PDMP for prescribers who provide care to pregnant or postpartum women. The baseline ratio for queries to the PDMP per high-dose opioid prescriptions dispensed to women age 18-44 will be analyzed with findings disseminated publicly to raise awareness among prescribers and promote the use of the PDMP as a tool to prevent misuse by 2017. As of March 2016, CDPHE was awarded a Center for Disease Control and Prevention grant for prescription drug overdose prevention which will be leveraged to further promote the use of the PDMP among prescribers and finance improvements to the electronic database to facilitate easy use. Additional community work in regions with a high burden of prescription drug overdose deaths will also be leveraged to help prevent misuse of prescription drugs by

pregnant or postpartum women.

By 2017, CDPHE will create a data report to understand prescription drug use by pregnant and postpartum women to ultimately inform recommendations regarding neonatal abstinence syndrome (NAS) and maternal mortality from prescription drugs. Since October 2015, CDPHE staff has worked with partners at the Substance-Exposed Newborns Steering Committee of the Substance Abuse Trend and Response Task Force to develop data and surveillance recommendations. Following the development of these recommendations in Spring 2016, CDPHE will continue to identify traditional and nontraditional data sources, coordinate with the Colorado Consortium for Prescription Drug Abuse Prevention and the Maternal Mortality Review group to discuss data improvements and analysis, to be reported in the 2017 data report.

Legislative requirements outlined in 501 (a)(1) and 505
Colorado's approach to choosing priorities aligns with the public health assurance role outlined in 501 (a)(1). Also, by virtue of MCH program policy and procedures, Colorado is fully compliant with the requirements outlined in section 505. Specific information in reference to 501 and 505 is included throughout the block grant application and report.

Critical partnerships with other MCHB-supported programs
MCH program partnerships with other MCHB-supported programs are discussed in section B.2.c. and throughout the population-domain program updates.

Cross-Cutting/Life Course - Annual Report

Priority: Substance misuse reduction (tobacco, marijuana and prescription drugs) among pregnant and postpartum women
1) Tobacco:
Old NPM 15: Percent of women who smoke in the last three months of pregnancy

The annual indicator for reporting year 2015 showed that 5.5 percent of women reported smoking in the last three months of pregnancy. The target for reporting year 2015 was 5.8 percent. The target was met.

In 2014, Colorado Medicaid expanded coverage for preventive services for all Medicaid clients, including tobacco cessation coverage. In July 2015, a total of $250,000 of the tobacco excise grant funds was awarded to a grantee for a project to provide targeted media promotion, technical assistance and training to Medicaid providers and Medicaid clients, including pregnant women, to increase awareness and promote utilization of the Colorado Medicaid tobacco cessation counseling benefit and pharmacotherapy benefit available to Medicaid clients across Colorado. New Medicaid provider materials were released in January 2016 and Medicaid provider webinars began in February 2016 and will continue through FY18. The targeted media campaign launched on February 2016. During February and March, FQHCs in high tobacco prevalence counties were provided with free posters and fliers, and targeted digital ads appeared online.

The STEPP program developed a QuitLine brochure specifically targeting pregnant women, which explains the free resources available to all of Colorado's expectant mothers. In addition, a customizable poster was created to promote these benefits, which feature two images - one Caucasian mother, the other an African American mother - and provides a synopsis of the benefits available to pregnant tobacco users.

The Colorado QuitLine Pregnancy Program has served 289 pregnant women from February 2015-February 2016.

The QuitLine also served 28 postpartum women during the same time frame. The state tobacco program is currently working with a media contractor to develop customizable templates for the QuitLine pregnancy program materials to promote the program to mothers who use tobacco.

In July 2015, the Baby and Me Tobacco Free program (a smoking cessation program created to reduce the burden of tobacco use on the pregnant and post-partum population) expanded to fund Rocky Mountain Health Plan Foundation to subcontract with 32 sites, reaching women in 33 additional counties. Colorado was the first state in which Baby and Me Tobacco Free was offered statewide. Between January 2015 and December 2015, the Baby and Me Tobacco Free program served 1,856 pregnant and postpartum women. During that same time period, the average birth weight of babies born to women in the program were successful in reaching a key milestone in birth weight, averaging 7 pounds (versus a baby diagnosed as low birth weight at 5 pounds, eight ounces or less). Over half (53 percent) of participants remained abstinent from smoking during pregnancy and 78 percent were smoke-free at their last prenatal visit before delivery. Each additional week of enrollment in the program increased the likelihood that a woman would remain abstinent from smoking during pregnancy. Among the women who returned to the program after delivery, 75 percent remained smoke-free for at least three months postpartum and quit rates at 3, 6, and 12 months postpartum were 43.0 percent, 35.4 percent, and 25.3 percent respectively. The Rocky Mountain Health Plan Foundation continues to work with the University of Colorado Cancer Center to conduct a robust evaluation of the effectiveness of the program.

Beginning January 2014, Exempla Lutheran Medical Center (ELMC) was funded by the CDPHE tobacco program with Amendment 35 tobacco excise tax dollars to implement a comprehensive Tobacco Cessation project in its Women and Family Inpatient Unit. Healthy You, Healthy Baby (HYHB) provides evidence-based tobacco cessation treatment and follow-up for mothers (prenatal, during hospitalization and postnatal). From January 2015 to December 2015, the program served 751 women. During this time period, HYHB conducted an audit to ensure that at least 90% of admitted patients to Labor and Delivery (L&D) were being screened for tobacco use. Overall, the six-month smoking rate decreased from 48.33% to 29.17%. Approximately nineteen local health “tobacco community” grantees were funded to work with approximately sixty Federally Qualified Health Centers (FQHCs) to implement evidenced-based services to promote cessation among clients and patients including pregnant women, such as provider reminder systems, e-referral, QuitLine referrals and reminders to protect their infant from exposure to secondhand tobacco smoke by making a smoke-free rule for their home and car. The 2014 Child Health Survey found 28.8 percent of parents reported their health care provider talked to them about their child’s exposure to secondhand smoke compared with 27.7 percent in 2012Although not statistically significant, the percent of children who live with a smoker and exposed to secondhand smoke increased to 22.2 percent (CI14.0 percent - 30.1 percent) in 2014 compared with 19.7 percent (CI13.0 percent - 26.4 percent) in 2013.The STEPP program is funding eight local health “community tobacco” grantees to promote smoking bans in affordable multiunit housing. The STEPP program also contracted with Denver Health to provide technical assistance and training to the tobacco community grantees and to public housing authorities to implement smoking bans in all indoor areas of the housing authority property. Information from a 2015 study conducted by the American Lung Association about the health and economic benefits of smoking bans was shared with all public housing authorities in Colorado. Denver Health is currently drafting model policy provisions and resources to assist grantees and local housing authorities in passing comprehensive policies and has begun providing training and technical assistance to housing providers on how to implement smoke-free policies. As of December 2015, 950 additional units are covered by smoke-free policies, bringing the total number of units to 4847. The total number of housing authorities with smoke-free policies is 33.

Other Programmatic Activities

Local public health agencies are contractually required to focus most of their efforts on the MCH priorities as well as

to implement the HCP model of care coordination.

Local Discretionary Work

A small number of local public health agencies are contracted to implement efforts that supplement the overall, targeted portfolio of strategies.

In FY15 and FY16, as a subset of their work (10 percent or less of their budget), Larimer County Health Department implemented AFIX (Assess, Feedback, Incentives, eXchange). AFIX is an evidence based quality improvement program used to raise immunization coverage levels, reduce missed opportunities to vaccinate, and improve standards of practice at the provider level. Larimer County engaged two medical practices in increasing vaccine services to children under three years old. The agency worked with the selected provider offices to implement interactive assessments, improvements, and follow-up to increase immunization delivery rates among the target population.

In FY15, Boulder County Public Health was one of several local agencies implementing initiatives in support of Colorado's Youth Sexual Health Priority. As a result of Colorado's 2015 Needs Assessment, this initiative was phased out as a state-level priority; however Boulder County Health was supported in investing one additional year toward this work as a discretionary subset of their overall funding. Boulder's local Youth Sexual Health Coalition held two Askable Adult trainings to teach local youth-serving adults the necessary skills to have effective, meaningful conversations with youth about sexual health issues. Askable Adult trainings were incorporated into three other BCPH programs including its evidence-based GENESIS/GENESISTER programs which reduce teen fertility rates among parenting teens and their sisters. Staff worked with agency leadership and county policy staff to increase awareness regarding the efficacy of long-acting reversible contraceptives and the negative impacts of unintended pregnancy, while increasing awareness of policy options for increasing access to LARC. To further this message, staff arranged for two GENESIS youth participants to be interviewed for a Denver Post article on the impact of LARC in their lives; empowering the youth and influencing community and political will by giving voice to their experience. Boulder County staff also worked to increase knowledge regarding state policy efforts to expand the Medicaid Teen Pregnancy and School Dropout Prevention Program. The team created a document outlining ACA requirements for health insurance to cover contraception copays, which was distributed to Boulder County physicians through the Epi-Connections newsletter. This work will continue under an alternate funding source beginning in FY17.

Newborn Hearing

Newborn Hearing Program staff is partially funded by MCH to increase the rate of infants who receive appropriate screening. Colorado's overall newborn hearing screening rate is over 97 percent. Efforts during FY17 will focus on identifying the appropriate role for public health and the primary care medical home regarding diagnosis and follow-up.

II.F.2 MCH Workforce Development and Capacity

Professional Development

The MCH section organizes learning circles every other month. Last year's sessions focused on the MCH data-to-action process. Specific topics included: Performance Management: What is it? Who does it? How? And Why? (Parts I and II); Data Visualization and Communication for Effective Program Implementation; and Evaluation and Performance Management. In addition, the MCH program hosted two trainings on implementation science for state and local MCH staff, along with a two-day facilitation training.

For FY17, the MCH Program has developed a comprehensive training and technical assistance plan to guide future training and technical assistance efforts for state and local staff implementing the MCH priorities. The training plan

focuses on the MCH fundamentals of health equity; community engagement; and continuous quality improvement, performance management and evaluation. MCH learning circles will continue every other month, along with quarterly MIT meetings to support priority implementation. In addition to the group peer learning opportunities, designated MCH staff will serve as coaches for each fundamental to provide individualized technical assistance to MIT leads, specific to their priority area.

As priority area content experts, MIT leads coordinate shared learning opportunities for the cohort of local contractors who have selected to work on their respective MCH priority. In addition to providing MIT content expertise, these capacity building opportunities are intended to promote cross-agency sharing of resources, best practices and lessons learned. Discussion format includes conference calls, webinars, and in-person meetings. For example, in August 2015, the Medical Home MIT coordinated a face-to-face meeting amongst the four agencies with local medical home action plans to discuss successes and challenges and exchange ideas related to implementation strategies. Additional technical assistance for local public health agencies is provided through structured check-in meetings and conference calls that are held between MIT leads, the MCH Generalist Consultant and the staff from individual agencies a minimum of three times per year.

In addition, the HCP consultants coordinate a statewide meeting for HCP staff located in local public health agencies. The goal of this meeting is to create a forum for shared learning across agencies and to improve the quality and consistency of HCP care coordination. For example, the November meeting focused on transition to adulthood and included a case review of an HCP client. The review provided opportunities to provide context, resources, and best practices around transition. A similar monthly meeting is held to support pediatric specialty clinic services across the state.

In addition to MCH-specific workforce development efforts, the Prevention Services Division has chartered a Staff Engagement Approach Team to focus on recruiting and hiring a strong and diverse workforce; implementing creative retention strategies; and promoting bi-directional feedback at all levels of the organization.

Major MCH Staff Changes

A number of new employees were added to the MCH team over the past year.

The MCH section of the Children, Youth and Families Branch (CYFB) added Isabel Dickson as a new MCH Generalist Consultant. This position is responsible for providing public health consultation and technical assistance to assist local public health agencies in priority implementation. Isabel provides public health programmatic consultation in collaboration with content specialists that includes guidance and technical assistance on evidence-based program planning, development, and implementation. Isabel has a master's in public health from the University of Washington and transferred to the MCH unit from the state WIC office.

The HCP program added Abraham de Herrera as a HCP Program Consultant. He will support the local implementation and evaluation of HCP care coordination services. Abraham began his career at CDPHE in 2007 in the DCEED division, serving in the STI/HIV Program. He is a Spanish-speaking licensed medical social worker with twelve years experience in Hospice care and Refugee resettlement. Abraham holds master's of public health and master's of social work degrees.

The Maternal Wellness and Early Childhood Unit hired Caitlin Evrard as the Behavioral Health Integration Specialist. In her role, Caitlin is responsible for identifying and promoting best practices for behavioral health integration for children and their caregivers through the State Innovation Model (SIM). She provides public health and systems expertise to improve coordination and integration of social-emotional and developmental screening for children in

the primary care setting with an intentional focus on simultaneously addressing social-emotional health of parents and caregivers. She has a master's in public health from the Tulane School of Public Health and most recently worked for the Louisiana Public Health Institute on projects related to behavioral health integration and clinical quality improvement.

Jodi Drisko serves as the MCH Evaluation Manager. In this role, she will work with MCH program staff to establish evaluation plans for key priorities. She received her MSPH in 1994 from the University of Colorado Health Sciences Center and has over 20 years of experience in public health planning and evaluation. She has worked primarily in the areas of maternal child health, chronic disease prevention and control, school based health centers, patient navigation and clinical quality improvement. For the last nine years, she has worked with state and local health departments in Colorado and Hawaii on program planning and evaluation.

There are two new MCH Implementation Team (MIT) leads this year. Kirstin Hoagland is the new Interpersonal Violence Prevention program coordinator. Kirstin will be providing support and TA to LPHAs who chose to focus on bullying and youth suicide prevention. Prior to joining the CDPHE team, Kirstin served two years in the AmeriCorps VISTA program.

Felicia Fognani is leading the tobacco portion of the substance misuse priority. Felicia joined the State Tobacco Education and Prevention Partnership (STEPP) Team in June 2015 with an expertise in women's health and the prevention of chronic conditions in the low-SES/Medicaid population. Previously, Felicia worked for the state Medicaid office as the Women's Health Specialist. Felicia received her Master's of Public Policy from American University and her Bachelor's in political science from the University of Colorado at Boulder.

II.F.3. Family Consumer Partnership

Over the next five years, youth, family and community engagement will be integrated into state action plans for each of Colorado's priorities at the state and local level.

In addition to the practical application of and investment in this engagement, staff has recently created a "CDPHE Community Engagement Continuum" to guide CDPHE staff and partners in how to engage community effectively. This continuum honors various forms of engagement in addition to highlighting the varying levels of support, resources, trust, ownership and skill-building that are required for effective engagement. Staff with expertise in youth and family engagement recently hosted a learning circle for MCH and other department staff to learn skills and share resources in engaging youth and families, in addition to presenting a session at the statewide MCH conference.

The cornerstone of Colorado's community engagement work is the Colorado Family Leadership Training Institute (FLTI). The FLTI curriculum is a twenty-session course designed to enhance personal leadership skills, as well as teach civic engagement strategies, to improve outcomes for children. All graduates of the FLTI program are required to complete a community project as part of their learning experience. Issues of health equity continue to be identified and addressed through the community projects led by FLTI graduates, including poverty, homelessness and toxic stress.

FLTI has now grown to twelve communities and 700 graduates. The twelve communities span the state, including urban and rural representation, as well as tribal communities in the southern part of the state. The demographics of the family leaders who participated in 2014 and 2015:
-Participants were 27 percent male, 72 percent female, one percent other

-Participants were 12 percent Black/African American, 12 percent Hispanic/Latino, 70 percent White, one percent Native American, two percent Asian/Pacific Islander, two percent Mixed
-Education levels were widespread among the participants: three percent with less than high school diploma, 19 percent with GED or High School education, 19 percent with Associates Degree, 38 percent with Bachelor's degree, 21 percent with Master's, Doctoral degree or post-graduate work
-Income was almost equally distributed across all annual income levels: 20 percent report less than $20,000, 20 percent report $20-40,000, 17 percent report $40-60,000, 19 percent report $60-85,000 and 24 percent report more than $85,000

Family Leaders are now serving on several advisory boards, councils, task forces and work groups, as well as hired as employees as a result of their competency and leadership training. Highlights include:
-Denver Public Health hired an FLTI graduate as their new Mental Health Program Coordinator as the lead for their SIM grant. This FLTI graduate will be responsible for stakeholder engagement and overall SIM grant activities with a focus on community/stakeholder engagement and integration.
-Colorado Department of Education has two FLTI graduates on the State Advisory Council for Parent Involvement in Education (SACPIE).
-The state's Early Childhood Commission, housed in the Governor's Office, now requires two Family Leaders as part of the composition of the group.
-An FLTI graduate is the chair of the Children's Hospital of Colorado Patient Advisory Council, and has provided leadership related to multiple policies within the hospital, including discharge procedures, sibling inclusion and communication mechanisms.
-Trusted relationships have been developed between FLTI graduates and their respective elected officials, resulting in collaborative work on local issues across several MCH domain areas.
-Due to the success of broad family engagement in local communities as well as state level, FLTI is noted as a promising practice by the independent evaluators from Colorado State University.

The FLTI program is fully funded through a partnership with the Colorado MCH program, Colorado State University (CSU) Extension and the Colorado Health Foundation. FLTI is directed by a full time state employee and a parent of a YSHCN. In addition, two additional Family Advisors support the FLTI implementation – both are state employees, are women of color and have YSHCN who previously received services from the CYSHCN Program. They are also fully credentialed on the FLTI curriculum and serve as facilitators and trainers accordingly. There are also 60 paid Family Leaders statewide who are funded through the local FLTI sites.

Favorable outcomes reflected in an evaluation of the program by Colorado State University (CSU) are driving the growth of FLTI statewide, as programs and communities continue to seek evidence-based strategies to enhance their family/community engagement efforts. The CSU evaluation found that participants showed improved government and policy knowledge; civic literacy and empowerment; current skills and activities; and participation in civic activities during the past six months, as a result of the FLTI training.

In addition to the FLTI activities, CDPHE has also hosted the Colorado Family Leadership Summit for the past three years. This statewide Summit is completely designed, implemented and evaluated by a team of family leaders. The Summit, in partnership with Children's Hospital Colorado, attracts over 200 participants statewide. Trainings and technical assistance related to strategies for family engagement have increased dramatically, with requests from internal, as well as external partners, such as other state agencies and non-profit organizations. For example, MCH staff advised other state agencies and statewide initiatives regarding best practices related to family engagement across multiple domains including early childhood obesity prevention, traumatic brain injury, mental health, family centered care, adverse childhood experiences and fatherhood initiatives.

CDPHE has also developed the Colorado Family Leadership Registry. This innovative data system connects FLTI graduates with leadership opportunities with state, local and national organizations. Similar to a LinkedIn platform, family leaders can upload a professional leadership profile that includes their areas of interest such as women's wellness, teen pregnancy, health policy, etc. At the same time, "systems partners" can upload their request to have family leaders participate on their council, advisory group, grant project, workgroup, etc. The family leaders are then "matched" to leadership opportunities using a word match feature of the software. The family leader receives an alert when an opportunity matches their interest area. Conversely, an alert can be sent to a systems partner if a family leader is interested in the leadership opportunity. This single tool will exponentially build and strengthen the partnerships with family leaders in all MCH areas, especially as the new MCH priorities are featured in the Registry as areas for connection.

Youth Partnerships

MCH staff engages youth and young adults in the work of the department through a variety of mechanisms, including the Youth Partnership for Health (YPH) and the Youth Advisor Model.

For the past 16 years, YPH continues to meet monthly during the academic year to provide feedback and recommendations to national, state, local and community organizations/programs. Examples of partners that have utilized YPH's expertise include:

-CDPHE's Marijuana Prevention and Education Unit
-CDPHE's Immunization Unit
-CDPHE's Healthy Eating Active Living Branch
-Healthy Kids Colorado Survey
-Colorado 9to25
-Denver Public Health
-Jefferson County Public Health
-National Institute of Justice
-Colorado Access
-CDPHE's Mental Health Promotion and Violence Prevention Branch
-Colorado Department of Education

In recent years, YPH has garnered the support of numerous CDPHE programs and now has multiple funding streams supporting and sustaining the council. YPH youth leaders will continue to receive intensive training on topics related to public health, such as the MCH Core Competencies, the ten essentials of public health, the social determinants of health, health equity, and positive youth development. Understanding of these topic areas will be coupled with skills development in the areas of public speaking, spokesperson training, and creating/identifying additional youth engagement strategies. This council will be participating in the creation of Core Competencies for Youth Council members. Identifying and disseminating these competencies will assist youth councils in creating common language, strategies and expectations to enhance the growth and development of youth leaders statewide.

CDPHE's Youth Advisor Model began in 2012 with the hiring of two young people, between the ages of 16-19, within the Youth and Young Adult Unit. These Youth Advisors were hired as term-limited state employees who partner with adult staff to inform, advise and develop materials and processes for youth-serving programs to ensure meaning and relevancy for the youth populations it aims to impact. Youth Advisors have three main focus areas in their work, which include, giving feedback, getting feedback and MCH specific project work. They host weekly Office Hours, participate in leadership positions on various efforts including the Colorado 9to25 Steering Committee and State Youth Development Plan committee. They connect to various youth groups around the state to hear what young people currently experience and what they need to assist them in navigating those experiences.

The Youth Advisor model has been replicated, or is being considered, within several state, local and community organizations, including:
-Colorado Department of Education
-Colorado Department of Human Services
-Denver Public Health
-Colorado Youth Matter
-San Luis Valley's Tu Casa Inc
-The Civic Canopy
-Get Outdoors Colorado

In addition, the Denver Chamber is partnering with the Youth and Young Adult Unit supervisor and Youth Advisor's to provide trainings and technical assistance to local business interested in hiring "Opportunity Youth" ages 16-24.

Staff from the Youth and Young Adult Unit within CDPHE have been requested to provide trainings, presentations, writings and technical assistance on the Youth Advisor model, at both the state and national level (e.g., The Office of Adolescent Health's "Think, Act, Grow" initiative, AMCHP, and CityMatch).

CDPHE holds a leadership role in strengthening efforts statewide for engaging young people across the engagement continuum. This leadership has resulted in both the Board of Health and the Tony Grampsas Youth Services Program approved legislation to include young people as members of their boards. Resources have also been developed and disseminated, including Youth Engagement Standards, which were created in partnership with Kaiser Permanente's youth advisory council. These standards are a resource for youth serving agencies interested in enhancing youth engagement. Department staff also participated in the development of the Statewide Youth Development Plan (HB13-1239). A CDPHE youth advisor was appointed to the steering committee, as well as young people representing other organizations/initiatives. CDPHE continues to provide leadership in the areas of youth engagement in Colorado's statewide coordinated and comprehensive youth system, Colorado 9to25. Young people co-chair the steering committee, action teams and co-lead the facilitation of the advisory committee, otherwise known as the CO9to25 Council.

Funded and supported by CDPHE, Colorado 9to25, in addition to prioritizing the engagement of youth and young adults, has been a mechanism for bringing many partners to the table to build a comprehensive and coordinated youth system across the state. These partners play various roles, including acting as leaders on the steering committee, contributing to funding the backbone organization for Colorado 9to25, providing guidance on the leadership team and partnering to accomplish specific activities on the Colorado 9to25 action plan. Some of the partners include:
-Family members
-Kaiser Permanente
-The Boys and Girls Club Alliance
-Project Pave
-Colorado Department of Human Services
-Mile High United Way
-The Civic Canopy
-Planned Parenthood
-Health Team Works
-Local Public Health Agencies
-City and County of Boulder

The collective work of Colorado 9to25 has garnered national recognition including being highlighted in a report released from the Institute of Medicine. In addition, the Colorado 9to25 Action Plan served as the foundation in the development of the recommendations included in the Statewide Youth Development Plan (HB12-1239).

MCH staff will continue to provide training, technical assistance and coaching to CDPHE staff and partners, as well as develop relevant resources, to aid in ensuring best practices are utilized when engaging young people as partners. Staff will continue to share and develop the “Hiring Youth Advisors” toolkit, as well as continue to convene and lead a community of practice for both supervisors of youth and the Youth Advisors themselves to connect, share resources and learn from one another. A few partners who are currently participating as partners in this learning community are Boulder Public Health, Denver Public Health, the Civic Canopy, the Colorado Department of Human Services, the Colorado Department of Education, the Denver Chamber, Mi Casa Resource Center and various other local and community agencies who have committed to hiring young people as employees.

II.F.4. Health Reform

A significant component of Colorado’s health care reform efforts is embodied within the Accountable Care Collaboratives (ACC) program. Current ACC contracts with the Regional Care Collaborative Organizations (RCCOs) will expire in July 2018. In order to capitalize on this re-procurement opportunity, HCPF is developing a framework for ACC Phase II that will be launched with the contracts that begin in SFY 18-19. In October 2015, HCPF released a concept paper describing the core components of ACC Phase II. One of the most significant infrastructure changes proposed in the concept paper is the integration of physical health and behavioral health systems through the creation of Regional Accountability Entities (RAEs). The RAEs will be responsible for the duties currently performed by the RCCOs and the Behavioral Health Organizations in their region.

Colorado MCH is supporting these state Medicaid health reform efforts by providing ongoing content expertise and support to HCPF’s Accountable Care Collaborative Unit, as well as the Medicaid Reform Unit to maximize access to a medical home approach that meets the needs of the MCH population in Colorado. CDPHE staff participates in the ACC Program Improvement Advisory Council (PIAC), as well as the Payment Reform; Quality; and Improving and Bridging Systems and Provider and Community Relations Subcommittees of the PIAC. These subcommittees serve as the platform for generating solutions and stakeholder driven discussions concerning the Accountable Care Collaborative and allow for continuous improvement in the program to ensure access to care is maximized for all populations.

CDPHE staff is part of Colorado’s State Innovation Model (SIM) grant to create a coordinated, accountable system of care that gives Coloradans access to integrated primary care and behavioral health. The CDPHE Executive Director is a member of the SIM Advisory Board and the other CDPHE staff participate on the SIM subcommittees. CDPHE administers SIM grants to local public health agencies to support SIM population health efforts. MCH/CYSHCN staff participated on the review committee to select the SIM cohort 1 practices, which include pediatric, family and adult practices. A SIM-funded position, supervised by MCH staff, helps support alignment of effort between SIM and MCH priorities, specifically pregnancy-related depression, developmental screening and referral, and medical home. The quarterly Medical Home Community Forums, which are coordinated by MCH/CYSHCN and HCPF staff, have been focused on integrated care throughout SFY 2015-16.

MCH/CYSHCN is continuing its partnership with HCPF, Tri-County Health Department and Colorado Access, a nonprofit health plan that manages three of the seven RCCOs contracts, to maximize state and federal resources supporting care coordination for children and youth including those with special health care needs, through systems mapping and identification of policy change (See Section II.F.1. Children with Special Health Care Needs Domain).

In the upcoming year, these efforts will be replicated in four additional communities (See Section F.1.b.i., Medical Home). MCH/CYSHCN staff are also working to coordinate CDPHE's care coordination efforts for children with Children's Hospital Colorado on their Centers for Medicare and Medicaid Innovation (CMMI) CARE award. This award is to test coordinating all resources effectively for Medicaid children with medical complexity. CDPHE will continue to engage with Children's Hospital Colorado as they build on evidence-based practices and introduce innovations across delivery settings and systems to improve care, optimize health and reduce costs for these children.

During the 2015 legislative session a bill was passed to expand the Children with Autism Waiver, with the intent to provide services to every eligible child. The bill was intended to remove the waiting list for the waiver and to expand the age cap for the waiver from six years to eight years. Additionally, the bill lengthened the duration of treatment, ensuring that children receive services for three years. However, in September 2015 the Centers for Medicare and Medicaid Services (CMS) sent a notice of disapproval for the Colorado Medicaid's proposed expansion of the Children with Autism Waiver. CMS denied the proposed waiver expansion because they believe the services provided in the Autism Waiver should be covered in Colorado's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program. The EPSDT program is more robust than the Medicaid state plan benefit and is designed to assure that children receive early detection and care. The Department is currently working with providers to enroll as EPSDT behavioral therapy providers in order to expand the number of children receiving needed services.

Also in 2015, SB 15-015 Mental Health Parity for Autism Spectrum Disorders was passed and took effect January 1, 2016. The bill includes autism spectrum disorders in the state's mental health parity law and repeals a provision that specifies that autism is not to be treated as a mental illness for purposes of health care coverage, thereby clarifying that health benefit plans issued in this state must include health care benefits for autism spectrum disorders that are no less restrictive than benefits available for a physical illness.

II.F.5. Emerging Issues

Youth Use of Recreational Marijuana

With the legalization of recreational marijuana in 2012, CDPHE has continued to monitor marijuana use among youth, while identifying and implementing strategies with documented success at reducing marijuana use among youth (Go to GoodToKnowColorado.com/talk). Recent data from the 2015 Healthy Kids Colorado Survey indicates that the majority of high school students do not use marijuana; youth marijuana use has actually decreased in the last 15 years. Additionally, high school students' perception of how "easy" it is to get marijuana remained relatively unchanged from the previous survey.

-Four out of five Colorado high school students have not used marijuana in the last 30 days, a rate that remains relatively unchanged since 2013 (19.7 percent in 2013 and 21.2 percent in 2015. This change is not considered significant since both numbers are within the margin of error for the survey).

-Colorado's 2015 rate of marijuana use among youth is still lower than the 2013 national average of 23.4 percent of high schoolers.

-Lifetime use also remains relatively unchanged, changing from 39 percent in 2011 to 37 percent in 2013, and to 38 percent in 2015. Again, all numbers are within the margin of error.

-None of the changes in use represent a statistically significant change.

-Reviewing the data over time, past 30-day use of marijuana by high school students has actually reduced from around 30 percent in 1999/2001 to approximately 20 percent in 2013/2015.

Methods of Use

-The vast majority of students who use marijuana usually smoke it (86.8 percent), followed by vaporizers (5.1 percent). There was a statistically significant reduction in those that usually use edibles from 2013 to 2015, dropping from 5.2 percent to 2.1 percent.

Access to the substance

-High school students' perception of how "easy" it is to get marijuana remained relatively unchanged (54.9 percent in 2013 and 55.7 percent in 2015, though both numbers are within the margin of error for the survey).
-Nearly half of high school students (47 percent) were given the marijuana by someone, and about a third (31.6 percent) said they got it in some other way.

Comparison to other substances

-Meanwhile, tobacco use among high school students continues to decline, according to the survey, and alcohol use remains relatively unchanged.

Perceptions of Risk

-Results from the 2015 Healthy Kids Colorado Survey show the percentage of students who perceived a moderate or great risk from marijuana use declined from 54 percent in 2013 to 48 percent.
-Despite perception of risk lowering since the last survey, the statistically flat use of marijuana among youth is an indication that prevention messages are working despite legalization.

Zika Virus

Colorado does not anticipate a major outbreak related to Zika, due to the current and historical absence of Aedes aegypti or albopictus populations in the state. However, the Title V MCH Director serves on the CDPHE Zika Task Force and has been involved in the development of Colorado's Zika Action Plan. It is anticipated that pregnant women identified with Zika virus in Colorado will be travel-associated cases. Women with laboratory confirmed Zika virus infection identified through passive surveillance efforts will be included in the National ZIka Virus Pregnancy Registry. The state's birth defects registry, Colorado Responds to Children with Special Needs (CRCSN), currently collects data on cases of microcepahaly. Colorado's long-standing work to increase utilization of long-acting reversible contraception (LARC) is viewed as beneficial, given the reproductive health implications of Zika infection. Technical assistance regarding LARC has been provided to several of the southern states.

The Health eMoms Project

Over the past few decades, the Pregnancy Risk Assessment Monitoring System (PRAMS) has been conducted in Colorado under a strict protocol set up through a cooperative agreement with CDC. PRAMS is considered by many to be "the" source of data on Mothers and Babies. The data from this surveillance system has been used for such diverse purposes as measuring the impact of MCH public health programs and changes in policy that influences the attitudes, beliefs, and behaviors among mothers caring for their children. All of this information is important to deliver public health services to women and children in Colorado. However, the limitations of this system include the lack of timely data and the inability to adapt to gathering information on emerging issues related to maternal and child health. PRAMS currently experiences about a 2.5 year lag from data collection to reporting and dissemination. Furthermore, since the survey instrument is only revised once every three to five years it can take up to five or six years before the system can report on any of the important emerging issues. By then, planning for MCH programs is focused on new issues and policies.

Aside from the timeliness of the data and the inability for PRAMS to adapt quickly to collect data on emerging issues, the system relies on a protocol that was developed more than 30 years ago and it only utilizes mail based surveys and telephone administered interviews to collect data. The PRAMS project has relied on a cross-sectional study design that measures behavior among mothers in Colorado at one point in time, usually 2 to 4 months after

birth. The project has been slow to innovate and currently does not include web or mobile based surveys. In the last 15 years, staff have observed Colorado's PRAMS response rate decline from a high of nearly 80% to less than 60%.

In the fall of 2016, CDPHE proposes to bring together partners from MCH Professionals, Early Childhood Councils, Immunizations, and other interested leaders from across the state to assist in the development of a "Healthy eMoms" panel. The purpose of the panel is:
-To monitor MCH indicators to inform public health program development,
-To measure and understand trends in population behavior,
-To assess the impact of a change in MCH policy or services,
-To collect timely information on emerging MCH issues.

The initial plan is to develop a rotating panel design. This survey design is a combination of repeated cross-sectional and panel designs. Staff plans to draw a monthly sample of approximately 230 women (about 5 percent of births) from the Colorado birth certificate file for up to three years. Eligible women should be Colorado residents who gave birth to a live-born infant. Once a three-year accumulation of women are sampled, and shortly after the child's third birthday, monthly batches of the sample will gradually drop from the panel and replaced with a new but comparable sample drawn from a current birth certificate frame. The process of retiring portions of the existing sample and adding new members to the sample will continue until the original panel is completely replaced. The new members of the panel will be retained in the survey for three years and then gradually replaced with a comparable but more current sample and so on. The survey may continue indefinitely. Each sample of mothers selected at the same time and adhering to the same schedule of data collection is called a rotation batch. The strength of rotating panel designs lies in their ability to allow for short-term analysis of individual or household change and long-term analysis of population and subgroup change. As in panel surveys consisting of a single sample of the population, rotating panel designs provide direct information on change at the level of the individual household or person over the period in which the sample member is retained in the survey. As in repeated cross-sectional designs, they provide information on how health behaviors change over time at the population or other stratified levels. What sets this apart from PRAMS is that this gives staff the ability to measure longitudinal variation in behavior over time, provide rapid access to timely data, and adapt systems to emerging health issues for this population. The ultimate vision is to have rapid ascertainment of representative MCH data to disseminate in a matter of days or weeks instead of years. This will also continue to provide prevalence data, but in a more timely manner.

II.F.6. Public Input

Colorado's approach to soliciting public input occurs within the structure that has been established for implementation of the MCH priorities. Community engagement (Colorado's term for youth and family involvement) is included as a common strategy in every priority action plan. Public input is gathered within the course of an MCH Implementation team's work to implement a particular MCH priority action plan. Input gathered in the course of the team's work is utilized to improve and or change an MCH effort to better respond to community/consumer needs.

For example, the Early Childhood Obesity Prevention (ECOP) team convened the second meeting of Breastfeeding in Child Care Advisory Committee with great attendance including a mother, a child care provider and a child care sponsor where state and national resources were reviewed. Their feedback was used to inform resource identification and development. Also, the ABCD Initiative recruited a family member to their Board of Directors to provide feedback on developmental screening and referral to assure that the systems work is responsive to the needs of those being targeted and served.

Community members (i.e. pregnant and breastfeeding women) were engaged in focus groups and online surveys to

influence the development of the marijuana education campaign. Eight changes were made based on their feedback. From the focus groups, it was decided that 1) the campaign should be educational in nature, 2) that the campaign should be found in doctors' offices and baby centers, 3) that additional provider education was necessary since women were getting insufficient guidance from health care providers, 4) to focus the campaign on a population of younger, lower income, lower education women since that was the group with the most questions, least concerns about marijuana's impact while pregnant, and 5) that messaging for Latina women should focus on marijuana impacts while breastfeeding. From the online survey, respondents 6) prioritized concepts as most educational, 7) suggested alterations for graphic design to make the messaging more clear and understandable, 8) ruled out an entire campaign concept. Local public health MCH partners and other stakeholders provided input at an MCH priority planning meeting in December 2015 and during the state's annual MCH Meeting in March 2016. Numerous changes to logic models and action plans were initiated on the basis of this feedback.

More traditional means of soliciting public input were again utilized by posting a summary of the FY2017 application, with a link to a full draft, on CoPrevent, the Prevention Services Division's external web site and an email was sent to stakeholders seeking their feedback. The final copy was posted on CoPrevent and the MCH website (www.mchcolorado.org) upon completion. Given the size of the state's application, it is difficult for stakeholders to review and digest. Inclusion of opportunities for input into the work of each MCH Implementation Team results in the collection of more robust input that truly informs and improves the state's efforts.

II.F.7. Technical Assistance

For FY2017, the MCH program is seeking assistance on continuing to build state and local level capacity around implementation science.

III. Budget Narrative

	2013		2014	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$7,178,335	$7,120,349	$7,110,848	$7,430,330
Unobligated Balance	$0	$0	$0	$0
State Funds	$5,383,752	$5,340,262	$5,333,136	$5,572,748
Local Funds	$0	$0	$0	$0
Other Funds	$0	$0	$0	$0
Program Funds	$0	$0	$0	$0
SubTotal	$12,562,087	$12,460,611	$12,443,984	$13,003,078
Other Federal Funds	$138,573,144	$142,112,844	$141,360,596	
Total	$151,135,231	$154,573,455	$153,804,580	$13,003,078

Due to limitations in TVIS this year, States are not able to report their FY14 Other Federal Funds Expended on Form 2, Line 9. States are encouraged to provide this information in a field note on Form 2.

	2015		2016	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$7,120,349	$7,460,860	$7,430,330	
Unobligated Balance	$0	$0	$0	
State Funds	$5,340,262	$5,595,645	$5,572,748	
Local Funds	$0	$0	$0	
Other Funds	$0	$0	$0	
Program Funds	$0	$0	$0	
SubTotal	$12,460,611	$13,056,505	$13,003,078	
Other Federal Funds	$142,112,844	$118,785,817	$122,031,753	
Total	$154,573,455	$131,842,322	$135,034,831	

	2017	
	Budgeted	Expended
Federal Allocation	$7,460,860	
Unobligated Balance	$0	
State Funds	$5,595,645	
Local Funds	$0	
Other Funds	$0	
Program Funds	$0	
SubTotal	$13,056,505	
Other Federal Funds	$125,798,755	
Total	$138,855,260	

III.A. Expenditures

The Federal allocation for 2015 was more than budgeted ($7,460,860 vs $7,120,349). 2015 MCH expenditures (not including match) were allocated 33.1 percent to children with special health care needs, 38.2 percent to preventive and primary care for children and 6.4 percent to Title V administrative costs.

Local funds from MCH partners were not utilized for match purposes. Match was derived wholly from state sources utilizing funding from the Health Care Program for Children with Special Needs, School Based Health Centers and Family Planning.

Given the revised definition for Direct Health Care Services, Colorado is spending MCH dollars solely in the enabling and public health domains.

III.B. Budget

Federal allocation is budgeted at $7,460,860. Of these dollars, a total of 38.2 percent is budgeted for Preventive and Primary Care for Children; 33.1 percent for Children with Special Health Care Needs, and 6.4 percent for Administration. These proportions meet the MCH Block Grant requirements.

Total state match consists of state general funds in the amount of $5,595,645 which meets the minimum match requirement. Match sources will be derived wholly from state sources utilizing funding from the Health Care Program for Children with Special Needs, School Based Health Centers and Family Planning.

Given the revised definition for Direct Health Care Services, no funding is budgeted for this domain.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - New IA Agreement.pdf

V. Supporting Documents

No Supporting documents were provided by the state.

VI. Appendix

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Form 2

MCH Budget/Expenditure Details

State: Colorado

	FY17 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 7,460,860	
A. Preventive and Primary Care for Children	$ 2,850,926	(38.2%)
B. Children with Special Health Care Needs	$ 2,467,575	(33.1%)
C. Title V Administrative Costs	$ 477,583	(6.4%)
2. UNOBLIGATED BALANCE (Item 18b of SF-424)	$ 0	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 5,595,645	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 5,595,645	
A. Your State's FY 1989 Maintenance of Effort Amount $ 4,736,061		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Same as item 18g of SF-424)	$ 13,056,505	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	$ 125,798,755	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 138,855,260	

OTHER FEDERAL FUNDS	FY17 Application Budgeted
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 157,298
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 95,374
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 3,430,689
US Department of Agriculture (USDA) > Food and Nutrition Services > Child and Adult Care Food Program (CACFP)	$ 27,053,595
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 90,232,796
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > WISEWOMAN Program	$ 1,056,576
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Breast and Cervical Cancer Early Detection Program (NBCCEDP)	$ 3,472,427
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Implementation Grants for Systems of Services for CYSHCN	$ 300,000

	FY15 Application Budgeted		FY15 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 7,120,349		$ 7,460,860	
A. Preventive and Primary Care for Children	$ 2,668,827	(37.5%)	$ 2,850,926	(38.2%)
B. Children with Special Health Care Needs	$ 2,136,628	(30%)	$ 2,467,575	(33.1%)
C. Title V Administrative Costs	$ 658,306	(9.2%)	$ 477,583	(6.4%)
2. UNOBLIGATED BALANCE (Item 18b of SF-424)	$ 0		$ 0	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 5,340,262		$ 5,595,645	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0		$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0		$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0		$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 5,340,262		$ 5,595,645	
A. Your State's FY 1989 Maintenance of Effort Amount $ 4,736,061				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Same as item 18g of SF-424)	$ 12,460,611		$ 13,056,505	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$ 142,112,844		$ 118,785,817	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 154,573,455		$ 131,842,322	

OTHER FEDERAL FUNDS	FY15 Annual Report Expended
US Department of Agriculture (USDA) > Food and Nutrition Services > Child and Adult Care Food Program (CACFP)	$ 26,824,290
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 85,657,465
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 3,430,687
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 95,374
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Implementation Grants for Systems of Services for CYSHCN	$ 300,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > WISEWOMAN Program	$ 484,196
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 157,298
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > National Breast and Cervical Cancer Early Detection Program (NBCCEDP)	$ 1,836,507

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs:**
	Fiscal Year:	**2015**
	Column Name:	**Annual Report Expended**
	Field Note: Federal allocation of $7,460,860 was more than expected (or budgeted for) and resulted in greater spending in certain categories. This distribution meets or exceeds MCH Block Grant requirements.	
2.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2015**
	Column Name:	**Annual Report Expended**
	Field Note: Federal allocation of $7,460,860 was more than expected (or budgeted for) and resulted in greater spending in certain categories. This distribution meets or exceeds MCH Block Grant requirements.	

Data Alerts: None

Form 3a

Budget and Expenditure Details by Types of Individuals Served

State: Colorado

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY17 Application Budgeted	FY15 Annual Report Expended
1. Pregnant Women	$ 185,824	$ 185,824
2. Infants < 1 year	$ 178,145	$ 178,145
3. Children 1-22 years	$ 4,008,918	$ 4,008,918
4. CSHCN	$ 495,820	$ 495,820
5. All Others	$ 2,114,571	$ 2,114,571
Federal Total of Individuals Served	$ 6,983,278	$ 6,983,278

IB. Non Federal MCH Block Grant	FY17 Application Budgeted	FY15 Annual Report Expended
1. Pregnant Women	$ 148,899	$ 148,899
2. Infants < 1 year	$ 142,746	$ 142,746
3. Children 1-22 years	$ 3,212,315	$ 3,212,315
4. CSHCN	$ 397,296	$ 397,296
5. All Others	$ 1,694,389	$ 1,694,389
Non Federal Total of Individuals Served	$ 5,595,645	$ 5,595,645
Federal State MCH Block Grant Partnership Total	$ 12,578,923	$ 12,578,923

Form Notes for Form 3a:

FY17 Application Budgeted: The dollars in Form 2 are reported in four exclusive categories. Those categories are Children and Youth, Children with Special Health Care Needs, and Administrative Costs with the remainder budgeted to Pregnant Women. These figures are derived by allocating the budget by population.
On Form 3a, the funds are reported in 5 exclusive categories, with the admin cost proportionally spread across populations. These budget estimates were derived from the population numbers reported in Form 5b. These forms will not match because of the ways in which the state reports 5b as a population-based, not a service delivery-based figure.
FY15 Annual Report Expended: The dollars in Form 2 are reported in four exclusive categories. Those categories are children and Youth, Children with Special Health Care Needs, and Administrative Costs with the remainder allocated to Pregnant Women. These figures are derived from allocating all block grant expenditures by populati

Field Level Notes for Form 3a:

1.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1-22 years**
	Fiscal Year:	**2017**
	Column Name:	**Application Budgeted**
	Field Note: FY17 Application Budgeted: The dollars in Form 2 are reported in four exclusive categories. Those categories are Children and Youth, Children with Special Health Care Needs, and Administrative Costs with the remainder budgeted to Pregnant Women. These figures are derived by allocating the budget by population. On Form 3a, the funds are reported in 5 exclusive categories, with the admin cost proportionally spread across populations. These budget estimates were derived from the population numbers reported in Form 5b. These forms will not match because of the ways in which the state reports 5b as a population-based, not a service delivery-based figure.	
2.	**Field Name:**	**IA. Federal MCH Block Grant, 4. CSHCN**
	Fiscal Year:	**2017**
	Column Name:	**Application Budgeted**
	Field Note: FY17 Application Budgeted: The dollars in Form 2 are reported in four exclusive categories. Those categories are Children and Youth, Children with Special Health Care Needs, and Administrative Costs with the remainder budgeted to Pregnant Women. These figures are derived by allocating the budget by population. On Form 3a, the funds are reported in 5 exclusive categories, with the admin cost proportionally spread across populations. These budget estimates were derived from the population numbers reported in Form 5b. These forms will not match because of the ways in which the state reports 5b as a population-based, not a service delivery-based figure.	
3.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1-22 years**
	Fiscal Year:	**2015**
	Column Name:	**Annual Report Expended**

Field Note:
FY15 Annual Report Expended: The dollars in Form 2 are reported in four exclusive categories. Those categories are children and Youth, Children with Special Health Care Needs, and Administrative Costs with the remainder allocated to Pregnant Women. These figures are derived from allocating all block grant expenditures by population. These forms will not match because of the ways in which the state reports 5b as a population-based, not a service delivery-based figure. On Form 3a, the funds are reported in 5 exclusive categories, with the admin cost proportionally spread across populations. These figures are derived from the population numbers reported in Form 5b. Funds were expended in accordance with federal requirements (at a minimum 30% on Children with Special Health Care Needs, 30% on Children and Youth, and 10% on Administrative Costs).

4.	**Field Name:**	**IA. Federal MCH Block Grant, 4. CSHCN**
	Fiscal Year:	**2015**
	Column Name:	**Annual Report Expended**

Field Note:
FY15 Annual Report Expended: The dollars in Form 2 are reported in four exclusive categories. Those categories are children and Youth, Children with Special Health Care Needs, and Administrative Costs with the remainder allocated to Pregnant Women. These figures are derived from allocating all block grant expenditures by population. These forms will not match because of the ways in which the state reports 5b as a population-based, not a service delivery-based figure. On Form 3a, the funds are reported in 5 exclusive categories, with the admin cost proportionally spread across populations. These figures are derived from the population numbers reported in Form 5b. Funds were expended in accordance with federal requirements (at a minimum 30% on Children with Special Health Care Needs, 30% on Children and Youth, and 10% on Administrative Costs).

Data Alerts: None

Form 3b
Budget and Expenditure Details by Types of Services

State: Colorado

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY17 Application Budgeted	FY15 Annual Report Expended
1. Direct Services	$ 0	$ 0
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 0	$ 0
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 0	$ 0
2. Enabling Services	$ 920,018	$ 920,018
3. Public Health Services and Systems	$ 6,540,842	$ 6,540,842
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Direct Services Line 4 Expended Total		$ 0
Federal Total	$ 7,460,860	$ 7,460,860

IIB. Non-Federal MCH Block Grant	FY17 Application Budgeted	FY15 Annual Report Expended
1. Direct Services	$ 0	$ 0
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 0	$ 0
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 0	$ 0
2. Enabling Services	$ 3,690,214	$ 3,690,214
3. Public Health Services and Systems	$ 1,905,431	$ 1,905,431
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Direct Services Line 4 Expended Total		$ 0
Non-Federal Total	$ 5,595,645	$ 5,595,645

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

None

Form 4

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

State: Colorado

Total Births by Occurrence: 67,149

1. Core RUSP Conditions

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Core RUSP Conditions	66,317 (98.8%)	698	63	63 (100.0%)

Program Name(s)				
Methylmalonic acidemia (methylmalonyl-CoA mutase)	Methylmalonic acidemia (cobalamin disorders)	Isovaleric acidemia	3-Methylcrotonyl-CoA carboxylase deficiency	3-Hydroxy-3-methyglutaric aciduria
Holocarboxylase synthase deficiency	ß-Ketothiolase deficiency	Glutaric acidemia type I	Carnitine uptake defect/carnitine transport defect	Medium-chain acyl-CoA dehydrogenase deficiency
Very long-chain acyl-CoA dehydrogenase deficiency	Long-chain L-3 hydroxyacyl-CoA dehydrogenase deficiency	Trifunctional protein deficiency	Argininosuccinic aciduria	Citrullinemia, type I
Maple syrup urine disease	Homocystinuria	Classic phenylketonuria	Tyrosinemia, type I	Primary congenital hypothyroidism
Congenital adrenal hyperplasia	S,C disease	Biotinidase deficiency	Cystic fibrosis	Severe combined immunodeficiences
Classic galactosemia	Propionic acidemia	Methylmalonic acidemia (methylmalonyl-CoA mutase)		

2. Other Newborn Screening Tests

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Argininemia (ARG)	66,317 (98.8%)	0	0	0 (0%)
Hypermethioninemia (MET)	66,317 (98.8%)	10	0	0 (0%)
Tyronsinemia, type II (TYR II)	66,317 (98.8%)	11	0	0 (0%)
Tyronsinemia, type III (TYR III)	66,317 (98.8%)	11	0	0 (0%)
Carnitine acylcarnitine translocase deficiency (CACT)	66,317 (98.8%)	12	0	0 (0%)
Carnitine palmitoyltransferase I deficiency (CPT-IA)	66,317 (98.8%)	11	0	0 (0%)
Carnitine palmitoyltransferase type II deficiency (CPT-II)	66,317 (98.8%)	12	0	0 (0%)
Short-chain acyl-CoA dehydrogenase deficiency (SCAD)	66,317 (98.8%)	45	1	1 (100.0%)
3-Methylglutaconic aciduria (3MGS)	66,317 (98.8%)	17	0	0 (0%)
Glutaric acidemia, type II (GA-2)	66,317 (98.8%)	23	0	0 (0%)
Newborn Hearing Screening	64,280 (95.7%)	639	128	78 (60.9%)

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

The state health department contracts with subspecialty clinics at the University of Colorado and Children's Hospital Colorado. Children with all disorders except the two endocrine disorders are seen at these specialty clinics for life. There is no formal long-term followup for the endocrine disorders.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

1.	**Field Name:**	**Total Births by Occurrence**
	Fiscal Year:	**2015**
	Column Name:	**Total Births by Occurrence Notes**
	Field Note: The total births by occurrence are the number of births in calendar 2014.	
2.	**Field Name:**	**Newborn Hearing Screening - Receiving At Lease One Screen**
	Fiscal Year:	**2015**
	Column Name:	**Other Newborn**
	Field Note: Number of newborns born to Colorado residents who delivered in Colorado in 2014.	
3.	**Field Name:**	**Newborn Hearing Screening - Referred For Treatment**
	Fiscal Year:	**2015**
	Column Name:	**Other Newborn**
	Field Note: Actual referral rate is closer to 80 percent. Referral tracking is not required so every referral is not tracked.	

Data Alerts: None

Form 5a
Unduplicated Count of Individuals Served under Title V

State: Colorado

Reporting Year 2015

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	710	35.0	3.0	58.0	4.0	0.0
2. Infants < 1 Year of Age	92	60.0	1.0	39.0	0.0	0.0
3. Children 1 to 22 Years of Age	14,233	30.0	5.0	62.0	3.0	0.0
4. Children with Special Health Care Needs	1,781	61.0	3.0	18.0	0.0	18.0
5. Others	8,494	29.0	0.0	12.0	53.0	6.0
Total	25,310					

Form Notes for Form 5a:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2015**
	Field Note: Total pregnant women who received family planning services during calendar year 2014. Insurance distribution for pregnant women is from the 2013 Pregnancy Risk Assessment Monitoring System, and is based on responses to the question that asks who paid for prenatal care.	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2015**
	Field Note: Total infants ages 0-1 years with special health care needs who received HCP care coordination or specialty clinic services during federal fiscal year 2014-2015. Insurance distribution for infants with special health care needs is from the HCP data system.	
3.	**Field Name:**	**Children 1 to 22 Years of Age**
	Fiscal Year:	**2015**
	Field Note: Sum of children and youth served by school-based health centers during state fiscal year 2014-2015 plus total number of men and non-pregnant women ages <= 22 years who received family planning services during calendar year 2014. Insurance distribution is from the 2015 Colorado Health Access Survey.	
4.	**Field Name:**	**Children with Special Health Care Needs**
	Fiscal Year:	**2015**
	Field Note: Total children and youth ages 1-21 years with special health care needs who received HCP care coordination or specialty clinic services during federal fiscal year 2014-2015. Insurance distribution for children and youth with special health care needs is from the HCP data system.	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2015**
	Field Note: Total number of men and non-pregnant women ages 23+ years who received family planning services during calendar year 2014. Insurance distribution for others is from the Family Planning Annual Report: 2014 National Summary.	
6.	**Field Name:**	**Total_TotalServed**
	Fiscal Year:	**2015**

Field Note:
It is unknown if duplication exists among children and youth with special health care needs served by HCP, children and youth served in school-based health centers, and youth receiving family planning services. The Others category includes males receiving family planning services since this is considered a service to women of child-bearing age.

Form 5b
Total Recipient Count of Individuals Served by Title V

State: Colorado

Reporting Year 2015

Types Of Individuals Served	Total Served
1. Pregnant Women	64,930
2. Infants < 1 Year of Age	62,247
3. Children 1 to 22 Years of Age	1,400,786
4. Children with Special Health Care Needs	173,248
5. Others	738,868
Total	2,440,079

Form Notes for Form 5b:

None

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women**
	Fiscal Year:	**2015**
	Field Note: Pregnant women includes women who delivered live births, not total live births, plus total fetal deaths in calendar year 2014 from the Vital Statistics Program.	
2.	**Field Name:**	**Infants Less Than One Year**
	Fiscal Year:	**2015**
	Field Note: Infants <1 year is the total occurrent births in calendar year 2014 less the estimated number of children with special health care needs (CSHCN) <1 year of age based on the Colorado CSHCN estimates from the 2009-2010 National Survey of Children with Special Health Care Needs.	
3.	**Field Name:**	**Children 1 to 22 Year of Age**
	Fiscal Year:	**2015**
	Field Note: Children 1-22 years of age is calendar year 2014 estimates from the Colorado State Demography Office less the estimated number of children with special health care needs (CSHCN) ages 1-17 based on the Colorado CSHCN estimates from the 2009-2010 National Survey of Children with Special Health Care Needs and less the number of residents ages 22 and younger who gave birth in 2014.	
4.	**Field Name:**	**Children With Special Health Care Needs**
	Fiscal Year:	**2015**
	Field Note: The estimated number of children with special health care needs (CSHCN) ages 0-17 was calculated by applying the prevalence of CSHCN ages 0-17 in Colorado from the 2009-2010 National Survey of Children with Special Health Care Needs to the 2014 population ages 0-17 in the state.	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2015**
	Field Note: Others is the 2014 estimated number of women of reproductive ages 23-44 from the Colorado State Demography Office less the number of residents ages 23+ who gave birth in 2014.	
6.	**Field Name:**	**Total Served**
	Fiscal Year:	**2015**

Field Note:
In previous application years, Colorado has reported the total population for each participant category since the majority of the work is services as defined in the bottom of the MCH pyramid. This same methodology is being repeated to maintain consistency with what was reported in previous applications.

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

State: Colorado

Reporting Year 2015

I. Unduplicated Count by Race

	(A) Total All Races	(B) White	(C) Black or African American	(D) American Indian or Native Alaskan	(E) Asian	(F) Native Hawaiian or Other Pacific Islander	(G) More than One Race Reported	(H) Other & Unknown
1. Total Deliveries in State	65,815	55,345	3,749	693	2,932	0	0	3,096
Title V Served	65,815	55,345	3,749	693	2,932	0	0	3,096
Eligible for Title XIX	23,365	18,575	2,056	187	631	0	0	1,916
2. Total Infants in State	65,815	55,345	3,749	693	2,932	0	0	3,096
Title V Served	64,281	54,054	3,662	677	2,864	0	0	3,024
Eligible for Title XIX	33,973	27,008	2,990	272	917	0	0	2,786

II. Unduplicated Count by Ethnicity

	(A) Total Not Hispanic or Latino	(B) Total Hispanic or Latino	(C) Ethnicity Not Reported	(D) Total All Ethnicities
1. Total Deliveries in State	47,281	17,606	928	65,815
Title V Served	47,281	17,606	928	65,815
Eligible for Title XIX	14,814	8,551	0	23,365
2. Total Infants in State	47,281	17,606	928	65,815
Title V Served	46,179	17,196	906	64,281
Eligible for Title XIX	21,538	12,435	0	33,973

Form Notes for Form 6:

The most recent data available from the Colorado Department of Public Health and Environment Vital Statistics Program, the Newborn Hearing Screening Program, and the state Medicaid program are used in this form.

Field Level Notes for Form 6:

1.	**Field Name:**	**1. Total Deliveries in State**
	Fiscal Year:	**2015**
	Column Name:	**Total All Races**

Field Note:
The Colorado MCH Program has transitioned a majority of its work to align with the infrastructure and population-based level of the MCH Pyramid, thus total resident births are represented here.

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

State: Colorado

A. State MCH Toll-Free Telephone Lines	2017 Application Year	2015 Reporting Year
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 688-7777	(800) 688-7777
2. State MCH Toll-Free "Hotline" Name	The Family Healthline	The Family Healthline
3. Name of Contact Person for State MCH "Hotline"	Risa Friedman	Risa Friedman
4. Contact Person's Telephone Number	(303) 692-2503	(303) 692-2503
5. Number of Calls Received on the State MCH "Hotline"		6,502

B. Other Appropriate Methods	2017 Application Year	2015 Reporting Year
1. Other Toll-Free "Hotline" Names		
2. Number of Calls on Other Toll-Free "Hotlines"		
3. State Title V Program Website Address		
4. Number of Hits to the State Title V Program Website		
5. State Title V Social Media Websites		
6. Number of Hits to the State Title V Program Social Media Websites		

Form Notes for Form 7:

None

Form 8
State MCH and CSHCN Directors Contact Information

State: Colorado

1. Title V Maternal and Child Health (MCH) Director	
Name	Karen Trierweiler
Title	Deputy Division Director, PSD
Address 1	CDPHE
Address 2	4300 Cherry Creek Dr
City/State/Zip	Denver / CO / 80246
Telephone	(303) 692-2481
Extension	
Email	karen.trierweiler@colorado.state.us

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Rachel Hutson
Title	Branch Chief, CYFB
Address 1	CDPHE
Address 2	4300 Cherry Dr.
City/State/Zip	Denver / CO / 80246
Telephone	(303) 692-2365
Extension	
Email	rachel.hutson@state.co.us

3. State Family or Youth Leader (Optional)	
Name	Eileen Forlenza
Title	Family and Community Engagement Unit Supervisor
Address 1	CDPHE
Address 2	4300 Cherry Dr.
City/State/Zip	Denver / CO / 80246
Telephone	(303) 692-2794
Extension	
Email	eileen.forlenza@state.co.us

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: Colorado

Application Year 2017

No.	Priority Need
1.	Women's mental health, including pregnancy-related depression
2.	Reduction of infant mortality among African Americans
3.	Early childhood obesity prevention
4.	Developmental screening and referrals
5.	Bullying and youth suicide prevention
6.	Medical home for children and youth with special health care needs
7.	Substance misuse reduction (tobacco, marijuana and prescription drugs) among pregnant and postpartum women

Form 9 State Priorities-Needs Assessment Year - Application Year 2016

No.	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure
1.	Women's mental health, including pregnancy-related depression	Replaced	
2.	Reducing infant mortality among the Black/African-American population	New	
3.	Early childhood obesity prevention	Continued	
4.	Developmental screening and referral systems building	Continued	
5.	Bullying and youth suicide prevention integrating youth systems building	Continued	
6.	Medical home for children and youth with special health care needs	Continued	
7.	Substance use/abuse prevention among the MCH population including marijuana, prescription drug abuse, and smoking	New	

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 10a
National Outcome Measures (NOMs)

State: Colorado

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

None

NOM 1 - Percent of pregnant women who receive prenatal care beginning in the first trimester

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	75.8 %	0.2 %	48,959	64,602
2013	73.2 %	0.2 %	46,820	63,932
2012	73.2 %	0.2 %	46,833	63,961
2011	73.0 %	0.2 %	46,653	63,933
2010	71.7 %	0.2 %	47,003	65,525
2009	69.9 %	0.2 %	47,204	67,494

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 1 - Notes:

None

Data Alerts: None

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

Data Source: State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	174.0	5.4 %	1,057	60,754
2012	174.5	5.4 %	1,069	61,265
2011	157.2	5.1 %	963	61,275
2010	168.6	5.3 %	1,051	62,326
2009	150.0	4.8 %	976	65,062
2008	151.1	4.8 %	1,003	66,398

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 2 - Notes:

None

Data Alerts: None

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

FAD Not Available for this measure.

NOM 3 - Notes:

None

Data Alerts: None

NOM 4.1 - Percent of low birth weight deliveries (<2,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	8.8 %	0.1 %	5,769	65,797
2013	8.8 %	0.1 %	5,718	64,977
2012	8.8 %	0.1 %	5,749	65,157
2011	8.7 %	0.1 %	5,640	65,023
2010	8.8 %	0.1 %	5,811	66,332
2009	8.8 %	0.1 %	6,007	68,601

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 4.1 - Notes:

None

Data Alerts: None

NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	1.2 %	0.0 %	799	65,797
2013	1.3 %	0.0 %	844	64,977
2012	1.2 %	0.0 %	782	65,157
2011	1.3 %	0.0 %	810	65,023
2010	1.3 %	0.0 %	881	66,332
2009	1.2 %	0.0 %	829	68,601

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 4.2 - Notes:

None

Data Alerts: None

NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	7.6 %	0.1 %	4,970	65,797
2013	7.5 %	0.1 %	4,874	64,977
2012	7.6 %	0.1 %	4,967	65,157
2011	7.4 %	0.1 %	4,830	65,023
2010	7.4 %	0.1 %	4,930	66,332
2009	7.6 %	0.1 %	5,178	68,601

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 4.3 - Notes:

None

Data Alerts: None

NOM 5.1 - Percent of preterm births (<37 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	8.4 %	0.1 %	5,517	65,814
2013	8.6 %	0.1 %	5,571	64,971
2012	8.9 %	0.1 %	5,802	65,149
2011	8.9 %	0.1 %	5,754	65,029
2010	9.1 %	0.1 %	6,052	66,335
2009	9.3 %	0.1 %	6,347	68,575

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 5.1 - Notes:

None

Data Alerts: None

NOM 5.2 - Percent of early preterm births (<34 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	2.3 %	0.1 %	1,517	65,814
2013	2.4 %	0.1 %	1,577	64,971
2012	2.5 %	0.1 %	1,599	65,149
2011	2.4 %	0.1 %	1,587	65,029
2010	2.5 %	0.1 %	1,686	66,335
2009	2.5 %	0.1 %	1,712	68,575

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 5.2 - Notes:

None

Data Alerts: None

NOM 5.3 - Percent of late preterm births (34-36 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	6.1 %	0.1 %	4,000	65,814
2013	6.2 %	0.1 %	3,994	64,971
2012	6.5 %	0.1 %	4,203	65,149
2011	6.4 %	0.1 %	4,167	65,029
2010	6.6 %	0.1 %	4,366	66,335
2009	6.8 %	0.1 %	4,635	68,575

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 5.3 - Notes:

None

Data Alerts: None

NOM 6 - Percent of early term births (37, 38 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	23.0 %	0.2 %	15,145	65,814
2013	23.0 %	0.2 %	14,911	64,971
2012	23.9 %	0.2 %	15,538	65,149
2011	23.9 %	0.2 %	15,525	65,029
2010	24.3 %	0.2 %	16,123	66,335
2009	25.5 %	0.2 %	17,469	68,575

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 6 - Notes:

None

Data Alerts: None

NOM 7 - Percent of non-medically indicated early elective deliveries

Data Source: CMS Hospital Compare

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014/Q2-2015/Q1	2.0 %			
2014/Q1-2014/Q4	3.0 %			
2013/Q4-2014/Q3	2.0 %			
2013/Q3-2014/Q2	2.0 %			
2013/Q2-2014/Q1	2.0 %			

Legends:

Indicator results were based on a shorter time period than required for reporting

NOM 7 - Notes:

None

Data Alerts: None

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	5.8	0.3 %	375	65,179
2012	5.6	0.3 %	366	65,383
2011	6.5	0.3 %	422	65,257
2010	6.3	0.3 %	418	66,534
2009	6.4	0.3 %	438	68,831

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 8 - Notes:

None

Data Alerts: None

NOM 9.1 - Infant mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	5.1	0.3 %	333	65,007
2012	4.6	0.3 %	297	65,187
2011	5.5	0.3 %	358	65,055
2010	5.9	0.3 %	392	66,355
2009	6.2	0.3 %	428	68,628

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.1 - Notes:

None

Data Alerts: None

NOM 9.2 - Neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	3.7	0.2 %	240	65,007
2012	3.3	0.2 %	212	65,187
2011	3.9	0.3 %	255	65,055
2010	4.3	0.3 %	285	66,355
2009	4.2	0.3 %	287	68,628

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.2 - Notes:

None

Data Alerts: None

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	1.4	0.2 %	93	65,007
2012	1.3	0.1 %	85	65,187
2011	1.6	0.2 %	103	65,055
2010	1.6	0.2 %	107	66,355
2009	2.1	0.2 %	141	68,628

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.3 - Notes:

None

Data Alerts: None

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	190.8	17.2 %	124	65,007
2012	165.7	16.0 %	108	65,187
2011	204.4	17.8 %	133	65,055
2010	218.5	18.2 %	145	66,355
2009	212.7	17.6 %	146	68,628

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.4 - Notes:

None

Data Alerts: None

NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	64.6	10.0 %	42	65,007
2012	64.4	9.9 %	42	65,187
2011	61.5	9.7 %	40	65,055
2010	66.3	10.0 %	44	66,355
2009	83.1	11.0 %	57	68,628

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.5 - Notes:

None

Data Alerts: None

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

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	14.1 %	1.2 %	8,869	63,013
2012	10.4 %	1.2 %	6,596	63,166
2011	10.1 %	1.0 %	6,364	63,091
2010	11.6 %	1.0 %	7,448	64,331
2009	10.5 %	1.0 %	6,970	66,436
2008	10.7 %	1.0 %	7,210	67,504
2007	11.6 %	1.0 %	7,941	68,549

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 10 - Notes:

None

Data Alerts: None

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

Data Source: State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	6.7	0.3 %	405	60,755
2012	5.9	0.3 %	359	61,265
2011	4.5	0.3 %	276	61,275
2010	4.0	0.3 %	246	62,326
2009	2.9	0.2 %	187	65,062
2008	2.2	0.2 %	148	66,398

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 11 - Notes:

None

Data Alerts: None

NOM 12 - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

FAD Not Available for this measure.

NOM 12 - Notes:

None

Data Alerts: None

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

FAD Not Available for this measure.

NOM 13 - Notes:

None

Data Alerts: None

NOM 14 - Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	19.7 %	1.6 %	224,519	1,140,859

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM 14 - Notes:

None

Data Alerts: None

NOM 15 - Child Mortality rate, ages 1 through 9 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	15.1	1.6 %	94	623,451
2013	17.9	1.7 %	112	624,661
2012	16.3	1.6 %	102	625,609
2011	16.3	1.6 %	102	626,776
2010	19.0	1.7 %	119	625,969
2009	15.8	1.6 %	98	620,329

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 15 - Notes:

None

Data Alerts: None

NOM 16.1 - Adolescent mortality rate ages 10 through 19 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	31.0	2.1 %	216	696,916
2013	33.0	2.2 %	227	687,758
2012	28.6	2.1 %	195	681,073
2011	29.5	2.1 %	200	678,025
2010	30.2	2.1 %	203	672,129
2009	35.7	2.3 %	239	670,256

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.1 - Notes:

None

Data Alerts: None

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012_2014	11.7	1.1 %	120	1,022,242
2011_2013	11.8	1.1 %	120	1,018,996
2010_2012	11.7	1.1 %	119	1,018,964
2009_2011	11.5	1.1 %	117	1,020,741
2008_2010	12.7	1.1 %	130	1,021,079
2007_2009	14.9	1.2 %	152	1,018,913

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.2 - Notes:

None

Data Alerts: None

NOM 16.3 - Adolescent suicide rate, ages 15 through 19 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012_2014	12.9	1.1 %	132	1,022,242
2011_2013	13.0	1.1 %	132	1,018,996
2010_2012	12.1	1.1 %	123	1,018,964
2009_2011	12.9	1.1 %	132	1,020,741
2008_2010	13.1	1.1 %	134	1,021,079
2007_2009	12.7	1.1 %	129	1,018,913

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.3 - Notes:

None

Data Alerts: None

NOM 17.1 - Percent of children with special health care needs

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	16.7 %	1.3 %	204,120	1,224,557
2007	17.1 %	1.4 %	202,793	1,187,560
2003	15.7 %	1.0 %	179,585	1,147,831

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM 17.1 - Notes:

None

Data Alerts: None

NOM 17.2 - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system

Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2009_2010	17.1 %	2.0 %	25,521	149,366

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children diagnosed with an autism spectrum disorder

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	1.3 %	0.4 %	12,988	1,026,538
2007	1.4 %	0.6 %	13,558	978,970

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 17.3 - Notes:

None

Data Alerts: None

NOM 17.4 - Percent of children diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	5.3 %	0.8 %	53,769	1,021,377
2007	4.8 %	0.8 %	47,283	977,349

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 17.4 - Notes:

None

Data Alerts: None

NOM 18 - Percent of children with a mental/behavioral condition who receive treatment or counseling

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	66.1 %	6.3 %	50,946	77,063
2007	64.8 %	7.8 %	51,174	78,975
2003	57.5 %	5.8 %	28,385	49,409

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM 18 - Notes:

None

Data Alerts: None

NOM 19 - Percent of children in excellent or very good health

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	87.0 %	1.2 %	1,065,436	1,224,057
2007	84.3 %	1.6 %	1,001,551	1,187,560
2003	86.6 %	0.9 %	994,202	1,147,831

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 19 - Notes:

None

Data Alerts: None

NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	23.1 %	2.3 %	116,638	504,876
2007	27.2 %	2.6 %	137,517	505,975
2003	21.9 %	1.8 %	106,857	487,172

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	23.4 %	0.2 %	8,766	37,426

Legends:

Indicator has a denominator <50 or a relative standard error ≥30% and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011	18.0 %	1.8 %	33,771	187,217
2009	17.8 %	1.3 %	34,416	193,239
2005	19.7 %	2.3 %	41,266	209,512

Legends:

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	6.0 %	0.4 %	74,621	1,247,332
2013	8.4 %	0.4 %	104,208	1,240,587
2012	8.1 %	0.5 %	99,494	1,231,159
2011	9.3 %	0.5 %	114,118	1,226,362
2010	9.8 %	0.5 %	120,673	1,229,021
2009	9.8 %	0.5 %	120,415	1,227,509

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 21 - Notes:

None

Data Alerts: None

NOM 22.1 - Percent of children ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3*:3:1:4)

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	72.8 %	3.3 %	69,593	95,642
2013	69.2 %	3.5 %	66,847	96,605
2012	71.7 %	4.0 %	69,619	97,113
2011	65.7 %	4.5 %	66,097	100,618
2010	56.2 %	3.6 %	57,882	102,962
2009	46.9 %	4.5 %	49,366	105,245

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.1 - Notes:

None

Data Alerts: None

NOM 22.2 - Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014_2015	59.1 %	1.8 %	687,088	1,162,389
2013_2014	61.8 %	1.7 %	706,856	1,143,672
2012_2013	58.4 %	1.9 %	672,481	1,152,280
2011_2012	52.4 %	2.7 %	606,586	1,158,330
2010_2011	57.9 %	3.2 %	669,622	1,156,515
2009_2010	49.1 %	4.0 %	625,889	1,274,722

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.2 - Notes:

None

Data Alerts: None

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

Data Source: National Immunization Survey (NIS) - Female

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	62.5 %	4.2 %	104,891	167,926
2013	58.2 %	4.4 %	95,739	164,553
2012	61.4 %	5.5 %	99,707	162,499
2011	45.9 %	5.3 %	74,041	161,400
2010	52.5 %	4.6 %	82,145	156,433
2009	52.7 %	4.6 %	83,006	157,583

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

Data Source: National Immunization Survey (NIS) - Male

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	40.7 %	4.2 %	71,399	175,354
2013	33.5 %	4.4 %	57,669	172,328
2012	31.3 %	6.4 %	53,475	170,886
2011	13.6 %	3.7 %	23,240	170,477

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.3 - Notes:

None

Data Alerts: None

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	90.2 %	1.8 %	309,756	343,280
2013	87.1 %	2.3 %	293,445	336,881
2012	93.2 %	1.8 %	310,792	333,386
2011	84.7 %	3.0 %	281,104	331,877
2010	85.8 %	2.2 %	275,513	321,303
2009	76.6 %	2.7 %	247,697	323,247

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.4 - Notes:

None

Data Alerts: None

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	76.9 %	2.5 %	263,808	343,280
2013	73.6 %	2.9 %	247,776	336,881
2012	73.2 %	3.4 %	243,950	333,386
2011	64.4 %	3.6 %	213,667	331,877
2010	59.6 %	3.3 %	191,466	321,303
2009	53.8 %	3.2 %	173,730	323,247

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.5 - Notes:

None

Data Alerts: None

Form 10a
National Performance Measures (NPMs)

State: Colorado

NPM 2 - Percent of cesarean deliveries among low-risk first births

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	20.2	19.8	19.4	19.0	18.5	18.1

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	20.4 %	0.3 %	4,625	22,687
2013	20.6 %	0.3 %	4,686	22,806
2012	21.2 %	0.3 %	4,838	22,840
2011	20.0 %	0.3 %	4,664	23,311
2010	21.1 %	0.3 %	4,973	23,596
2009	21.7 %	0.3 %	5,236	24,147

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

1. **Field Name:** **2020**

Field Note:
Target setting method is ten percent improvement from baseline.

NPM 4 - A) Percent of infants who are ever breastfed

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	81.5	82.3	83.0	83.8	84.5	85.3

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	86.3 %	2.7 %	56,553	65,529
2011	81.0 %	3.2 %		
2010	79.5 %	4.1 %		
2009	86.0 %	2.9 %		
2008	81.4 %	2.7 %		
2007	87.7 %	2.3 %		

Legends:

Indicator has an unweighted denominator <50 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

1. **Field Name:** **2021**

Field Note:
Although the rate increased in 2012, we are uncertain if this is a true trend since the NIS data fluctuate over time. Thus, we decided not to change the 2016-2020 objectives and will reevaluate upon receipt of the 2013 NIS data.

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

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	26.0	26.5	27.0	27.5	28.0	29.5

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	30.3 %	3.3 %	19,394	64,063
2011	25.8 %	3.2 %		
2010	21.2 %	3.7 %		
2009	21.9 %	3.6 %		
2008	22.3 %	2.4 %		
2007	21.5 %	2.8 %		

Legends:

Indicator has an unweighted denominator <50 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

1. **Field Name:** **2021**

Field Note:
Although the rate increased in 2012, we are uncertain if this is a true trend since the NIS data fluctuate over time. Thus, we decided not to change the 2016-2020 objectives and will reevaluate upon receipt of the 2013 NIS data.

NPM 6 - Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	48.0	49.0	50.0	51.0	52.0	53.0

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	47.0 %	3.5 %	146,800	312,132
2007	25.9 %	3.4 %	84,174	324,716

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

1. **Field Name:** **2020**

Field Note:
Target setting method is ten percent improvement from baseline.

NPM 7 - Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19 (Adolescent Health)

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	247.1	242.0	237.0	231.9	226.9	221.8

Data Source: State Inpatient Databases (SID) - ADOLESCENT

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	226.8	5.7 %	1,580	696,631
2012	268.8	6.2 %	1,866	694,226
2011	275.8	6.4 %	1,881	682,112
2010	281.2	6.5 %	1,883	669,758
2009	304.4	6.8 %	2,018	663,007
2008	319.7	7.0 %	2,097	655,903

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

1. **Field Name:** **2016**

   Field Note:
   Targets are set for the rate of hospitalization from non-fatal injury per 100,000 adolescents ages 10-19 years.

2. **Field Name:** **2020**

   Field Note:
   Target setting method is ten percent improvement from baseline.

3. **Field Name:** **2021**

   Field Note:
   Although the rate dropped significantly in 2013, the CO data for 2014 show an increase in the rate. Thus, we decided not to change the 2016-2020 objectives.

NPM 8 - Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day (Child Health)

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	34.2	34.9	35.6	36.3	37.0	37.7

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	33.5 %	2.9 %	139,594	416,439
2007	36.5 %	3.2 %	139,463	381,685
2003	32.5 %	2.3 %	116,479	358,897

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

1. **Field Name:** **2016**

   Field Note:
   Targets are set for the percent of children ages 6 through 11 who are physically active at least 60 minutes per day.

2. **Field Name:** **2020**

   Field Note:
   Target setting method is ten percent improvement from baseline.

NPM 9 - Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	24.0	23.5	23.0	22.5	22.0	21.5

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	13.5 %	2.2 %	52,980	393,543
2007	12.0 %	2.3 %	46,911	390,501

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011	24.5 %	1.4 %	51,104	208,297

Legends:

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

1. **Field Name:** **2016**

   Field Note:
   Target is based on data from the YRBS (known as the Healthy Kids Colorado Survey in Colorado).

2. **Field Name:** **2020**

   Field Note:
   Target setting method is ten percent improvement from baseline.

NPM 11 - Percent of children with and without special health care needs having a medical home

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	50.0	52.0	53.0	54.0	55.0	56.0

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	48.3 %	4.2 %	97,225	201,227
2007	43.1 %	4.3 %	83,071	192,623

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	56.7 %	2.0 %	561,642	990,029
2007	62.6 %	2.1 %	589,502	941,904

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

1. **Field Name:** **2016**

Field Note:
Targets represent the percent of children with special health care needs having a medical home.

NPM 14 - A) Percent of women who smoke during pregnancy

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	6.9	6.7	6.5	6.3	6.1	5.9

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	6.7 %	0.1 %	4,399	65,615
2013	7.1 %	0.1 %	4,611	64,547
2012	7.4 %	0.1 %	4,798	64,753
2011	7.4 %	0.1 %	4,817	64,936
2010	8.1 %	0.1 %	5,381	66,249
2009	8.4 %	0.1 %	5,750	68,485

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

1. **Field Name:** **2020**

Field Note:
Target setting method was based on one percentage point decrease.

NPM 14 - B) Percent of children who live in households where someone smokes

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	20.2	19.8	19.4	19.0	18.5	18.0

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	20.6 %	1.5 %	249,950	1,214,588
2007	22.2 %	1.7 %	259,471	1,169,690
2003	24.6 %	1.3 %	243,711	992,273

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

1. **Field Name:** **2020**

Field Note:
Target setting method is ten percent improvement from baseline.

Form 10a
State Performance Measures (SPMs)

State: Colorado

SPM 1 - Percent of mothers that report a doctor, nurse or other health care worker talked with them about what to do if they felt depressed during pregnancy or after delivery

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	80.0	81.9	83.9	85.8	87.8

Field Level Notes for Form 10a SPMs:

1. **Field Name:** **2017**

   Field Note:
   2013 baseline is 78.0 percent.

2. **Field Name:** **2020**

   Field Note:
   Target setting method is ten percent improvement from baseline.

SPM 2 - Infant mortality rate among African Americans in Denver and Arapahoe counties

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	11.0	9.0	7.0	4.0	4.0

Field Level Notes for Form 10a SPMs:

1. **Field Name:** **2017**

   Field Note:
   2014 baseline is 13.0/1,000

SPM 3 - Percent of women who report using marijuana at any time during their pregnancy

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	6.2	6.1	6.0	5.9	5.7

Field Level Notes for Form 10a SPMs:

1.	**Field Name:**	**2017**
	Field Note: 2014 baseline is 6.5 percent (unweighted). Annual objectives could be revised upon receipt of weighted 2014 estimate.	
2.	**Field Name:**	**2020**
	Field Note: Target setting method is ten percent improvement from baseline.	

SPM 4 - Rate of emergency department visits for women for prescription drug use poisoning per 100,000 women ages 15 through 44

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	216.7	212.9	209.1	205.3	203.6

Field Level Notes for Form 10a SPMs:

1.	**Field Name:**	**2017**
	Field Note: 2014 baseline is 228.1/100,000	
2.	**Field Name:**	**2020**
	Field Note: Target setting method is ten percent improvement from baseline.	

SPM 5 - Rate of hospitalizations for prescription drug poisoning per 100,000 women ages 15 thought 44

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	92.8	91.2	89.5	87.9	86.3

Field Level Notes for Form 10a SPMs:

1.	**Field Name:**	**2017**
	Field Note: 2014 baseline is 97.7/100,000.	
2.	**Field Name:**	**2020**
	Field Note: Target setting method is ten percent improvement from baseline.	

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

State: Colorado

ESM 2.1 - Completion of a report identifying NTSV data/rates for all Colorado delivering hospitals to identify facilities for C/S reduction/QI interventions

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10a ESMs:

1. **Field Name:** **2018**

Field Note:
A new ESM will be established for 2018 and beyond.

ESM 4.1 - Number of delivering hospitals in Colorado that are certified as Baby-Friendly

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	9.0	12.0	12.0	18.0	19.0

Field Level Notes for Form 10a ESMs:

1. **Field Name:** **2017**

Field Note:
April 2016 baseline is 5.

ESM 6.1 - Number of LPHAs, community and/or health care partners in Colorado that have implemented ABCD quality standards that support early childhood screening, referral and treatment services for developmental needs

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	40.0	60.0	80.0	100.0	120.0

Field Level Notes for Form 10a ESMs:

1. **Field Name:** **2017**

Field Note:
2016 baseline is 20.

ESM 7.1 - Number of local partners reporting use of the Positive School Environment Toolkit in prioritized communities

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	8.0	12.0	16.0	20.0	24.0

Field Level Notes for Form 10a ESMs:

1. **Field Name:** **2017**

Field Note:
Annual objectives could change after counties set targets in May 2017.

ESM 8.1 - Number of licensed child care centers in select counties in Colorado that have physical activity as a part of daily curriculum

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	10.0	25.0	35.0	55.0	75.0

Field Level Notes for Form 10a ESMs:

1. **Field Name:** **2017**

Field Note:
Annual objectives could change after receipt of baseline data.

ESM 9.1 - Number of local partners reporting use of the Positive School Environment Toolkit in prioritized community

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	8.0	12.0	16.0	20.0	24.0

Field Level Notes for Form 10a ESMs:

1. **Field Name:** **2017**

Field Note:
Annual objectives could change after counties set targets in May 2017.

ESM 11.1 - Percent of children and youth with special health care needs (CYSHCN) who receive HCP Care Coordination services and have an interagency shared plan of care

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	50.0	52.0	54.0	56.0	58.0

Field Level Notes for Form 10a ESMs:

1. **Field Name:** **2017**

Field Note:
2016 baseline is 33.1 percent.

ESM 14.1 - Percent of women who report that a doctor, nurse, or other health care worker talked with them about how smoking during pregnancy could affect their baby

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	70.2	71.8	73.4	75.0	76.6

Field Level Notes for Form 10a ESMs:

1. **Field Name:** **2017**

Field Note:
2013 baseline is 68.6 percent.

ESM 14.2 - Percent of women who report that a doctor, nurse, or other health care worker advised them during pregnancy and postpartum about the harms of their child's exposure to secondhand smoke

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	35.9	37.3	38.7	40.0	41.4

Field Level Notes for Form 10a ESMs:

1. **Field Name:** **2017**

Field Note:
2013 baseline is 34.6 percent.

ESM 14.3 - Percent of children whose parents report that their child's' health care provider talked to them about their child's exposure to secondhand smoke

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	29.5	30.3	31.0	31.7	32.5

Field Level Notes for Form 10a ESMs:

1. **Field Name:** **2017**

Field Note:
2014 baseline is 28.8 percent.

Form 10b
State Performance Measure (SPM) Detail Sheets

State: Colorado

SPM 1 - Percent of mothers that report a doctor, nurse or other health care worker talked with them about what to do if they felt depressed during pregnancy or after delivery
Population Domain(s) – Women/Maternal Health

Goal:	Increase the number of Colorado women who are screened, referred, and treated for depressive symptoms during the pregnant and postpartum period.
Definition:	

Numerator:	Number (weighted) of women who report 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
Denominator:	Number (weighted) of live births
Unit Type:	Percentage
Unit Number:	100

Healthy People 2020 Objective:	Related to Maternal, Infant, and Child Health (MICH) 34: (Developmental) Decrease the proportion of women delivering a live birth who experience postpartum depressive symptoms
Data Sources and Data Issues:	The Colorado Pregnancy Risk Assessment Monitoring System (PRAMS) is the data source for this measure. Data are available on an annual basis and reflect the population of all women giving birth.
Significance:	Depression is the most common complication of pregnancy, therefore it is important for providers to educate women to raise awareness and reduce stigma. Response options to this measure are a dichotomous 'yes/no' because a woman either had this conversation with her provider or she did not.

SPM 2 - Infant mortality rate among African Americans in Denver and Arapahoe counties
Population Domain(s) – Perinatal/Infant Health

Goal:	Reduce Colorado's African American infant mortality rate to the current White, non-Hispanic rate (4.0/1000) or below.
Definition:	
	Numerator: Number of African American infant (<1 year of age) deaths in Arapahoe and Denver counties
	Denominator: Number of African American live births in Arapahoe and Denver counties
	Unit Type: Rate
	Unit Number: 1,000
Healthy People 2020 Objective:	Related to Maternal, Infant, and Child Health (MICH) 1.3: Reduce the rate of all infant deaths (within 1 year). (Target: 6.0 infant deaths per 1,000 live births)
Data Sources and Data Issues:	Colorado birth and death certificates
Significance:	The rate of infant mortality is widely used as a measure of population health. It is not only seen as a measure of the risk of infant death but is used more broadly as a broader indicator of community health status, poverty and socioeconomic status.

SPM 3 - Percent of women who report using marijuana at any time during their pregnancy
Population Domain(s) – Cross-Cutting/Life Course

Goal:	To decrease the number of women who use marijuana during pregnancy.
Definition:	**Numerator:** Number (weighted) of women who report using marijuana at any time during their pregnancy **Denominator:** Number (weighted) of live births **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	Related to Maternal, Infant, and Child Health (MICH) 11.4: Increase abstinence from illicit drugs among pregnant women (Target: 100 percent)
Data Sources and Data Issues:	The Colorado Pregnancy Risk Assessment Monitoring System (PRAMS) is the data source for this measure. Data are available on an annual basis and reflect the population of all women giving birth.
Significance:	Prenatal marijuana exposure is associated with impairment to executive functioning, impacts attention, problem solving, and working memory. Use may interfere with intellectual development and academic achievement. Executing mass reach health education campaigns targeting women of reproductive age and educating health care providers on risks of marijuana use on fetal development can help influence the woman's decision to abstain from marijuana use.

SPM 4 - Rate of emergency department visits for women for prescription drug use poisoning per 100,000 women ages 15 through 44
Population Domain(s) – Cross-Cutting/Life Course

Goal:	To decrease the number of women of reproductive age who misuse prescription drugs.
Definition:	

Numerator:	Number of emergency department visits with a primary diagnosis of prescription drug poisoning among women ages 15 through 44
Denominator:	Number of women ages 15 through 44
Unit Type:	Rate
Unit Number:	100,000

Healthy People 2020 Objective:	Related to Substance Abuse (SA) 19: Reduce the past-year nonmedical use of prescription drugs
Data Sources and Data Issues:	Emergency Department Visits, Colorado Hospital Association, analyzed by the Colorado Department of Public Health and Environment
Significance:	Prescription drug misuse during pregnancy increases risk for obstetric complications, such as premature birth, stroke, and drug withdrawal. Increasing access to safe medication disposal, educating health care providers on risks of prescription drug use during pregnancy, and promoting safe prescribing can limit the availability of drugs whose misuse can lead to poisonings and resultant emergency department visits.

SPM 5 - Rate of hospitalizations for prescription drug poisoning per 100,000 women ages 15 thought 44
Population Domain(s) – Cross-Cutting/Life Course

Goal:	To decrease the number of women of reproductive age who misuse prescription drugs.
Definition:	**Numerator:** Number of hospital admissions with a primary diagnosis of prescription drug poisoning among women ages 15 through 44 **Denominator:** Number of women ages 15 through 44 **Unit Type:** Rate **Unit Number:** 100,000
Healthy People 2020 Objective:	Related to Substance Abuse (SA) 19: Reduce the past-year nonmedical use of prescription drugs
Data Sources and Data Issues:	Hospital Discharge Dataset, Colorado Hospital Association, analyzed by the Colorado Department of Public Health and Environment
Significance:	Prescription drug misuse during pregnancy increases risk for obstetric complications, such as premature birth, stroke, and drug withdrawal. Increasing access to safe medication disposal, educating healthcare providers on risks of prescription drug use during pregnancy, and promoting safe prescribing can limit the availability of drugs whose misuse can lead to poisonings and resultant hospitalizations.

Form 10b
State Outcome Measure (SOM) Detail Sheets

State: Colorado

No State Outcome Measures were created by the State.

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

State: Colorado

ESM 2.1 - Completion of a report identifying NTSV data/rates for all Colorado delivering hospitals to identify facilities for C/S reduction/QI interventions
NPM 2 – Percent of cesarean deliveries among low-risk first births

Goal:	To reduce the percentage of cesarean deliveries among low-risk first births in delivering hospitals in Colorado with percentages of NTSV C/S over 23.9 percent.
Definition:	**Numerator:** N/A **Denominator:** N/A **Unit Type:** Text **Unit Number:** Yes/No
Data Sources and Data Issues:	Birth Certificate/Vital Statistics Data. These data will also be linked to the All Payer Claims Database (APCD) to enhance the analysis. A summary report will be generated identifying facility- specific and overall rates.
Significance:	Cesarean delivery can be a life-saving procedure for medical indications. However, for most low-risk pregnancies, cesarean delivery poses avoidable maternal risks of morbidity and mortality, including hemorrhage, infection, and blood clots - risks that compound with subsequent cesarean deliveries. While the cesarean birth rate has been rising in the US, according to Mac Dornan, Menacker and Declerq (as cited in the California Maternal Quality Care Collaborative Toolkit to Support Vaginal Birth and Reduce Primary Cesareans), this low risk population has been one of the larger contributors to the rise in C/S rates while also exhibiting the greatest variation among hospitals and providers. The HP 2020 goal for NTSV C/S has been set at less than 23.9 percent. Given these data, strategies targeted to hospitals with high rates should result in an overall reduction in NTSV cesarean births in individual facilitates as well as statewide.

ESM 4.1 - Number of delivering hospitals in Colorado that are certified as Baby-Friendly
NPM 4 – A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months

Goal:	Improve breastfeeding supportive maternity practices to increase the number of infants who initiate breastfeeding and breastfeed exclusively through 6 months to potentially reduce the incidence of childhood obesity.
Definition:	
	Numerator: Number of delivering hospitals in Colorado certified as Baby-Friendly
	Denominator: Does not apply
	Unit Type: Count
	Unit Number: 55
Data Sources and Data Issues:	Baby-Friendly USA Inc. facility listing (website updated monthly)
Significance:	Breastfeeding supportive practices as defined by Baby-Friendly Hospital Initiative are shown to increase breastfeeding initiation and exclusivity.

ESM 6.1 - Number of LPHAs, community and/or health care partners in Colorado that have implemented ABCD quality standards that support early childhood screening, referral and treatment services for developmental needs
NPM 6 – Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Goal:	By tracking this measure, the state can better assess and ensure that partners with identified roles on the screening to referral continuum are using evidenced-based best practices relative to their role.
Definition:	

Numerator:	Number of local public health agencies, community, and/or health care partners in Colorado that have implemented ABCD quality standards that support early childhood screening, referral, and treatment services
Denominator:	Not applicable since ESM is a count
Unit Type:	Count
Unit Number:	423

Data Sources and Data Issues:	Colorado Assuring Better Child Health and Development (ABCD) surveys
Significance:	Having an agreed upon set of quality standards based on evidence and best practices, creates a common foundation for community and health care partners to implement screening and referral processes. Quality standards provide common launching points for partners with various skills and knowledge to implement their roles, increasing the likelihood that the continuum of screenings, referral and treatment will be completed.

ESM 7.1 - Number of local partners reporting use of the Positive School Environment Toolkit in prioritized communities
NPM 7 – Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19

Goal:	Colorado is using a shared protective factor approach to address bullying and youth suicide to leverage resources and create greater impact.
Definition:	

Numerator:	Number of schools in El Paso County and Boulder County reporting use of the Positive School Environment Toolkit
Denominator:	Not applicable since ESM is a count
Unit Type:	Count
Unit Number:	50

Data Sources and Data Issues:	Colorado Department of Public Health and Environment, Interpersonal Violence Prevention Unit Data (state developed data collection system)
Significance:	Since schools are a logical point-of-contact for work on youth suicide prevention, the ESM for 2017 will focus on the number of local partners reporting use of the Positive School Environment Toolkit, as a means of fostering school connectedness. School connectedness, as demonstrated by the percent of high school students who strongly agree that teachers care about them and encourage them, is a shared protective factor for both bullying and youth suicide. School connectedness is an important and measurable intermediate outcome to assess initial impact on the strategies implemented under this priority.

ESM 8.1 - Number of licensed child care centers in select counties in Colorado that have physical activity as a part of daily curriculum
NPM 8 – Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day

Goal:	Reduce the percent of children ages 2 through 4 years considered overweight or obese.
Definition:	

Numerator:	Number of licensed child care centers in Colorado that have physical activity as a part of the daily curriculum
Denominator:	Not applicable since ESM is a count
Unit Type:	Count
Unit Number:	1,190

Data Sources and Data Issues:	Colorado Department of Public Health and Environment Early Childhood Obesity Prevention Unit (state developed data collection system)
Significance:	Physical activity experiences early in childhood influence children's preferences and activities throughout life. These experiences along with healthy eating and other healthy weight behaviors and practices protect against early childhood obesity. Young children raised with opportunities to be physically active (according to evidence-based recommendations for time and intensity) increases the likelihood that they will continue to be physically active at ages 6 through 11.

ESM 9.1 - Number of local partners reporting use of the Positive School Environment Toolkit in prioritized community
NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Goal:	Colorado is using a shared protective factor approach to address bullying and youth suicide prevention to leverage resources and create greater impact.
Definition:	**Numerator:** Number of schools in El Paso County and Boulder County reporting use of the Positive School Environment Toolkit **Denominator:** Not applicable since ESM is a count **Unit Type:** Count **Unit Number:** 50
Data Sources and Data Issues:	Colorado Department of Public Health and Environment, Interpersonal Violence Prevention Unit Data (state developed data collection system)
Significance:	Since schools are a logical point-of-contact for work on bullying, the ESM for 2017 will focus on the number of local partners reporting use of the Positive School Environment Toolkit, as a means of fostering school connectedness. School connectedness, as demonstrated by the percent of high school students who strongly agree that teachers care about them and encourage them, is a shared protective factor for both bullying and youth suicide. School connectedness is an important and measurable intermediate outcome to assess initial impact on the strategies implements under this priority.

ESM 11.1 - Percent of children and youth with special health care needs (CYSHCN) who receive HCP Care Coordination services and have an interagency shared plan of care
NPM 11 – Percent of children with and without special health care needs having a medical home

Goal:	Identify and implement policy/systems changes that support communication and collaboration between programs that provide care coordination for children and youth in order to increase the percentage of CYSHCN who experience a Medical Home approach.
Definition:	
	Numerator: Number of children and youth with special health care needs (CYSHCN) who receive HCP Care Coordination services and have an interagency shared plan of care
	Denominator: Number of children and youth with special health care needs (CYSHCN) who receive HCP Care Coordination services
	Unit Type: Percentage
	Unit Number: 100
Data Sources and Data Issues:	Colorado Department of Public Health and Environment HCP Care Coordination database (state developed data collection system)
Significance:	This priority aims to strengthen coordination and communication between the family, primary care medical provider (PCMP) and community-based systems of supports and services for CYSHCN through the promotion of shared plans of care across service delivery systems. Shared plans of care allow for better communication and coordination of support, which will ultimately increase the percentage of children who experience a medical home approach. measurement will focus on tracking the shared plans of care for CYSHCN receiving HCP (Title V funded) care coordination.

ESM 14.1 - Percent of women who report that a doctor, nurse, or other health care worker talked with them about how smoking during pregnancy could affect their baby
NPM 14 – A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes

Goal:	Colorado intends to decrease the number of women who smoke during pregnancy. Colorado also intends to decrease the number of children (ages 1-4) who are exposed to secondhand smoke.
Definition:	

Numerator:	Number (weighted) of women who report that a doctor, nurse, or other health care worker talked with them about how smoking during pregnancy could affect their baby
Denominator:	Number (weighted) of live births
Unit Type:	Percentage
Unit Number:	100

Data Sources and Data Issues:	The Colorado Pregnancy Risk Assessment Monitoring System (PRAMS) is the data source for this measure. Data are available on an annual basis and reflect the population of all women giving birth.
Significance:	Exposure to secondhand smoke in utero can result in low birth weight, SIDS, and cognitive impairments. Furthermore, exposure to secondhand smoke in early childhood has ramifications later in life, including: behavioral problems (ADHD), respiratory problems, asthma, metabolic syndrome, difficulty conceiving, and an increased risk of smoking in early adulthood.

ESM 14.2 - Percent of women who report that a doctor, nurse, or other health care worker advised them during pregnancy and postpartum about the harms of their child's exposure to secondhand smoke NPM 14 – A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes

Goal:	Colorado intends to decrease the number of women who smoke during the prenatal and postpartum periods. Colorado also intends to decrease the number of children (ages 1-4) who are exposed to secondhand smoke.
Definition:	

Numerator:	Number (weighted) of women who report that a doctor, nurse, or other health care worker talked with them during and after pregnancy about the harms of their child's exposure to secondhand smoke
Denominator:	Number (weighted) of live births
Unit Type:	Percentage
Unit Number:	100

Data Sources and Data Issues:	The Colorado Pregnancy Risk Assessment Monitoring System (PRAMS) is the data source for this measure. Data are available on an annual basis and reflect the population of all women giving birth.
Significance:	Exposure to secondhand smoke in utero can result in low birth weight, SIDS, and cognitive impairments. Furthermore, exposure to secondhand smoke in early childhood has ramifications later in life, including: behavioral problems (ADHD), respiratory problems, asthma, metabolic syndrome, difficulty conceiving, and an increased risk of smoking in early adulthood.

ESM 14.3 - Percent of children whose parents report that their child's' health care provider talked to them about their child's exposure to secondhand smoke
NPM 14 – A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes

Goal:	Colorado also intends to decrease the number of children (ages 1-4) who are exposed to secondhand smoke.
Definition:	

Numerator:	Number (weighted) of children ages 1-14 whose parents report that their child' health care provider talked to them about their child's exposure to secondhand smoke
Denominator:	Number (weighted) of children ages 1-14
Unit Type:	Percentage
Unit Number:	100

Data Sources and Data Issues:	The Colorado Child Health Survey (CHS) is the data source for this measure. Data are available on an annual basis and reflect the population of children ages 1-14 years.
Significance:	Exposure to secondhand smoke in early childhood has ramifications later in life, including: cognitive impairments, behavioral problems (ADHD), respiratory problems, asthma, metabolic syndrome, difficulty conceiving, and an increased risk of smoking in early adulthood.

Form 10d
National Performance Measures (NPMs) (Reporting Year 2014 & 2015)

State: Colorado

Form Notes for Form 10d NPMs and SPMs

None

NPM 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.

	2011	2012	2013	2014	2015
Annual Objective	100.0	100.0	100.0	100.0	100.0
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	73	68	69	72	63
Denominator	73	68	69	72	63
Data Source	CDPHE Newborn Screening Laboratory	CDPHE Newborn Screening Laboratory	CDPHE Newborn Screening Laboratory	CDPHE Newborn Screening Laboratory	CDPHE Newborn Screening Laboratory
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2015**

   Field Note:
   Data for reporting year 2015 represent calendar year 2014 births.

2. **Field Name:** **2014**

   Field Note:
   Data for reporting year 2014 represent calendar year 2013 births.

3. **Field Name:** **2013**

   Field Note:
   Data for reporting year 2013 represent calendar year 2012 births.

4. **Field Name:** **2012**

   Field Note:
   Data for reporting year 2012 represent calendar year 2011 births.

5.	**Field Name:**	**2011**

Field Note:
Data for reporting year 2011 represent calendar year 2010 births.

Data Alerts: None

NPM 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)

	2011	2012	2013	2014	2015
Annual Objective	61.0	68.0	68.0	69.0	70.0
Annual Indicator	66.5	66.5	66.5	66.5	66.5
Numerator					
Denominator					
Data Source	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2015**

Field Note:
For 2011-2015, 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.

2. **Field Name:** **2014**

Field Note:
For 2011-2015, 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.

3. **Field Name:** **2013**

Field Note:
For 2011-2015, 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.

4. **Field Name:** **2012**

Field Note:
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.

5. **Field Name:** **2011**

Field Note:
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.

Data Alerts: None

NPM 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)

	2011	2012	2013	2014	2015
Annual Objective	52.0	45.0	45.0	46.0	47.0
Annual Indicator	43.7	43.7	43.7	43.7	43.7
Numerator					
Denominator					
Data Source	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2015**

Field Note:
For 2011-2015, 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.

2. **Field Name:** **2014**

Field Note:
For 2011-2015, 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.

3. **Field Name:** **2013**

Field Note:
For 2011-2015, 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.

4. **Field Name:** **2012**

Field Note:
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.

5. **Field Name:** **2011**

Field Note:
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.

Data Alerts: None

NPM 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)

	2011	2012	2013	2014	2015
Annual Objective	61.0	51.0	51.0	51.5	53.0
Annual Indicator	49.9	49.9	49.9	49.9	49.9
Numerator					
Denominator					
Data Source	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2015**

Field Note:
For 2011-2015, 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.

2. **Field Name:** **2014**

Field Note:
For 2011-2015, 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.

3. **Field Name:** **2013**

Field Note:
For 2011-2015, 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.

4. **Field Name:** **2012**

Field Note:
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.

5. **Field Name:** **2011**

Field Note:
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.

Data Alerts: None

NPM 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)

	2011	2012	2013	2014	2015
Annual Objective	89.0	61.0	61.0	61.5	62.0
Annual Indicator	60.1	60.1	60.1	60.1	60.1
Numerator					
Denominator					
Data Source	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2015**

Field Note:
For 2011-2015, 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.

2. **Field Name:** **2014**

Field Note:
For 2011-2015, 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.

3. **Field Name:** **2013**

Field Note:
For 2011-2015, 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.

4. **Field Name:** **2012**

Field Note:
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.

5. **Field Name:** **2011**

Field Note:
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.

Data Alerts: None

NPM 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.

	2011	2012	2013	2014	2015
Annual Objective	49.0	44.0	44.0	45.0	46.0
Annual Indicator	42.1	42.1	42.1	42.1	42.1
Numerator					
Denominator					
Data Source	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2015**

Field Note:
For 2011-2015, 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.

2. **Field Name:** **2014**

Field Note:
For 2011-2015, 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.

3. **Field Name:** **2013**

Field Note:
For 2011-2015, 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.

4. **Field Name:** **2012**

Field Note:
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.

5. **Field Name:** **2011**

Field Note:
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.

Data Alerts: None

NPM 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.

	2011	2012	2013	2014	2015
Annual Objective	80.0	80.0	80.0	80.0	80.0
Annual Indicator	75.6	76.3	75.9	73.4	76.1
Numerator					
Denominator					
Data Source	2010 National Immunization Survey	2011 National Immunization Survey	2012 National Immunization Survey	2013 National Immunization Survey	2014 National Immunization Survey
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2015**

   Field Note:
   Data shown for reporting year 2015 are for the 4:3:1:3*:3 series for calendar year 2014. Previous reporting years 2010-2014 are for 4:3:1:3:3, so the percentages are not directly comparable.

2. **Field Name:** **2014**

   Field Note:
   Data shown for reporting year 2014 are for the 4:3:1:3:3 series for calendar year 2013. This indicator represents the 4:3:1:3:3 series as defined originally, and can only be compared with the reporting year 2010, 2011, 2012, and 2013 indicators. 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. The is no statistically significant difference between reporting year 2013 and 2014.

3. **Field Name:** **2013**

   Field Note:
   Data shown for reporting year 2013 are for the 4:3:1:3:3 series for calendar year 2012. This indicator represents the 4:3:1:3:3 series as defined originally, and can only be compared with the reporting year 2010, 2011, and 2012 indicators. 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.

4. **Field Name:** **2012**

Field Note:
Data shown for reporting year 2012 are for the 4:3:1:3:3 series for calendar year 2011. This indicator represents the 4:3:1:3:3 series as defined originally, and can only be compared with the reporting year 2010 and 2011 indicators. 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.

5. **Field Name:** **2011**

Field Note:
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.

Data Alerts: None

NPM 08 - The rate of birth (per 1,000) for teenagers aged 15 through 17 years.

	2011	2012	2013	2014	2015
Annual Objective	19.5	17.0	13.5	11.5	11.0
Annual Indicator	17.4	14.0	11.9	11.4	8.7
Numerator	1,688	1,362	1,157	1,119	877
Denominator	97,252	97,123	97,485	98,523	100,778
Data Source	Birth Certificates	Birth Certificates	Birth Certificates	Birth Certificates	Birth Certificates
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2015**

   Field Note:
   Data shown for reporting year 2015 are calendar year 2014 births. These data are available from the Colorado Health Information Dataset (CoHID) at http://www.chd.dphe.state.co.us/Cohid/Default.aspx.

2. **Field Name:** **2014**

   Field Note:
   Data shown for reporting year 2014 are calendar year 2013 births. These data are available from the Colorado Health Information Dataset (CoHID) at http://www.chd.dphe.state.co.us/Cohid/Default.aspx.

3. **Field Name:** **2013**

   Field Note:
   Data shown for reporting year 2013 are calendar year 2012 births. These data are avaialble from the Colorado Health Information Dataset (CoHID) at http://www.chd.dphe.state.co.us/Cohid/Default.aspx.

4. **Field Name:** **2012**

   Field Note:
   Data shown for reporting year 2012 are calendar year 2011 births. These data are available from the Colorado Health Information Dataset (CoHID) at http://www.chd.dphe.state.co.us/cohid/Default.aspx.

5. **Field Name:** **2011**

   Field Note:
   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.

Data Alerts: None

NPM 09 - Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

	2011	2012	2013	2014	2015
Annual Objective	40.0	46.0	47.0	48.0	49.0
Annual Indicator	44.9	44.9	44.9	44.9	44.9
Numerator					
Denominator					
Data Source	2011-2012 CO Basic Screening Survey	2011-2012 CO Basic Screening Survey	2011-2012 CO Basic Screening Survey	2011-2012 CO Basic Screening Survey	2011-2012 CO Basic Screening Survey
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2015**

   Field Note:
   Data for reporting year 2015 are final 2011-2012 Basic Screening Survey results for a representative sample of third graders. The survey will be conducted again in 2016.

2. **Field Name:** **2014**

   Field Note:
   Data for reporting year 2014 are final 2011-2012 Basic Screening Survey results for a representative sample of third graders. The survey will be conducted again in 2016.

3. **Field Name:** **2013**

   Field Note:
   Data for reporting year 2013 are final 2011-2012 Basic Screening Survey results for a representative sample of third graders. The survey will be conducted again in 2016.

4. **Field Name:** **2012**

   Field Note:
   Data for reporting year 2012 are final 2011-2012 Basic Screening Survey results for a representative sample of third graders. The survey will be conducted again in 2016.

5. **Field Name:** **2011**

   Field Note:
   Data for reporting year 2011 are final 2011-2012 Basic Screening Survey results for a representative sample of third graders. The survey is conducted every three to four years.

Data Alerts: None

NPM 10 - The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.

	2011	2012	2013	2014	2015
Annual Objective	2.2	1.9	1.8	1.6	2.0
Annual Indicator	2.0	2.1	1.6	2.8	1.3
Numerator	20	22	17	29	14
Denominator	1,025,217	1,034,643	1,040,722	1,047,714	1,057,976
Data Source	Death certificates	Death certificates	Death certificate	Death certificate	Death certificate
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2015**

   Field Note:
   Data shown for reporting year 2015 are calendar year 2014 deaths. The data were retrieved from the Colorado Health Information Dataset (CoHID) at http://www.chd.dphe.state.co.us/cohid/Default.aspx.

2. **Field Name:** **2014**

   Field Note:
   Data shown for reporting year 2014 are calendar year 2013 deaths. The data were retrieved from the Colorado Health Information Dataset (CoHID) at http://www.chd.dphe.state.co.us/cohid/Default.aspx.

3. **Field Name:** **2013**

   Field Note:
   Data shown for reporting year 2013 are calendar year 2012 deaths. The data were retrieved from the Colorado Health Information Dataset (CoHID) at http://www.chd.dphe.state.co.us/cohid/Default.aspx. Annual performance objectives were not changed since this rate is based on a low number of deaths causing it to fluctuate.

4. **Field Name:** **2012**

   Field Note:
   Data shown for reporting year 2012 are calendar year 2011 deaths. The data were retrieved from the Colorado Health Information Dataset (CoHID) at http://www.chd.dphe.state.co.us/cohid/Default.aspx. Annual performance objectives were not changed since this rate is based on a low number of deaths causing it to fluctuate.

5. **Field Name:** **2011**

   Field Note:
   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.

Data Alerts: None

NPM 11 - The percent of mothers who breastfeed their infants at 6 months of age.

	2011	2012	2013	2014	2015
Annual Objective	60.0	60.0	60.0	58.0	57.0
Annual Indicator	52.4	56.9	56.5	55.2	60.0
Numerator					
Denominator					
Data Source	2010 National Immunization Survey	2011 National Immunization Survey	2012 National Immunization Survey	2013 National Immunization Survey	2014 National Immunization Survey
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2015**

Field Note:
Data shown for reporting year 2015 are breastfeeding data collected by the National Immunization Survey for infants born in 2012 (see http://www.cdc.gov/breastfeeding/data/reportcard.htm). The 2012 rates are based on the landline and cellular telephone samples in NIS so comparisons with rates from infants born in 2008 and earlier should be made with caution.

2. **Field Name:** **2014**

Field Note:
Data shown for reporting year 2014 are breastfeeding data collected by the National Immunization Survey for infants born in 2011 (see http://www.cdc.gov/breastfeeding/data/reportcard.htm). The 2011 rates are based on the landline and cellular telephone samples in NIS so comparisons with rates from infants born in 2008 and earlier should be made with caution.

3. **Field Name:** **2013**

Field Note:
Data shown for reporting year 2013 are breastfeeding data collected by the National Immunization Survey for infants born in 2010 (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.

4. **Field Name:** **2012**

Field Note:
Data shown for reporting year 2012 are breastfeeding data collected by the National Immunization Survey for infants born in 2009 (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.

5. **Field Name:** **2011**

Field Note:
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.
4-4-2013: Added final rate for 2008 births.

Data Alerts: None

NPM 12 - Percentage of newborns who have been screened for hearing before hospital discharge.

	2011	2012	2013	2014	2015
Annual Objective	98.0	98.0	98.0	98.3	98.3
Annual Indicator	97.3	97.8	98.3	98.0	98.0
Numerator	64,265	63,382	63,463	63,391	64,280
Denominator	66,066	64,779	64,574	64,716	65,561
Data Source	Newborn Hearing Screening Program	Newborn Hearing Screening Program	Newborn Hearing Screening Program	Newborn Hearing Screening Program	Newborn Hearing Screening Program
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2015**

Field Note:
Data shown for reporting year 2015 are calendar year 2014 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.)

2. **Field Name:** **2014**

Field Note:
Data shown for reporting year 2014 are calendar year 2013 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.)

3. **Field Name:** **2013**

Field Note:
Data shown for reporting year 2013 are calendar year 2012 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.)

4. **Field Name:** **2012**

Field Note:
Data shown for reporting year 2012 are calendar year 2011 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.)

5. **Field Name:** **2011**

Field Note:
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.)

Data Alerts: None

NPM 13 - Percent of children without health insurance.

	2011	2012	2013	2014	2015
Annual Objective	5.0	10.0	10.0	8.5	3.0
Annual Indicator	10.8	10.3	5.0	3.1	2.7
Numerator					
Denominator					
Data Source	Colorado Child Health Survey	Colorado Child Health Survey	Colorado Child Health Survey	Colorado Child Health Survey	Colorado Child Health Survey
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2015**

   Field Note:
   Data shown for reporting year 2015 are calendar year 2015 Colorado Child Health Survey results. The percentage includes children ages 1-14 uninsured at the time of the survey.

2. **Field Name:** **2014**

   Field Note:
   Data shown for reporting year 2014 are calendar year 2014 Colorado Child Health Survey results. The percentage includes children ages 1-14 uninsured at the time of the survey.

3. **Field Name:** **2013**

   Field Note:
   Data shown for reporting year 2013 are calendar year 2013 Colorado Child Health Survey results. The percentage includes children ages 1-14 uninsured at the time of the survey.

   Estimates from RY2010 and earlier are not comparable to estimates from more current reporting years due to methodological changes.

4. **Field Name:** **2012**

   Field Note:
   Data shown for reporting year 2012 are calendar year 2012 Colorado Child Health Survey results. The percentage includes children ages 1-14 uninsured at the time of the survey.

   Estimates from RY2010 and earlier are not comparable to estimates from more current reporting years due to methodological changes.

5. **Field Name:** **2011**

Field Note:
Data shown for reporting year 2011 are calendar year 2011 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 reflect changes to sampling and weighting methodology based on the 2011 BRFSS changes, therefore annual indicators prior to reporting year 2011 should not be compared to the reporting year 2011 annual indicator.

Data Alerts: None

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

	2011	2012	2013	2014	2015
Annual Objective	23.0	23.0	22.7	21.8	21.6
Annual Indicator	24.2	22.9	22.0	21.9	21.2
Numerator	6,662	7,683	7,455	6,910	6,403
Denominator	27,529	33,615	33,875	31,613	30,217
Data Source	2011 Pediatric Nutrition Surveillance	2012 WIC PC File	2013 WIC PC File	2014 WIC PC File	2015 WIC PC File
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2015**

Field Note:
Data shown for reporting year 2015 are from the April 2015 WIC Participant Characteristics (PC) file.

Estimates from RY 2011 and earlier are not comparable to estimates from more current reporting years due to methodological changes.

2. **Field Name:** **2014**

Field Note:
Data shown for reporting year 2014 are from the April 2014 WIC Participant Characteristics (PC) file.

Estimates from RY2011 and earlier are not comparable to estimates from more current reporting years due to methodological changes.

3. **Field Name:** **2013**

Field Note:
Data shown for reporting year 2013 are from the April 2013 WIC Participant Characteristics (PC) file.

Estimates from RY2011 and earlier are not comparable to estimates from more current reporting years due to methodological changes.

4. **Field Name:** **2012**

Field Note:
Data shown for reporting year 2012 are from the April 2012 WIC Participant Characteristics (PC) file. CDC no longer produces the Pediatric Nutrition Surveillance System, so a new methodology had to be implemented to assess this indicator.

Estimates from RY2011 and earlier are not comparable to estimates from more current reporting years due to methodological changes.

5. **Field Name:** **2011**

Field Note:
Data shown for reporting year 2011 are from the 2011 Pediatric Nutrition Survey. The WIC program changed computer systems in the middle of the year, thus the 2011 annual indicator represents data collected from September through December 2011.

Data Alerts: None

NPM 15 - Percentage of women who smoke in the last three months of pregnancy.

	2011	2012	2013	2014	2015
Annual Objective	8.5	6.5	6.0	7.0	5.8
Annual Indicator	6.5	6.1	6.2	6.0	5.5
Numerator		3,969	4,018	3,853	3,600
Denominator		64,980	64,800	64,592	65,692
Data Source	Birth certificates	Birth certificates	Birth certificates	Birth certificates	Birth certificates
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2015**

   Field Note:
   Data for reporting year 2015 represent calendar year 2014 births.

2. **Field Name:** **2014**

   Field Note:
   Data for reporting year 2014 represent calendar year 2013 births.

3. **Field Name:** **2013**

   Field Note:
   Data for reporting year 2013 represent calendar year 2012 births.

4. **Field Name:** **2012**

   Field Note:
   Data for reporting year 2012 are from 2011 births. Because of changes in how the question was asked in PRAMS, the birth certificate question is now 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.

5. **Field Name:** **2011**

   Field Note:
   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.

Data Alerts: None

NPM 16 - The rate (per 100,000) of suicide deaths among youths aged 15 through 19.

	2011	2012	2013	2014	2015
Annual Objective	11.0	9.0	9.0	10.0	13.0
Annual Indicator	11.5	12.3	11.7	13.7	12.4
Numerator	39	43	41	48	44
Denominator	339,475	349,522	350,947	351,258	356,266
Data Source	Death certificates	Death certificates	Death certificates	Death certificates	Death certificates
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2015**

   Field Note:
   Data shown for reporting year 2015 are calendar year 2014 deaths. The data were retrieved from the Colorado Health Information Dataset (CoHID) at http://www.chd.dphe.state.co.us/cohid/Default.aspx.

2. **Field Name:** **2014**

   Field Note:
   Data shown for reporting year 2014 are calendar year 2013 deaths. The data were retrieved from the Colorado Health Information Dataset (CoHID) at http://www.chd.dphe.state.co.us/cohid/Default.aspx.

3. **Field Name:** **2013**

   Field Note:
   Data shown for reporting year 2013 are calendar year 2012 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.

4. **Field Name:** **2012**

   Field Note:
   Data shown for reporting year 2012 are calendar year 2011 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.

5. **Field Name:** **2011**

   Field Note:
   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.

Data Alerts: None

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

	2011	2012	2013	2014	2015
Annual Objective	82.0	89.5	91.0	89.0	90.0
Annual Indicator	89.2	90.6	87.9	89.3	88.9
Numerator	793	752	696	766	721
Denominator	889	830	792	858	811
Data Source	Birth Certificates	Birth Certificates	Birth Certificates	Birth Certificates	Birth Certificates
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2015**

   Field Note:
   Data for reporting year 2015 represent calendar year 2014 births.

2. **Field Name:** **2014**

   Field Note:
   Data for reporting year 2014 represent calendar year 2013 births.

3. **Field Name:** **2013**

   Field Note:
   Data for reporting year 2013 represent calendar year 2012 births.

4. **Field Name:** **2012**

   Field Note:
   Data shown for reporting year 2012 represent calendar year 2011 births. The denominator represents very low birth weight births to Colorado residents.

5. **Field Name:** **2011**

   Field Note:
   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.

Data Alerts: None

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

	2011	2012	2013	2014	2015
Annual Objective	78.0	79.5	80.0	80.5	81.0
Annual Indicator	79.0	79.4	80.2	80.8	80.3
Numerator	51,457	50,313	50,426	50,777	51,017
Denominator	65,114	63,384	62,891	62,816	63,500
Data Source	Birth certificates	Birth certificates	Birth certificates	Birth certificates	Birth certificates
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2015**

Field Note:
Data shown for reporting year 2015 are calendar year 2014 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.

2. **Field Name:** **2014**

Field Note:
Data shown for reporting year 2014 are calendar year 2013 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.

3. **Field Name:** **2013**

Field Note:
Data shown for reporting year 2013 are calendar year 2012 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.cohttp://www.chd.dphe.state.co.us/cohid/Default.aspx.us/cohid/Default.aspx.

4. **Field Name:** **2012**

Field Note:
Data shown for reporting year 2012 are calendar year 2011 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.cohttp://www.chd.dphe.state.co.us/cohid/Default.aspx.us/cohid/Default.aspx.

5. **Field Name:** **2011**

Field Note:
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.cohttp://www.chd.dphe.state.co.us/cohid/Default.aspx.us/cohid/Default.aspx.

Data Alerts: None

Form 10d
State Performance Measures (SPMs) (Reporting Year 2014 & 2015)

State: Colorado

SPM 1 - Percent of sexually active women and men ages 18-44 years using an effective method of birth control to prevent pregnancy.

	2011	2012	2013	2014	2015
Annual Objective	73.0	74.0	62.5	68.0	69.0
Annual Indicator	73.3	61.8	68.3	68.3	65.5
Numerator					
Denominator					
Data Source	Behavioral Risk Factor Surveillance System	Behavioral Risk Factor Surveillance System	Behavioral Risk Factor Surveillance System	Behavioral Risk Factor Surveillance System	Behavioral Risk Factor Surveillance System
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d SPMs:

1. **Field Name:** **2015**

Field Note:
Data for reporting year 2015 are based on 2014 survey data. Methodological changes in reporting year 2012 do not allow comparisons of data since then with reporting years 2011 or earlier. The percentage shown for reporting year 2015 is not statistically different from the percentage shown for reporting year 2014.

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.

2. **Field Name:** **2014**

Field Note:
Data for reporting year 2014 are based on 2012 survey data. The birth control questions were inadvertently left off the 2013 BRFSS so 2013 data are not available. While reporting year data for 2012 and 2013 may be compared with each other, methodological changes in reporting year 2012 do not allow comparisons with reporting years 2011 or earlier.

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.

3. **Field Name:** **2013**

Field Note:
Data for reporting year 2013 are based on 2012 survey data. While reporting year data for 2012 and 2013 may be compared with each other, methodological changes in reporting year 2012 do not allow comparisons with reporting years 2011 or earlier. The change in the indicator between reporting year 2012 and reporting year 2013 is not statistically significant, however.

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.

4. **Field Name:** **2012**

Field Note:
Data for reporting year 2012 represent 2011 data. The 2011 data reflect a number of methodological changes in the Behavioral Risk Factor Surveillance Systems Survey. The changes include the addition of surveys among cell phone users and the replacement of post-stratification weighting with a more advanced method called ”iterative proportional fitting,” also sometimes called “raking.” Consequently, results for reporting year 2012 should not be directly compared with results in earlier years based on different methods.

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.

5. **Field Name:** **2011**

Field Note:
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.

Data Alerts: None

SPM 2 - Percent of live births to mothers who were overweight or obese based on BMI before pregnancy.

	2011	2012	2013	2014	2015
Annual Objective	35.5	43.0	42.5	44.0	43.5
Annual Indicator	43.2	43.0	44.3	45.2	45.2
Numerator	27,885	27,171	28,085	28,607	28,887
Denominator	64,520	63,233	63,348	63,303	63,893
Data Source	Birth certificates	Birth certificates	Birth certificates	Birth certificates	Birth certificates
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d SPMs:

1. **Field Name:** **2015**

Field Note:
Data for reporting year 2015 represent calendar year 2015 births.

Data for reporting years 2011-2015 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 years 2011-2015 are not comparable to data from earlier reporting years.

2. **Field Name:** **2014**

Field Note:
Data for reporting year 2014 represent calendar year 2013 births.

Data for reporting years 2011-2014 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 years 2011-2014 are not comparable to data from earlier reporting years.

3. **Field Name:** **2013**

Field Note:
Data for reporting year 2013 represent calendar year 2012 births.

Data for reporting years 2011-2013 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 years 2011-2013 are not comparable to data from earlier reporting years.

4. **Field Name:** **2012**

Field Note:
Data for reporting year 2012 represent calendar year 2011 births.

Data for reporting years 2011 and 2012 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 and 2012 are not comparable to data from earlier reporting years.

5. **Field Name:** **2011**

Field Note:
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.

Data Alerts: None

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.

	2011	2012	2013	2014	2015
Annual Objective	73.0	75.5	77.0	78.0	79.0
Annual Indicator	75.1	76.6	76.6	78.9	78.0
Numerator					
Denominator					
Data Source	Pregnancy Risk Assessment Monitoring System	Pregnancy Risk Assessment Monitoring System	Pregnancy Risk Assessment Monitoring System	Pregnancy Risk Assessment Monitoring System	Pregnancy Risk Assessment Monitoring System
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d SPMs:

1. **Field Name:** **2015**

   Field Note:
   Data for reporting year 2015 represent 2013 data. 2014 PRAMS data are not yet available from CDC.

2. **Field Name:** **2014**

   Field Note:
   Data for reporting year 2014 represent 2012 data. 2013 PRAMS data are not yet available from CDC.

3. **Field Name:** **2013**

   Field Note:
   Data for reporting year 2013 represent 2011 data (repeated from the previous reporting year). CDC will not provide weighted 2012 PRAMS data to states until August 2014. The 2012 data point will be added to this application in early September and annual performance objectives will be adjusted accordingly.

4. **Field Name:** **2012**

   Field Note:
   Data for reporting year 2012 represent 2011 data.

5. **Field Name:** **2011**

   Field Note:
   Data for reporting year 2011 represent 2010 data.

Data Alerts: None

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.

	2011	2012	2013	2014	2015
Annual Objective	44.0	40.0	53.5	49.0	68.0
Annual Indicator	39.8	53.0	55.4	67.1	56.3
Numerator					
Denominator					
Data Source	Colorado Child Health Survey	Colorado Child Health Survey	Colorado Child Health Survey	Colorado Child Health Survey	Colorado Child Health Survey
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d SPMs:

1. **Field Name:** **2015**

   Field Note:
   Data for reporting year 2015 represent 2015 Colorado Child Health Survey results. The decrease between reporting year 2014 and 2015 is not statistically significant.

2. **Field Name:** **2014**

   Field Note:
   Data for reporting year 2014 represent 2014 Colorado Child Health Survey results.

3. **Field Name:** **2013**

   Field Note:
   Data for reporting year 2013 represent 2013 Colorado Child Health Survey results. The estimates for RY2012 and RY2013 are not statistically different.

   Estimates from RY2010 and earlier are not comparable to estimates from more current reporting years due to methodological changes.

4. **Field Name:** **2012**

   Field Note:
   Data for reporting year 2012 represent 2012 Colorado Child Health Survey results. The estimates for RY2011 and RY2012 are not statistically different.

   Estimates from RY2010 and earlier are not comparable to estimates from more current reporting years due to methodological changes.

5. **Field Name:** **2011**

Field Note:
Data for reporting year 2011 represent 2011 Colorado Child Health Survey results.

The 2011 Child Health Survey results reflect changes to sampling and weighting methodology based on the 2011 BRFSS changes, therefore annual indicators prior to reporting year 2011 should not be compared to the reporting year 2011 annual indicator.

Data Alerts: None

SPM 5 - Percent of Early Intervention Colorado referrals coming from targeted screening sources.

	2011	2012	2013	2014	2015
Annual Objective	42.0	43.0	44.0	48.0	49.0
Annual Indicator	42.5	41.9	47.1	46.3	48.8
Numerator	4,059	4,020	4,915	6,174	5,013
Denominator	9,557	9,586	10,429	13,328	10,276
Data Source	Early Intervention Colorado	Early Intervention Colorado	Early Intervention Colorado	Early Intervention Colorado	Early Intervention Colorado
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d SPMs:

1. **Field Name:** **2015**

   Field Note:
   Data for reporting year 2015 represent the first three quarters of calendar year 2015. Data collection was transitioned to a new system in late 2015. Data are provided by Early Intervention Colorado.

2. **Field Name:** **2014**

   Field Note:
   Data for reporting year 2014 represent calendar year 2014. Data are provided by Early Intervention Colorado.

3. **Field Name:** **2013**

   Field Note:
   Data for reporting year 2013 represent calendar year 2013. Data are provided by Early Intervention Colorado.

4. **Field Name:** **2012**

   Field Note:
   Data for reporting year 2012 represent calendar year 2012. Data are provided by Early Intervention Colorado.

5. **Field Name:** **2011**

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

Data Alerts: None

SPM 6 - Percent of live births where mothers gained an appropriate amount of weight during pregnancy according to pre-pregnancy BMI.

	2011	2012	2013	2014	2015
Annual Objective	34.0	34.0	34.0	34.5	35.0
Annual Indicator	33.1	33.2	34.3	34.2	34.1
Numerator	21,309	20,964	20,923	20,941	21,646
Denominator	64,380	63,147	61,077	61,167	63,423
Data Source	Birth certificates	Birth certificates	Birth certificates	Birth certificates	Birth certificates
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d SPMs:

1. **Field Name:** **2015**

Field Note:
Data for reporting year 2015 represent 2014 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 years 2013-2015 are not comparable to data in earlier reporting years.

2. **Field Name:** **2014**

Field Note:
Data for reporting year 2014 represent 2013 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 years 2013-2014 are not comparable to data in earlier reporting years.

3. **Field Name:** **2013**

Field Note:
Data for reporting year 2013 represent 2012 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 years 2011-2013 are not comparable to data in earlier reporting years.

4. **Field Name:** **2012**

Field Note:
Data for reporting year 2012 represent 2011 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 years 2011 and 2012 are not comparable to data in earlier reporting years.

5. **Field Name:** **2011**

Field Note:
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.

Data Alerts: None

SPM 7 - Percent of parents reporting that their child (age 1 through 3) first went to the dentist by 12 months of age.

	2011	2012	2013	2014	2015
Annual Objective	3.4	10.0	11.0	3.0	12.0
Annual Indicator	11.2	10.3	6.7	11.1	6.6
Numerator					
Denominator					
Data Source	Colorado Child Health Survey	Colorado Child Health Survey	Colorado Child Health Survey	Colorado Child Health Survey	Colorado Child Health Survey
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d SPMs:

1. **Field Name:** **2015**

   Field Note:
   Data for reporting year 2015 represent 2015 Colorado Child Health Survey results.

2. **Field Name:** **2014**

   Field Note:
   Data for reporting year 2014 represent 2014 Colorado Child Health Survey results.

3. **Field Name:** **2013**

   Field Note:
   Data for reporting year 2013 represent 2013 Colorado Child Health Survey results. This data point represents children ages 1-3, which can be compared to the reporting year 2011 and 2012 data points. The 2013 prevalence estimate is not significantly different from the 2012 estimate.

   Estimates from reporting year 2010 and earlier are not comparable to estimates from more current reporting years due to methodological changes.

4. **Field Name:** **2012**

   Field Note:
   Data for reporting year 2012 represent 2012 Colorado Child Health Survey results. This data point represents children ages 1-3, which can be compared to the RY2011 data point.

   Estimates from RY2010 and earlier are not comparable to estimates from more current reporting years due to methodological changes.

5. **Field Name:** **2011**

Field Note:
Data for reporting year 2011 represent 2011 Colorado Child Health Survey results.

The 2011 Child Health Survey results reflect changes to sampling and weighting methodology based on the 2011 BRFSS changes, therefore annual indicators prior to reporting year 2011 should not be compared to the reporting year 2011 annual indicator.

4-4-13: Updated RY2011 data point to 11.2% due to shift in methodology (ask parents of 1-3 year olds, instead of parents of 1-5 year olds).

Data Alerts: None

SPM 8 - Percent of sexually active high school students using an effective method of birth control to prevent pregnancy.

	2011	2012	2013	2014	2015
Annual Objective	27.0	30.0	30.0	30.5	31.5
Annual Indicator	29.1	29.1	29.1	31.0	31.7
Numerator					
Denominator					
Data Source	Youth Risk Behavior Survey	Youth Risk Behavior Survey	Youth Risk Behavior Survey	Healthy Kids Colorado Survey	Healthy Kids Colorado Survey
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d SPMs:

1. **Field Name:** **2015**

Field Note:
Data for reporting year 2015 represent 2015 Healthy Kids Colorado Survey results. Colorado did not obtain a sufficient sample size for weighted 2015 YRBS data. Effective birth control includes birth control pills, Depo-Provera, patch, ring, IUD, implant.

2. **Field Name:** **2014**

Field Note:
Data for reporting year 2014 represent 2013 Healthy Kids Colorado Survey results. Colorado did not obtain a sufficient sample size for weighted 2013 YRBS data. Effective birth control includes birth control pills, Depo-Provera, patch, ring, IUD, implant.

3. **Field Name:** **2013**

Field Note:
Data for reporting year 2013 represent 2011. The 2011 YRBS was weighted. Effective birth control includes birth control pills and Depo-Provera. Data are available at www.chd.dphe.state.co.us/Resources/yrbs/2011/2011COH%20Summary%20Tables.pdf

Data for 2013 were not available at time of grant application submission. The 2013 data point will be added to this application in early September and the annual performance objectives will be adjusted accordingly.

4. **Field Name:** **2012**

Field Note:
Data for reporting year 2012 represent 2011. The 2011 YRBS was weighted. Effective birth control includes birth control pills and Depo-Provera. Data are available at www.chd.dphe.state.co.us/Resources/yrbs/2011/2011COH%20Summary%20Tables.pdf

5. **Field Name:** **2011**

Field Note:
Data for reporting year 2011 represent 2011. The 2011 YRBS was weighted. Effective birth control includes birth control pills and Depo-Provera.

Data Alerts: None

SPM 9 - Motor vehicle death rate for teens ages 15-19 years old.

	2011	2012	2013	2014	2015
Annual Objective	12.5	12.0	10.1	11.0	10.8
Annual Indicator	12.1	10.3	11.4	11.7	9.8
Numerator	41	36	40	41	35
Denominator	339,475	349,522	350,947	351,258	356,266
Data Source	Death certificates	Death certificates	Death certificates	Death certificates	Death certificates
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d SPMs:

1. **Field Name:** **2015**

   Field Note:
   Data for reporting year 2015 represent calendar year 2014 deaths.

2. **Field Name:** **2014**

   Field Note:
   Data for reporting year 2014 represent calendar year 2013 deaths.

3. **Field Name:** **2013**

   Field Note:
   Data for reporting year 2013 represent calendar year 2012 deaths.

4. **Field Name:** **2012**

   Field Note:
   Data for reporting year 2012 represent calendar year 2011 deaths.

5. **Field Name:** **2011**

   Field Note:
   Data for reporting year 2011 represent calendar year 2010 deaths.

Data Alerts: None

SPM 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.

	2011	2012	2013	2014	2015
Annual Objective	30.0	90.0	80.0	80.0	78.0
Annual Indicator	90.0	75.0	72.7	76.0	88.5
Numerator	9	6	8	19	23
Denominator	10	8	11	25	26
Data Source	Wilder Collaboration Factors Inventory	Wilder Collaboration Factors Inventory	Wilder Collaboration Factors Inventory	Wilder Collaboration Factors Inventory	Wilder Collaboration Factors Inventory
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d SPMs:

1. **Field Name:** **2015**

   Field Note:
   Data for reporting year 2015 were collected in February 2016. Respondents include PHYT and CO9to25 GPS team members.

2. **Field Name:** **2014**

   Field Note:
   Data for reporting year 2014 were collected in March 2015. Respondents include PHYT and CO9to25 GPS team members.

3. **Field Name:** **2013**

   Field Note:
   Data for reporting year 2013 were collected in December 2013. Respondents include PHYT and CO9to25 GPS team members. A few group members were new to the group at the time of survey administration, which contributed to the lower Wilder score for this indicator. Since they were new, they did not have enough experience to determine whether group members invested the right amount of time.

4. **Field Name:** **2012**

   Field Note:
   Data for reporting year 2012 were collected in October 2012. A few group members were new to the group at the time of survey administration, which contributed to the lower Wilder score for this indicator. Since they were new, they did not have enough experience to determine whether group members invested the right amount of time.

5. **Field Name:** **2011**

   Field Note:
   Data for reporting year 2011 were collected in November 2011.

Data Alerts: None

Form 11
Other State Data

State: Colorado

While the Maternal and Child Health Bureau (MCHB) will populate the data elements on this form for the States, the data are not available for the current application/annual report.

State Action Plan Table

State: Colorado

Please click the link below to download a PDF of the full version of the State Action Plan Table.
State Action Plan Table

Abbreviated State Action Plan Table

State: Colorado

Women/Maternal Health

State Priority Needs	NPMs	ESMs	SPMs
Women's mental health, including pregnancy-related depression	NPM 2 - Low-Risk Cesarean Delivery	ESM 2.1	
Women's mental health, including pregnancy-related depression			SPM 1

Perinatal/Infant Health

State Priority Needs	NPMs	ESMs	SPMs
Reduction of infant mortality among African Americans			SPM 2
Early childhood obesity prevention	NPM 4 - Breastfeeding	ESM 4.1	

Child Health

State Priority Needs	NPMs	ESMs	SPMs
Early childhood obesity prevention	NPM 8 - Physical Activity	ESM 8.1	
Developmental screening and referrals	NPM 6 - Developmental Screening	ESM 6.1	

Adolescent Health

State Priority Needs	NPMs	ESMs	SPMs
Bullying and youth suicide prevention	NPM 7 - Injury Hospitalization	ESM 7.1	
Bullying and youth suicide prevention	NPM 9 - Bullying	ESM 9.1	

Children with Special Health Care Needs

State Priority Needs	NPMs	ESMs	SPMs
Medical home for children and youth with special health care needs	NPM 11 - Medical Home	ESM 11.1	

Cross-Cutting/Life Course

State Priority Needs	NPMs	ESMs	SPMs
Substance misuse reduction (tobacco, marijuana and prescription drugs) among pregnant and postpartum women	NPM 14 - Smoking	ESM 14.1 ESM 14.2 ESM 14.3	
Substance misuse reduction (tobacco, marijuana and prescription drugs) among pregnant and postpartum women			SPM 3
Substance misuse reduction (tobacco, marijuana and prescription drugs) among pregnant and postpartum women			SPM 4
Substance misuse reduction (tobacco, marijuana and prescription drugs) among pregnant and postpartum women			SPM 5