Maternal and Child Health Services Title V Block Grant

Colorado

FY 2024 Application/ FY 2022 Annual Report

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I. General Requirements

I.A. Letter of Transmittal

COLORADO
Department of Public Health & Environment

July 20, 2023

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

Dear Dr. Payne:

It is with pleasure that I submit the 2024 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,

Rachel Hutson

Rachel Hutson, MSN, RN, CPNP
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I.B. Face Sheet

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

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix F of the 2021 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the *"Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms,"* OMB NO: 0915-0172; Expires: January 31, 2024.

II. Logic Model

Please refer to figure 4 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms," OMB No: 0915-0172; Expires: January 31, 2024.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

Colorado's MCH Program

Colorado's MCH program is administered by the Colorado Department of Public Health and Environment (CDPHE). MCH collaborates with programs across CDPHE, other state agencies and statewide organizations, local public health agencies and community partners to implement strategies that have a population impact on Colorado's statewide MCH priorities.

2021-2025 MCH Priorities

The MCH Framework for the current five-year block grant cycle is based on the statewide MCH needs assessment and prioritization process that was completed in 2020 that resulted in the following seven prioritized needs:

- Create safe and connected built environments
- Increase prosocial connection
- Promote positive child and youth development
- Improve access to supports
- Increase social emotional wellbeing
- Reduce racial inequities
- Increase economic mobility

MCH Priority Implementation

Evidence-informed strategy measures and associated objectives are outlined in logic models and action plans for each priority and are posted on www.MCHColorado.org. The logic models and action plans, used to guide Colorado's state and local MCH work, are a combination of best and promising practices, along with emerging practices to drive innovation. MCH funds are leveraged with state resources, as well as aligned with other federally-funded programs and initiatives, to support priority implementation efforts. MCH funds are also used to build the capacity of the state and local MCH workforce in the areas of racial equity, community inclusion and moving upstream. Interim progress toward the performance measures is tracked through quarterly performance management reporting and evaluation summaries are produced each year to monitor impact on each priority. A summary for each MCH priority and associated performance measure is included below.

Create Safe and Connected Built Environments

State Performance Measure 3: Percent of children ages 0-17 years who live in a supportive neighborhood.

Daily experiences such as feeling safe, taking a walk, visiting a park, having healthy food nearby, and being part of social networks are critical to physical, mental, and social well-being. Thoughtful planning and design of a community's buildings, streets, sidewalks, transportation networks, parks, and homes can make it easier for children, youth, and families to engage, connect with others, and access resources in their communities. Safe and accessible built environments increase opportunities for physical activity by being able to walk, bike, or wheelchair roll to everyday destinations and decrease violence by creating safer environments for people to meet and connect. The MCH program funds built environment staff to build cross-sector partnerships and increase capacity for implementing place-based policy strategies that promote equity, community safety, and activity-friendly routes.

Increase Prosocial Connection

National Performance Measure 9: Percent of adolescents, ages 12 through 17, who are bullied or who bully others.

Data and research has shown that youth who have a trusted adult are less likely to experience bullying, as well as other health outcomes like suicide and substance use. Research also shows that if prevention efforts are focused on those who are most disproportionately impacted, it will also improve the outcomes for other youth. Evidence-based strategies supported through Colorado's MCH program include integrating a positive youth development approach into youth-serving programs throughout the state and supporting model policies and practices, such as Gender Sexuality Alliances, which increase trusted adults in young people's lives and enhances school climate and connectedness. The MCH program also supports the implementation of best practice youth violence prevention programs in schools.

Promote Positive Child and Youth Development

National Performance Measure 4: A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 month

Families experiencing low socioeconomic status have greater breastfeeding disparities, are more likely to experience barriers to breastfeeding, and thus have lower breastfeeding rates. The MCH program is focused on increasing the number of Baby-Friendly designated hospitals that serve high proportions of Medicaid paid births to decrease the breastfeeding disparities.

Research shows as the number of evidence-based Baby-Friendly Hospital Initiative's *Ten Steps to Successful Breastfeeding* practices increase in a hospital, breastfeeding rates increase as well. This is especially true for families enrolled in Medicaid or have no health insurance, as well as among families participating in the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), where significant increases in breastfeeding initiation and long term success is shown when Baby-Friendly policies were in place at a hospital.

Improve Access to Supports

National Performance Measure 11: Percent of children with and without special health care needs having a medical home

A core component of a medical home is timely access to specialty care, including behavioral health. In Colorado, only 15 out of 64 counties have a child psychiatrist, which creates a barrier for identifying, diagnosing and connecting children with complex behavioral health needs with services and supports. One of the recommendations included in the MCH-funded policy agenda, The ABC's of Health Equity for Children and Youth with Special Health Care Needs: A Policy Agenda for Colorado, centers on strengthening the capacity of the primary care provider network through telehealth and e-consultation. To advance this policy recommendation and strengthen access to behavioral health consultation and expertise statewide, MCH partners with the Pediatric Mental Health Institute and the Department of Psychiatry at the University of Colorado to implement the Colorado Pediatric Psychiatry Consultation and Access Program. The program offers pediatric primary care providers a phone, email or telehealth consultation with a child psychiatrist to support diagnosis or treatment. Enrolled practices can also receive continuing education opportunities tailored to their community, free screening tools and educational materials.

National Performance Measure 6: Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

While Colorado remains in the top tier amongst states for developmental screening rates, barriers in the process to access evaluation and intervention services after screening still remain. In 2022, approximately 22% of Early Intervention Colorado referrals were closed before completing the process. Barriers between child and family-serving systems in Colorado make it difficult to access and share data to know when children are screened, referred and, ultimately, whether they are able to access needed services. This results in children and families not receiving appropriate and timely support, and providers being unable to help coordinate care. To address this challenge, the MCH program is supporting a developmental screening and e-referral pilot project to improve communication and coordination among providers, early intervention partners, and families.

Increase Social Emotional Wellbeing

State Performance Measure 4: Percent of women of reproductive age (18-44 years) who report good mental health

As outlined in Postpartum Behavioral Health in Colorado, depression and anxiety continue to be the most common conditions that people experience before and after pregnancy. To improve the awareness and knowledge of pregnancy-related depression among pregnant and postpartum women and to improve women's perceptions and attitudes toward seeking support, Colorado's MCH program supports provider education and a statewide public awareness campaign. MCH also coordinates the state's Maternal Mortality Review Committee. Based on Colorado's most recent review committee data, suicide and unintentionaloverdose continue to be leading causes of maternal mortality. The MCH program is an active partner in the Colorado Perinatal Care Quality Collaborative, which supports the implementation of the Alliance for Innovation on Maternal Health (AIM) care for pregnant people with substance use disorders patient safety bundle, with 19 hospitals throughout Colorado.

National Performance Measure 14a: Percent of women who smoke during pregnancy

People who smoke during pregnancy are more likely to experience a fetal death or deliver a low birth weight baby. The MCH program partners with the state's tobacco prevention, education and cessation program to implement evidence-based

strategies in every county in Colorado to reduce the number of pregnant people who smoke, such as the community-based Baby and Me Tobacco Free Program and the QuitLine Pregnancy Protocol Program. Quit rates for QuitLine average 37% vs. 4-7% for unaided quit attempts. Those who access the Quitline are up to seven times more successful than people who try to quit unaided. A study of the Colorado Baby and Me Tobacco Free Program found program participants saw a 24% to 28% reduction in the risk of preterm birth and a 24% to 55% reduction in the risk of neonatal intensive care unit admissions.

Reduce Racial Inequities

State Performance Measure 2: Number of points for racial equity related policy, practices and systems changes implemented at the program, division and department level

Colorado's MCH program integrates strategies and activities to advance racial equity across each of the priorities. In addition, the program tracks changes to state and local policies and practices and assesses the potential impacts those systemic and institutional changes may have across staff and programs that serve the MCH population. While reducing racial inequities is a priority unto itself, strategies to impact racial inequities are integrated across the action plans for all seven statewide MCH priorities.

Increase Economic Mobility

State Performance Measure 1: Percent of households that spend more than 30% of household income on housing costs (Note: this year the measure has changed to "State Performance Measure 5: Percent of children in poverty according to the supplemental poverty measure" as a more proximal measure of the strategies being implemented to impact the economic mobility priority)

The connection between economic status and health is well-established, and poverty can have serious effects on children's long-term health. Among U.S. children younger than 18 years of age, one-third (33.2%) live in families with incomes below 200 percent of the federal poverty level ($50,200 for a family of four), the level at which Colorado families can be economically self-sufficient (The Self-Sufficiency Standard for Colorado 2018, Colorado Center on Law and Policy). Colorado is an increasingly expensive place to live, and many Colorado families have trouble meeting critical needs. Expanded tax credits support economic mobility and are associated with reduced child and household poverty, increased food security, and fewer adverse childhood events. MCH coordinates a tax outreach campaign, created a partner toolkit and provides statewide resources and information to help Coloradans access federal and state tax credits through Get Ahead Colorado.

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

Colorado's MCH program has and will continue to align resources to meet the needs of the MCH population, as identified through the statewide MCH needs assessment and prioritization process completed in 2020. Strategies and activities outlined in the state action plans for each priority are used to identify resource needs and scope annual budgets to support implementation.

Progress towards MCH measures and outcomes for each priority is not achievable without the federal Title V MCH Block Grant award. Colorado MCH uses the block grant to leverage a wide range of partnerships and resources to implement strategies that impact national and state performance measures associated with the state's MCH priorities. Each year, Colorado receives approximately $7.3 million through the federal Title V MCH Block Grant and designates about $5.5 million in state General Funds to meet the maintenance of effort and match requirements. Colorado's MCH funds and the state match allocations that are designated for maintenance of effort are distributed across the Colorado Department of Public Health and Environment's organizational structure to maximize alignment and coordination of MCH implementation efforts. In addition, MCH funds are allocated via funding formula to the state's 56 local public health agencies to support MCH implementation of local strategies to impact the MCH priorities.

The use of Title V MCH Block Grant funding to support the Prosocial and Community Connectedness Specialist within Colorado's Office of Youth Suicide is one example of how the MCH award is leveraged with other partners and resources. The MCH-funded position leads the implementation of strategies outlined in the MCH state action plan for the prosocial connection priority and coordinates these activities with other CDPHE violence prevention programs. The position also provides technical assistance to local public health agencies, schools, and school districts to implement local action plans for the prosocial connection MCH priority. Additional state funding supports implementation of best practice programs in nearly 250 schools throughout the state.

Additionally, Title V MCH Block Grant funds continue to be braided with state tobacco tax dollars and state General Funds to develop and implement the state action plan for the built environment priority. Leveraging these funds enables CDPHE's Health Promotion and Chronic Disease Prevention Branch to focus additional implementation efforts on the MCH population.

Colorado also leverages state General Funds with Title V MCH Block Grant dollars to support implementation of strategies outlined in the access to supports state action plan to advance Colorado's social-health information exchange infrastructure. State and federal MCH dollars are currently funding a developmental screening and e-referral pilot project to create electronic pathways between health systems, one of the state's Health Information Exchanges and Early Intervention Colorado's data platform to support closed loop e-referrals. Braiding these funds will also help take the pilot project to scale in the future, expanding to additional health systems throughout the state.

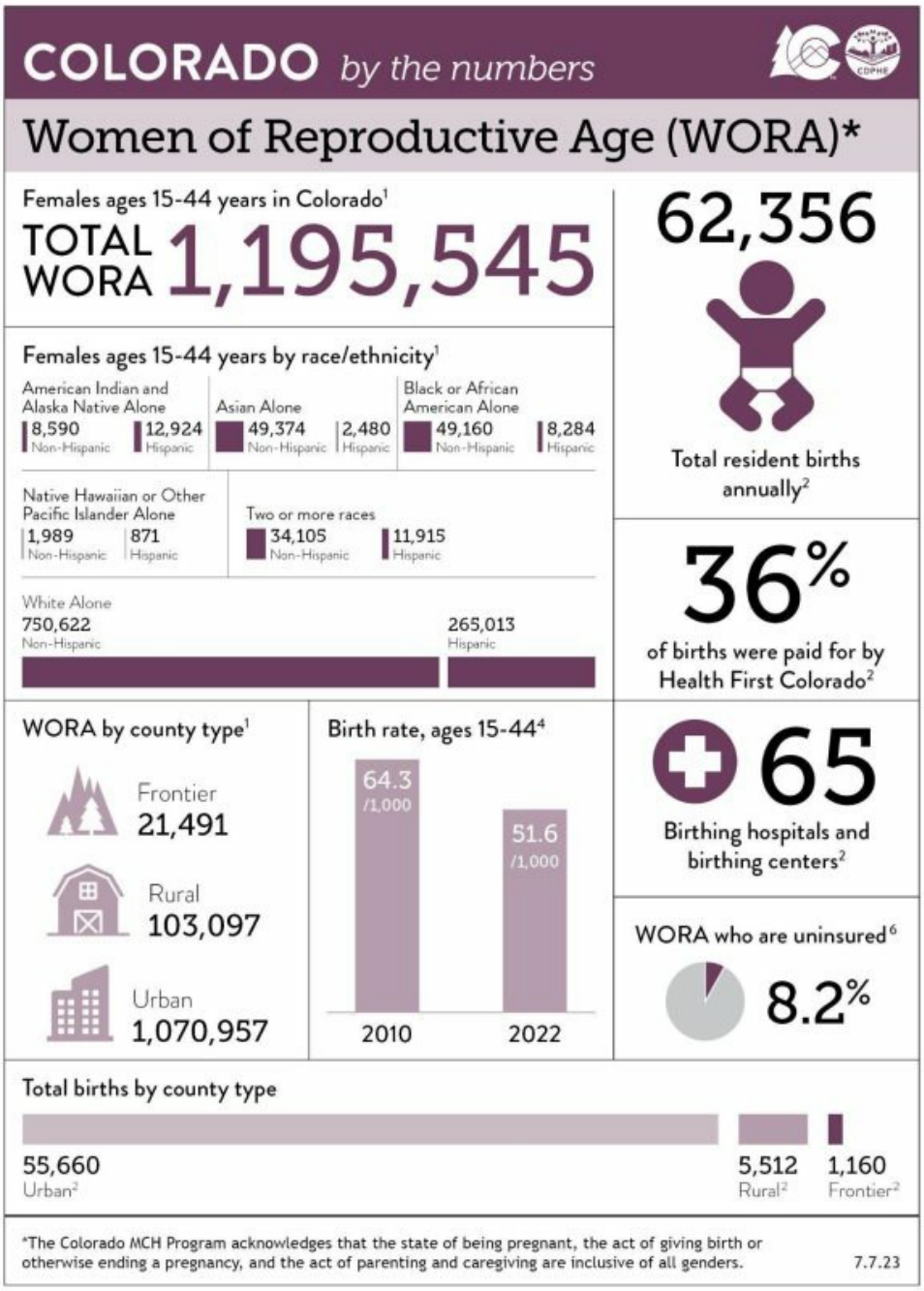
III.A.3. MCH Success Story

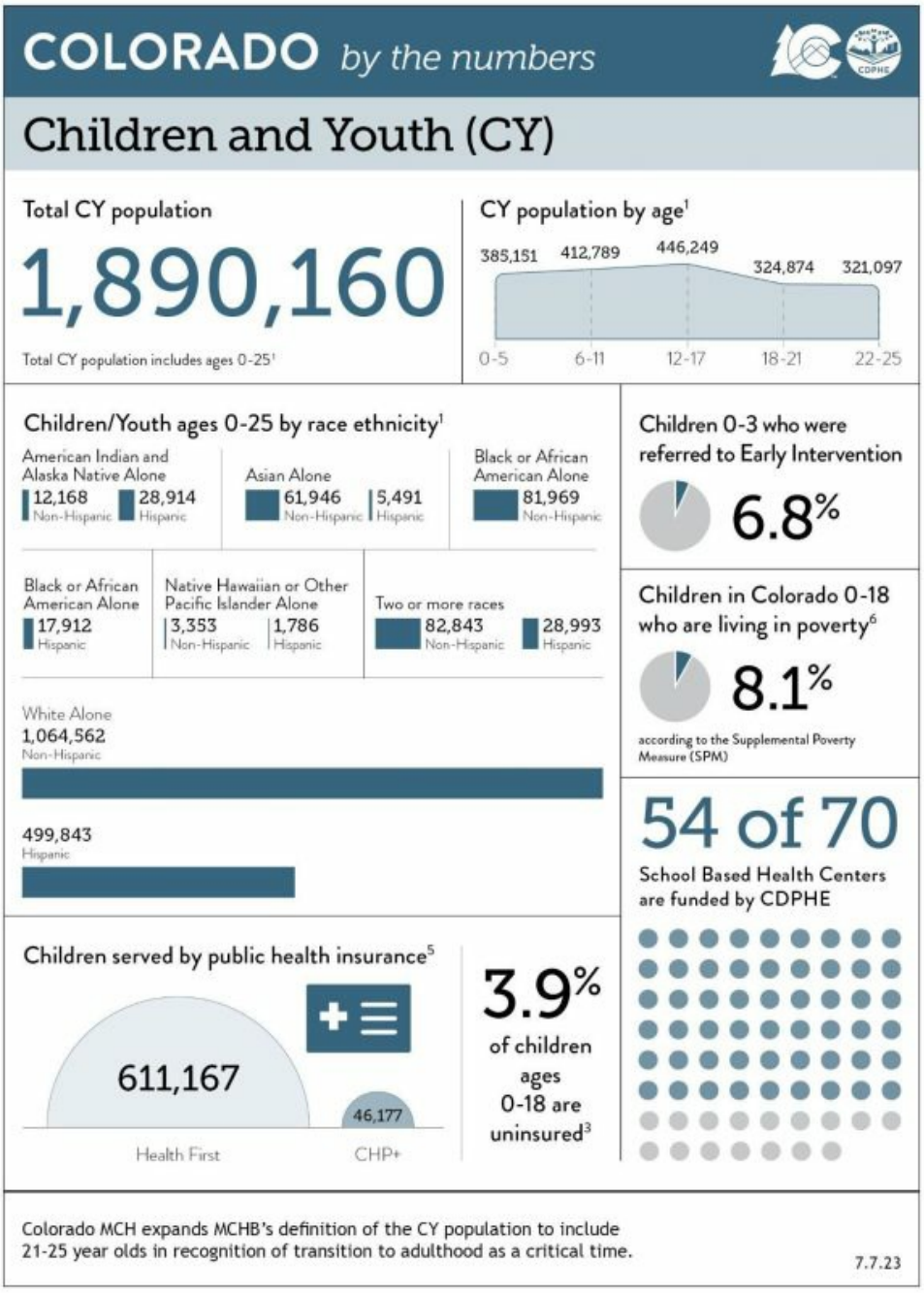
While Colorado remains in the top tier amongst states for developmental screening rates, significant barriers exist in the process for families to move from screening to receiving an evaluation for early intervention services. To more closely assess these challenges, the Early Childhood Screening and Referral Policy Council, co-facilitated by MCH, developed a recommendation to develop more integrated data system linkages to increase the quality of the data being shared and to support more timely and meaningful communication between the family, health care providers and Early Intervention Colorado, from the time of referral throughout the evaluation process. To enable a more comprehensive and timely data analysis, a subgroup of the policy council developed an interagency data dashboard to compile screening and referral data from Early Intervention Colorado, the state's Medicaid program, and Healthy Steps, an evidence-based, early childhood integrated behavioral health model embedded in primary care clinics. The dashboard is updated quarterly and aggregated annually to monitor progress. Currently the dashboard is internal with the goal of an external facing release within the next year.

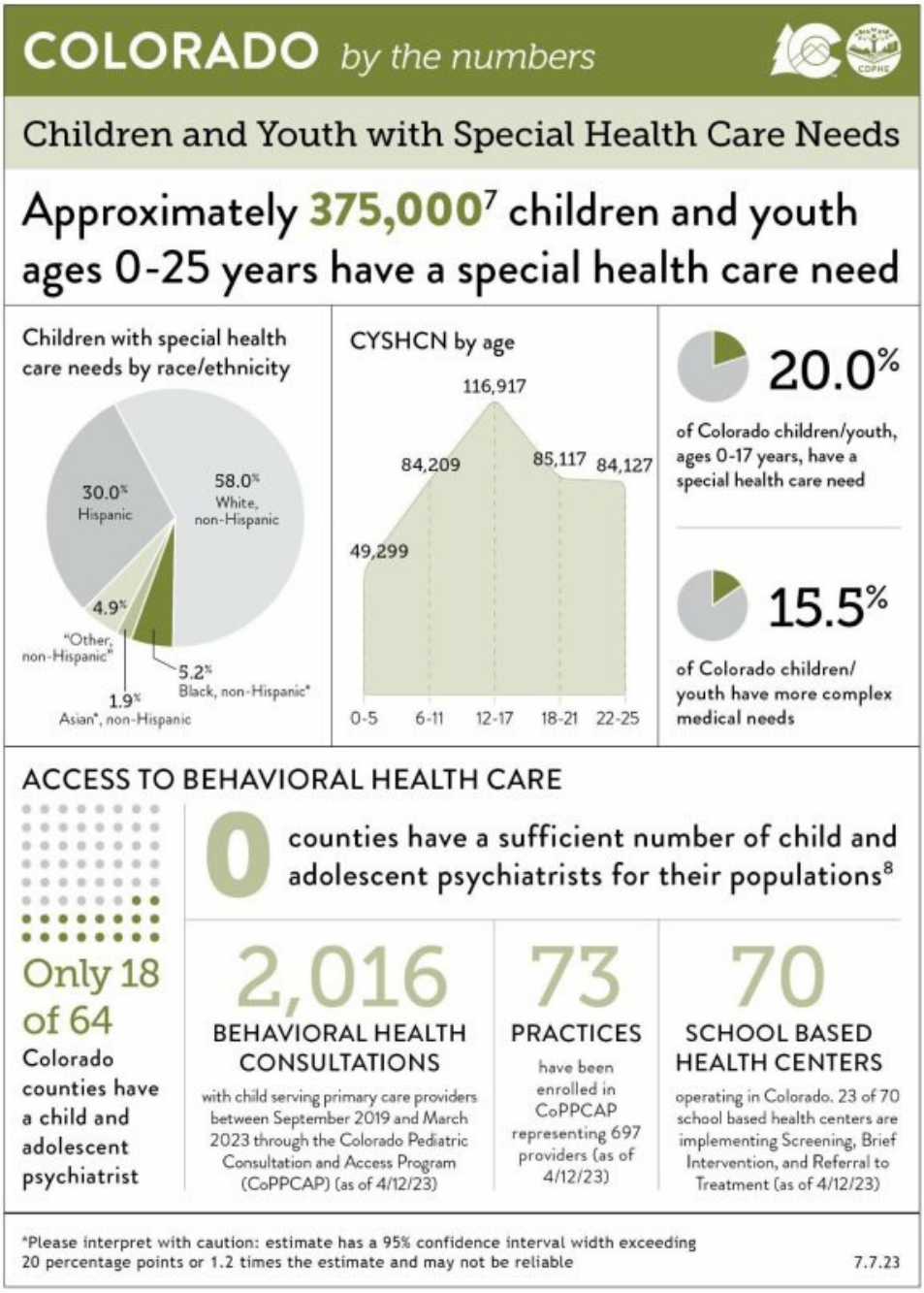
As a strategy to strengthen data quality and bi-directional communication between providers who do developmental screening and Early Intervention Colorado, MCH launched an electronic referral pilot. The implementation plan for the e-referral pilot was developed in partnership with staff from Early Intervention Colorado, the Office (now Department) of Early Childhood, MCH/CYSHCN, Assuring Better Child Health and Development (ABCD) and one of Colorado's two health information exchanges. The referral is initiated via the patient's electronic health record to a health information exchange, then sent directly into Early Intervention Colorado's newly centralized intake system. Salud Family Health Centers (which has seven clinics across the state) was selected to be the first health system to participate in the pilot, which went live in July 2022. Initial data showed an increase in overall referrals from the pilot practice to Early Intervention Colorado over the previous year. Project goals have been expanded to include comprehensive evaluation strategies to determine the impact of the pilot in increasing provider satisfaction, workflow enhancement, and decreasing the number of referrals that were not completed due to missing or incorrect contact information. Progress notes have improved communication about referral status and have provided real time updates related to early intervention services received by the child. The overall percentage of Early Intervention Colorado referrals that were not completed decreased from 32.3% in 2021 to 22.2% in 2022.

In the upcoming year, the developmental screening and e-referral project will scale up with a much larger health system, Children's Hospital Colorado. This partnership will greatly expand impact, as current referrals from Children's Hospital Colorado to Early Intervention Colorado are more than four times the referrals from the initial health system that participated in the pilot. Ongoing evaluation measures and lessons learned from the first phase of the pilot will help improve the identification of barriers and implement solutions to ensure effective, standardized developmental screening and referral systems and improve coordination of follow up services for children and families.

III.B. Overview of the State




COLORADO by the numbers
Children and Youth (CY)
Total CY population
1,890,160
Total CY population includes ages 0-25[1]
CY population by age[1]
385,151
412,789
446,249
324,874
321,097
0-5
6-11
12-17
18-21
22-25
Children/Youth ages 0-25 by race ethnicity[1]
American Indian and Alaska Native Alone
12,168 Non-Hispanic
28,914 Hispanic
Asian Alone
61,946 Non-Hispanic
5,491 Hispanic
Black or African American Alone
81,969 Non-Hispanic
Black or African American Alone
17,912 Hispanic
Native Hawaiian or Other Pacific Islander Alone
3,353 Non-Hispanic
1,786 Hispanic
Two or more races
82,843 Non-Hispanic
28,993 Hispanic
White Alone
1,064,562
Non-Hispanic
499,843
Hispanic
Children 0-3 who were referred to Early Intervention
6.8%
Children in Colorado 0-18 who are living in poverty[6]
8.1%
according to the Supplemental Poverty Measure (SPM)
54 of 70
School Based Health Centers are funded by CDPHE
Children served by public health insurance[5]
611,167
Health First
46,177
CHP+
3.9%
of children ages 0-18 are uninsured[3]
Colorado MCH expands MCHB's definition of the CY population to include 21-25 year olds in recognition of transition to adulthood as a critical time.
7.7.23



See the references list for more information on sources used in the "Colorado by the numbers" infographics.

This section presents an overview of the state's geography and demographics, data on the social determinants of health affecting the MCH population, an overview of the infrastructure that supports the delivery of Title V MCH services, and statutes and regulations related to the MCH population. For additional background data, see the most current MCH Snapshot. For a list of references, see Overview of the State Reference List.

Geography

Colorado is located in the Rocky Mountain region of the United States. Colorado has the highest mean elevation of any state with more than a thousand mountain peaks over 10,000 feet high including 58 that are over 14,000 feet. The Continental Divide runs from north to south through west central Colorado and bisects the state into the eastern plains and western slopes. The state is further divided into five regions: the Front Range, the Western Slope, the Eastern Plains, the Central Mountains, and the San Luis Valley. Eighty-four percent of the state's population lives along the Front Range, which includes

the metropolitan areas of Denver, Boulder, Fort Collins, Greeley, Colorado Springs and Pueblo, and Grand Junction on the Western Slope.[3] In total, there are 64 counties in the state with 17 designated as urban, 24 rural, and 23 frontier counties.[4] Frontier counties have a population density of six or fewer persons per square mile.[4] In Colorado's 47 rural and frontier counties, residents' health may be impacted by more limited local provider options, lack of specialty healthcare, the difficulty of travel to health care due to long distances and weather conditions, limited public transit options, a scarcity of resources and services, and fewer economic opportunities.

There are two sovereign Indian nations in Colorado, the Southern Ute Indian Tribe and the Ute Mountain Ute Tribe. Both tribes have reservations located in the southwest corner of the state. These tribes have their own governance separate from state and local governments.[5] The Colorado State Demography Office reports that 37,367 people who identify as American Indian/Alaska Native alone non-Hispanic live in Colorado. The State Demography Office also reports there are 60,442 people who identify as American Indian/Alaska Native alone Hispanic living in Colorado.[6]

Tourism

Tourism is a major driver of Colorado's economy, which generates earnings, employment, and taxes across the state. Several counties across the state contain attractive travel destinations and cite tourism as their primary economic driver. The state is divided into eight travel regions (Canyons and Plains, Denver and Cities of the Rockies, Mountains and Mesas, Mystic San Luis Valley, Pikes Peak Wonders, Pioneering Plains, Rockies Playground, and The Great West). For a list of counties within each region, see page 23 of the reference cited for this section. When comparing travel earnings in relation to total earnings, the Rockies Playground, The Great West, and Mountains & Mesas (8.1%) regions had the top three highest proportions.[7]

Population and demographics

Colorado ranks 21st among states in population size.[8] The total state population in 2022 was 5,857,513. In terms of Colorado's MCH population, 21 percent of the state's population is females ages 15-44 and 32 percent are children and youth ages 0-25.[9] Of the overall population of children and youth, approximately 375,000 are identified as having special health care needs.[10] The two major racial and ethnic groups in Colorado are composed of white non-Hispanic persons and persons of any race who are of Hispanic origin or ethnicity. Estimates from the Colorado State Demography Office (2021) show that 22.2 percent of Coloradans identify their ethnicity as Hispanic. Categories by race include white alone (67.1%), Black/African-American alone (4.1%), Asian alone (3.4%), Native Hawaiian/Other Pacific Islander alone (0.2%), American Indian and Alaska Native alone (0.6%), and people who report two or more races (2.5%).[11]

Approximately 16 percent of Colorado residents ages five years and older speak a language other than English at home; 67 percent of those speaking another language in the home speak Spanish.[12] Two 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.[13]

Although Colorado is a mid-sized state, it has had one of the fastest growth rates of all states and migration continues to be an important factor in the state's population growth. Between 2020 and 2025, Colorado's population is expected to grow from 5,784,156 to 6,034,548. While natural increase (births minus deaths) will contribute 90,586 persons, net migration will contribute 159,806 to the total increase of 250,392.[14]

Employment

Employment, income, housing, food security, and transportation are all closely linked to health and wellness and should be considered in understanding the overall health status of the MCH population in Colorado. As of April 2023, Colorado's unemployment rate was 2.8 percent. This was lower than the national unemployment rate for the same time period, 3.4 percent.[15] Colorado's unemployment ranking was 16th in the nation.[16]

Income and poverty

Colorado has an income advantage. The median household income in Colorado is $82,254, higher than the national median of $53,913[17] which is the 9th highest among all 50 states.[18] However, the median household income does fluctuate significantly among Colorado's counties. Douglas County, located just south of Denver along the Front Range, has the highest median household income at $119,730. Bent County, located in southeast Colorado, has the lowest at $30,900.[19]

The level at which Colorado families can be economically self-sufficient generally requires an income above 200 percent of federal poverty level, sometimes higher depending on geographic location.[20] One in four (26.4%) Coloradoans live with incomes below 200 percent of the federal poverty level.[21] Among children younger than 18 years of age, one-third (28%) live in families with incomes below 200 percent of the federal poverty level.[22] ($60,000 for a family of four[23]).

Housing

Having safe, stable and affordable housing contributes to optimal health by allowing money to be directed to healthy food, recreation, and health care. Among occupied housing units in Colorado, 33.2 percent are rented. In renter-occupied units, more than half (53.3%) pay 30 percent or more of the household income to rent. The median rent in Colorado is $1,491. The median home value for owner-occupied units in Colorado is $466,200 (2021) compared to $314,200 in 2016. This is a 48 percent increase in median home value in five years.[24]

"The cost of living is super high. Luckily, we were able to secure a house through the affordable housing program. Families need more affordable options for housing." - Health eMoms participant[25]

Some communities are not able to find safe and affordable housing, which means they are more likely to live in poor quality homes. Poor housing conditions and environmental toxins can be detrimental to health, especially during early childhood.[26] Severe housing problems are indicative of housing quality. Sixteen percent of households in Colorado experience at least one of four severe housing problems (incomplete kitchen facilities, incomplete plumbing facilities, more than one person per room, and cost burden greater than 50%).[27] As of January 2022, there were an estimated 10,397 people in Colorado experiencing homelessness; 2,151 of these were persons in households with at least one adult and one child.[28]

Nutrition security

Having access to nutritious food influences healthy eating. People who live in neighborhoods where grocery stores are not being built have limited access to fresh, healthy food such as fruits and vegetables. Among women who recently had a baby, 3.9 percent ate less than they felt they should because of lack of money for food.[29] Among Colorado families with children ages 0-17 years, 3.3 percent sometimes or often could not afford enough to eat.[30] Among low-income Coloradans, 5 percent do not live close to a grocery store.[31] The Supplemental Nutrition Assistance Program (SNAP) and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) are programs that have been demonstrated to positively impact food security and nutrition outcomes. Seven in ten (73%) Coloradans who are eligible for SNAP have access to SNAP benefits.[32] This is lower than the national average of 82 percent for SNAP enrollment.[33] As of November 2022, the Colorado average for comparing the total number of WIC infant and child participants to the total number of WIC-eligible Medicaid infant and child participant averaged 43 percent.[34]

"SNAP has been a tremendous help to us. Some months we worry about not being able to buy diapers, but we have made it by so far."- Health eMoms participant[25]

Transportation

Transportation is necessary to travel to work and school, access healthy food and medical care, and foster community connections. When transportation systems don't provide access to all communities, some groups have a harder time accessing resources. Direct transportation and by-products can also impact health. Most Coloradans commute to work in a single occupancy vehicle (63.7%) or due to the pandemic work from home (23.7%). Less than one in ten use public transport (1.3%), walk to work (2.3%), bike to work (0.8%). About 2 percent of working Coloradans do not have a vehicle.[35]

Air quality

Many forms of transportation lead to air pollution thus impacting air quality, especially in low-income neighborhoods. Latinos experience the highest air pollution exposure (index of 52), while Native Americans experience the lowest air pollution (index of 37).[36] A recent report ranks two of Colorado's metropolitan areas in the top 25 for poor air quality (based on ozone and particle pollution). Denver-Aurora is ranked 6th and Fort Collins is ranked 15th. Poor air quality can be a greater burden on older and younger populations, those with chronic conditions (asthma or other chronic lung disease, cardiovascular disease or diabetes), and those with low socioeconomic status.[37]

Climate change

Colorado has shown signs of climate change. A changing climate results in warmer temperatures, drier air, and changing weather patterns. These changes increase the risk for fire, drought, and heat, which impact health. The Colorado Health Institute built a Health and Climate Index based on 24 variables related to health and climate. Counties in western Colorado are the state's most vulnerable region (it is prone to wildfire, flooding, drought, and extreme heat). Counties in southeast and eastern Colorado are the state's least vulnerable region.[38]

Education

Education is critical to the health and well-being of the MCH population. Higher levels of education can lead to employment with strong incomes resulting in the ability to live in healthy neighborhoods. Overall, Colorado has a highly educated population. More than half (52.7%) of Coloradans age 25 and older have a associate's degree or higher, and Colorado is ranked 3rd among all states in the percentage of the population with a college degree.[39]

Yet inequities in educational opportunities exist among different racial and ethnic groups. Many of these opportunities are affected by systemic inequities like community disinvestment and school poverty. Three in five (62.9%) Asians have an associate's degree or higher, as do 57.8 percent of white, non-Hispanics. One in three (34.5%) Black/African Americans and one in four (28.4%) Hispanics have an associates degree or higher.[40-43]

While the prevalence of college graduates in Colorado is high among Asian and white non-Hispanics, the percentage of high school students who graduate overall is relatively low (43 states have higher rates of high school graduation [44]). Inequities in graduation rates mimic the disparities in college graduation attainment among adult Coloradans, with Native Hawaiians or Other Pacific Islanders having the lowest high school graduation rate and Asians having the highest.[45]

Social connectedness and civic engagement

Participation in civic life or religious organizations has been shown to positively impact individual longevity and well-being. In Colorado, three in five (59.6%) high school students participate in extracurricular activities. One in three (35.9%) high school students participate in organized community services as a non-paid volunteer during the past 30 days.[46] Among parents with young children, 54.2 percent report having a somewhat strong or very strong sense of belonging to their local community.[47]

"Emotional support typically stemmed from friends that were also mom's [sic] - nice chatting with people you trust/respect who have been through a lot of the same things that come with being a mama! I am a member of a MOPS group at (a church) and they have been very helpful for me. There are about 50 other moms in my group and they are amazing and we all support each other."- Health eMoms participant[25]

Social and emotional support

Social support can help improve quality of life and decrease emotional distress, while limited social support can negatively impact well-being. Overall, 5.4 percent of Colorado family households are headed by a single adult and may lack needed support systems.[48] The majority of Colorado parents (79.0%) report that they have someone to turn to for day-to-day emotional support with parenting or raising children. Hispanic parents are less likely to report having emotional support with parenting compared to white, non-Hispanic parents (67.3% vs. 88.3%, respectively).[49] Seven in ten (73.5%) high school students have an adult to go to for help with a serious problem,[46] which has been demonstrated in research as a critical protective factor in avoidance of risky behaviors.

"The care and emotional support I received and still receive has helped me survive this year." - Health eMoms participant[25]

Racism

Racism and discrimination are two other social determinants of health that negatively impact health, though the data describing these issues in Colorado is limited. Among high school students who were teased in the past year, three in ten (32.5%) were teased because of their actual or perceived race or ethnic background, and two in ten (21.8%) because of their actual or perceived sexual orientation.[46] Among parents with young children, 19 percent reported experiencing discrimination or harassment because of their race, ethnicity or culture since their baby was born. Of those parents who reported experiencing this discrimination or harassment, 83.3 percent experienced it in daily life, 12.7 percent at work or school, 18.7 in a doctor's office, clinic, or other health care setting, and 4.7 percent when interacting with law enforcement.[50]

Health insurance marketplace

Colorado was an early adopter, passing legislation in 2011 to create a state-run health insurance exchange, Connect for Health Colorado. Colorado is now among just 18 states/DC that are running their own exchanges and enrollment platforms for 2023 coverage. Here is a summary of milestones and current events related to Colorado's health insurance marketplace:

- Colorado has implemented a permanent 2.5 month open enrollment period; enrollment runs from November 1 to January 15 each year, expanding the federal platform's annual enrollment period of November 1 to December 15;[51]
- Connect for Health Colorado is among the most robust exchanges in the country, with six carriers offering plans in 2023.[52]
- In the individual/family market, there were 166 on-exchange plans available in Colorado for 2023, up from 132 in 2020 (however, plan availability varies considerably from one area to another).[52]
- A total of 201,758 people enrolled in 2023 plans during open enrollment.[52]
- Colorado implemented a reinsurance program starting in 2020. It pays a larger portion of claims in areas where premiums are highest, in an effort to make coverage more affordable in those areas.

- Colorado's Easy Enrollment Program (referred to as a Tax Time Enrollment) debuted in 2022. The program lets Colorado residents indicate on their state tax returns that they would like Connect for Health Colorado to determine, based on the information on their tax return, whether they might be eligible for free or subsidized health coverage. If so, the exchange contacts the person to help them enroll in coverage — Medicaid, CHP+, or a subsidized private plan in the individual market. It also allows for enrollment outside of the open enrollment period.

Since 2015, Colorado's insured rate has remained consistent: About 93.4 percent of Coloradans have health insurance coverage. However, this consistency masks some instability in the health insurance market. According to the most recent Colorado Health Access Survey (2021), 9.5 percent of Coloradans experienced churn (a change in insurer). In Colorado, 56.1 percent of residents had private insurance, 25.6 percent are enrolled in Medicaid or Child Health Plan Plus (CHP+), and 11.5 percent are enrolled in Medicare. The uninsured rate dropped by more than 50 percent from 14.3 percent in 2013 to 6.6 percent in 2021. Of the 6.6 percent who are uninsured in Colorado, 6.1 percent were insured for part of the year. The uninsured rate was highest among Coloradans ages 19-64 years at 9.0 percent. Only 3.9 percent of children ages 0-18 years are uninsured. The uninsured rate among White non-Hispanics is 4.0 percent. By contrast, 14.4 percent of Hispanics in Colorado are uninsured. The uninsured rate for Coloradans with incomes at or below 100 percent of the federal poverty level (9.2%) compared to those with incomes above the federal poverty level (6.3%).[53]

Several programs are available to reach low-income families and those without health insurance. 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 March 2023, 611,167 children are enrolled in Medicaid and 46,177 children are enrolled in CHP+.[54] As of 2019, 22.2 percent of those eligible for Medicaid or CHP+ are not enrolled.[55] In 2022, 35.6 percent of live births in Colorado were paid for by Medicaid.[56]

Colorado Medicaid programs impacting MCH populations include Programs for Children, Programs for Pregnant People, and Programs for Parents and Caretakers. The Affordable Care Act expanded Medicaid eligibility for all adults (including parents and adults without dependent children) with incomes below 133% of the federal poverty level (FPL). From January 2022 through January 2023, Medicaid enrolled more than 173,000 members and children represented 17% of the increase in enrollment.

Since 2014, with Medicaid expansion, children and youth with special health care needs in Colorado have 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% of the Federal Poverty Level. Eligible families receive Medicaid benefits by paying a monthly premium on a sliding scale based on their adjusted income.

Colorado's Medicaid program also offers waivers for children and youth who meet certain criteria. Of the Medicaid members who qualify for Long Term Services and Supports based on functional needs, 10% are children and youth with special health care needs. This table provides an overview of the children's waiver programs and this table shows adult waiver programs. There are currently no waitlists for any of Colorado Medicaid's children's waivers and all but one of the adult waivers, as a result of legislation passed in 2014.

Medicaid also offers the Prenatal Plus program, which is a special program for at-risk pregnant people during their pregnancy through 60 days postpartum. Services include case management, behavioral health services, and nutrition counseling. These services are meant to lower risk for negative maternal and infant health outcomes due to social determinants of health and other non-medical parts of a member's life that could affect their pregnancy. There are currently ten Prenatal Plus providers across the state as of June 2023.

There is also a program for pregnant people struggling with substance use disorder, called Special Connections. Special Connections helps pregnant people and their families have healthier pregnancies and healthier babies by providing case management, counseling, and health education during pregnancy and up to one year after delivery. There are currently seven Special Connections programs in the state of Colorado as of June 2023.

Home visiting services are also available to Health First Colorado members during their first pregnancy through their child's second birthday through the Nurse Home Visitor Program. The evidence-based home visiting model supported through this program is Nurse Family Partnership. In 2022, 313 Health First Colorado families enrolled in Nurse Home Visitor Program services.

The state's Medicaid program implemented the Accountable Care Collaborative (ACC) program in 2011 to build a comprehensive statewide network to support a medical home infrastructure for all enrolled members. This program originally included seven Regional Care Collaborative Organizations to support community-based solutions to care.

Beginning July 2018, new contracts integrated the Regional Care Collaborative Organization infrastructure with the state's Behavioral Health Organizations, creating a new regional network of Regional Accountable Entities. Seven Regional Accountable Entities across the state are responsible for coordinating physical and behavioral health care for members and administering Health First Colorado's capitated behavioral health benefit. The RAEs develop, contract, and manage a network of primary care physical health providers and behavioral health providers to ensure member access to appropriate care. Current contracts between the Department of Health Care Financing and the Regional Accountability Entities will end on June 30, 2025. The Department of Health Care Policy and Financing is currently engaged in the planning and program design process for the new contracts.

Health care services for low-income and uninsured persons in Colorado include 20 Community Health Centers that operate 238 clinic sites in 46 counties and provide care to patients living in 63 of the state's 64 counties. Colorado Community Health Centers provide care to over 855,000 people (one in seven Coloradans). Ninety percent of patients at community health centers have family incomes at or below 200% of the federal poverty level.[57] Children's Hospital Colorado and the University of Colorado School of Medicine form the largest pediatric specialty care network in Colorado, serving over 283,000 children and youth annually, with roughly 50% enrolled in Medicaid or CHP+. Children and youth from every county in the state receive care either onsite at the main campus in metro Denver, and/or through approximately 40 Network of Care and Special Outreach locations, as well as through telehealth (more than 1000 telehealth visits per week).

Health information exchange
Colorado, like many states, has more than one regional health information exchange. The first health information exchange in Colorado was Quality Health Network (QHN), which is based out of Grand Junction and serves the Western Slope. QHN has been fully operational since 2004 and has focused on advancing health information exchange in the western parts of the state. Starting in 2010, CORHIO (now Contexture) began offering health information exchange services to providers in communities along the Front Range, Eastern Plains and some of the mountain towns.

The Colorado Community Managed Care Network works closely with both health information exchanges as a health center controlled network comprised of 20 community health centers with over 190 clinic sites (including school based clinics, pharmacies, and mobile units). The organization was founded as a non-profit in 1994 to respond proactively to the advent of mandatory Medicaid managed care, and has evolved with Colorado's changing health care landscape. Areas of focus now include managed and accountable care, health information technology, and clinical quality improvement programming.

Located within the Governor's Office, Colorado's Office of eHealth Innovation works closely with all three health information entities and is responsible for defining, maintaining, and evolving Colorado's Health IT strategy concerning care coordination, data access, healthcare integration, payment reform and care delivery.

State health agency roles and responsibilities
The Colorado Title V Maternal Child Health program is administered by the Colorado Department of Public Health and Environment (CDPHE). CDPHE is one of 22 cabinet-level entities whose Executive Director is appointed by the Governor. Jill Hunsaker Ryan is the Department's Executive Director. CDPHE serves Coloradans by providing public health and environmental protection services that promote healthy people in healthy places. Public health professionals use evidence-based practices in the public health and environmental fields to create the conditions in which residents can be healthy. In addition to maintaining and enhancing core programs, the Department continues to identify and respond to emerging issues affecting Colorado's public and environmental health.

CDPHE pursues its mission through broad-based health and environmental protection programs and activities. These include chronic disease prevention; control of infectious diseases; family planning; injury and suicide prevention; general promotion of health and wellness; provision of health statistics and vital records; health facilities licensure and certification; laboratory and radiation services; emergency preparedness; air and water quality protection; hazardous waste and solid waste management; pollution prevention; and consumer protection. The statutory authority for the Department is found predominantly in Title 25 of the Colorado Revised Statutes.

Colorado's most recent Public Health Improvement Plan was released in June 2022. CDPHE's new strategic plan was released in July 2023. The Prevention Services Division's current strategic plan was developed in 2022. The external-facing priorities reflected in the strategic plan directly align with the MCH framework:

- Priority 1: Increase access to safe, healthy and connected communities
- Priority 2: Expand meaningful community inclusion and improve racial equity
- Priority 3: Increase social and emotional wellbeing
- Priority 4: Increase equitable economic opportunities and access

The MCH program, administered by the Children, Youth and Families Branch, collaborates with and leverages programs across the Prevention Services Division and other CDPHE programs/work units to address the needs of the MCH

population. Colorado MCH includes state strategies and also works with 56 local public health agencies serving 64 counties to improve the health of Coloradans using population-based and infrastructure-building strategies. In Colorado, the 4,562 local governments across the state including counties, municipalities, special districts and public school districts have local control. Colorado has a decentralized public health system in which each of its 64 counties are required to either operate a local public health agency or participate in a district public health agency. The MCH program is state supported and county administered with an emphasis on state and local partnerships to align efforts. This allows for centralized coordination, support, and technical assistance, and a responsiveness to the unique needs and strengths of local communities.

The Colorado MCH Framework is grounded in the program's strategic anchors–racial equity, community inclusion, and moving upstream–which guide efforts to impact seven priorities and three health impact areas.The use of evidence based practices, dedication to quality and process improvement, commitment to core public health services, as well as emerging issues are just a few of the key qualities influenced by the specific interests of CDPHE, the Prevention Services Division and the Children, Youth and Families Branch.

Statutes and Regulations
The first regular session of the 74th General Assembly commenced on January 9th, 2023, which is earlier than previous years to accommodate the inauguration, and ended at midnight, on May 8, 2023, at the 120-day cap, as directed by the Colorado Constitution.

Bills this session were introduced to repeal a 40-year prohibition on local governments from enacting rent control measures, various gun control bills marking an historic change to gun control in Colorado, and ensuring reproductive rights were further codified in statute, and more.

Included below are descriptions of bills passed during the 2023 session that are aligned with Colorado MCH strategies. Click here for a full list of state statutes relevant to MCH efforts.

Reducing Racial Inequities

Affidavit to Support Eligibility of Public Benefits: HB23-1117 acknowledges the strain unnecessary familial separation has on immigrant families, and removes the prohibitory language in current law, which states that immigrants cannot sponsor another individual to come to the US.

Deceptive Trade Practice Pregnancy-related Service: SB23-190 recognizes the deceptive messaging and advertising 'crisis pregnancy centers' provide to people seeking abortion services. Classifies "deceptive trade practice" to also include misleading information about a clinic providing abortion related services to abortion seeking individuals when they in fact do not provide such services. This bill also subjects a health care provider to disciplinary action if they administer an "abortion reversal drug" unless the Colorado Medical Board, the State Board of Pharmacy, and the State Board of Nursing find that this is an acceptable practice and standard to engage in.

Coverage for Doula Services: SB23-288 recognizes the association between doula support and positive perinatal outcomes for pregnant people who use doula services, especially for lower-income individuals, people of color, and people who experience language and/or cultural barriers to accessing pregnancy care. This bill requires the Department of Health Care Policy and Financing to start a stakeholder process and promote the expansion and utilization of doula services for pregnant and postpartum medicaid recipients. Requires the Department to seek federal authorization for Medicaid providers to provide doula services for pregnant and postpartum people by July 1, 2024. Also creates a doula scholarship program for individuals interested in seeking doula training and certification and requires the department to contract with an independent entity to conduct a review of the potential health care costs and benefits of including coverage for doula services for pregnant and postpartum people covered by health benefit plans.

Increase Prosocial Connection

Employment of School Mental Health Professionals: SB23-004 recognizes the need for school based therapists, given students reporting of increased feelings of sadness or hopelessness, and that schools are crucial partners in supporting the health and well-being of students.

Disproportionate Discipline in Public Schools: SB23-029 recognizes the disproportionate disciplinary practices in schools against Black and Hispanic students, which often pushes students of color into the criminal justice system. The

legislature charged the Department of Education to convene the “School Discipline Task Force” with the intention to study and make recommendations regarding school district discipline policies and practices. Various representatives will sit on this new task force from state agencies, and community organizations. The task force is responsible for: identifying alternative approaches to discipline like positive behavioral intervention and supports, bullying intervention, behavior intervention plans, all of which contribute to increasing prosocial connection policies among students, as an alternative to utilizing school discipline policies.

Reduce Child and Incarcerated Parent Separation: SB23-039 recognizes the importance of reducing unnecessary child and incarcerated parent separation which can negatively impact a child’s mental health and academic achievement. This bill requires the Colorado Department of Human Services to promulgate rules that facilitate communication and family time between children and their parents who are incarcerated, and sets criteria for engagement. Requires the Department of Corrections to submit an annual report to the Judiciary Committees of both chambers and other relevant committees, concerning parents who are incarcerated, along with other metrics.

Create Safe and Connected Built Environments

Gun Safety: raises the age to buy any firearm to 21 from 18 and makes it illegal to sell any gun to someone younger than 21 (SB23-169); mandates a three-day waiting period between buying and receiving a gun (HB23-1219); and expands the state’s red flag law (SB23-170); and makes it easier to sue gun manufacturers (SB23-168).

Sunset Continue Community Crime Victims Services Grant Program: SB23-160 extends the repeal of the grant program, created in §25-20.5-801 CRS to September 1, 2029 with the requirement of another sunset review prior to repeal. The Long Bill appropriated a one-time, $4 million increase to the program with the goals of increasing and scaling up the impact of the program and services for survivors of crime across the state.

Reporting of Emergency Overdose Deaths: HB23-1167 clarifies and extends the current “Good Samaritan law” to provide immunity for individuals who did not report the overdose, but sought help or directly aided another individual suffering from an emergency drug or alcohol overdose. This bill recognizes the importance of immunity from prosecutorial charges in preventing overdoses and overdose fatalities in the state.

Portable Screening Report for Residential Leases: HB23-1099 recognizes the importance of increasing access and reducing barriers to attaining affordable housing, inclusive of barriers to be considered for housing. The bill attempts to address barriers such as application fees for apartments and other rental units. HB23-1099 allows prospective renters to pay for the preparation of one screening report that is acceptable to all landlords and leasing offices so as to remove the barrier of paying these fees for every apartment/housing unit a tenant is applying for.

Improve Access to Supports

Medicaid Reimbursement for Community Health Worker Services: SB23-002 directs the Department of Health Care Policy and Financing (HCPF) to request federal approval for community health workers to be covered through Medicaid. CDPHE will participate in a public stakeholder process to solicit feedback on this request. The bill also creates the definition of “community health worker,” and directs HCPF to outline the qualifications and training for these professionals to receive reimbursement. HCPF is also required to consult with CDPHE about its registry of health navigators, who would qualify as community health workers. CDPHE’s health navigator registry will transition to the broader community health worker registry, which will serve as the registry to qualify for reimbursement through Medicaid.

Multi-year Continuous Eligibility for Medicaid CHP+: HB23-1300 allows the state to provide continuous Medicaid and Child Health Plan *Plus* (CHP+) coverage to children from birth to age 3 and to provide 12 months of coverage for Coloradans leaving state prison. The bill also creates a study of how to improve the state Medicaid program to support Coloradans’ health, food security, and housing stability.

Increasing Access to Reproductive Health Care: SB23-189 makes various changes to improve insurance coverage of reproductive health care services and access to family planning. These changes include requiring large employer plans to cover the total cost of abortion services without cost-sharing and prohibiting insurance carriers from imposing cost-sharing for covered treatment for sexually-transmitted infections or requiring prior authorization for HIV treatments. The bill also directs the CDPHE Family Planning Program to convene a stakeholder collaborative to identify gaps in family planning access and publish recommendations by December 15, 2023.

Protections for Accessing Reproductive Health Care: SB23-188 codifies HB22-1279: Reproductive Health Equity Act, by prohibiting insurers that issue medical malpractice insurance from taking action against an applicant or a named insured provider from engaging in any sort of protected health care activity so long as the activity did not violate state law; prohibits an employer (carrier) from taking disciplinary action against a provider if they provide a legally protected health care activity; prohibits a licensing or credentialing authority from refusing to credential a provider solely based on their participation or provision over a legally protected health care activity; prohibits a regulator to deny licensure, registration, or certification to an applicant or impose disciplinary action based solely on the applicant's participation or provision of a legally protected health care activity nor revocation, surrender, or relinquishment of the individual's license, certification, registration; prohibits courts, etc., from issuing a subpoena in connection with a proceeding in another state concerning an individual engaging in a legally protected activity; prohibits an out of state civil action against a person or entity for engaging or attempting to engage in a legally protected health care activity, includes prohibiting another state from applying their law to a case heard in a Colorado court; prohibits a peace officer from arresting a provider issuing protected health care services, and prohibits other legal actions such as an ex parte order, summons, extradition, and more.

Doula Services: SB23-288 and an approved budget request, coverage for doula services and donor breast milk will be taking effect by July 2024 for eligible Medicaid members. There will be a stakeholder process starting in 2023.

Expanded Lactation Benefit: Medicaid is creating an expanded lactation benefit that includes coverage for lactation consultant services, per HB22-1289.

Increase Social and Emotional Well-being

Disordered Eating Prevention: SB23-014 recognizes the impact of disordered eating across Colorado communities. This bill establishes the Disordered Eating Prevention Program within the CDPHE branch that administers the MCH program. The Program will align ongoing work on disordered eating by collaborating with schools and other government programs, conducting public outreach, and maintaining a public resource with key information about risk and prevention of disordered eating.

School Mental Health Assessment: HB23-1003 recognizes the opportunity to better connect students with care and resources in their school and/or community with the goal to reach them before a mental health crisis. Therefore, this bill charges the Behavioral Health Administration to coordinate the sixth through twelfth grade mental health screening program to identify potential risks related to unmet mental or emotional health needs among students in these grades. This provides support and resources to address the student's mental or emotional health concerns and sets criteria for parental consent, and other requirements of the screening program.

Alternatives in Criminal Justice System and Pregnant Persons: HB23-1187 recognizes the importance of exploring alternatives to incarceration of a pregnant or postpartum individual and to reduce separation after birth. Aims to improve the health and welfare of pregnant persons in the justice system, so as to reduce the likelihood of negative health and social outcomes for the pregnant/postpartum individual and newborn child. Sets criteria for the court to consider for alternative forms of incarceration such as: diversion, deferred judgment and sentence, or furlough.

Promote Positive Child and Youth Development

Task Force to Prioritize Grants Target Population: HB23-1223 creates a new task force in CDPHE to establish shared goals, objectives, and guidelines for government agencies and community-based organizations in order to reduce youth violence, suicide, and delinquency risk factors for priority communities with the highest prevalence of these risk factors. Also requires the task force to consult with the following entities: city and county officials, law enforcement, district attorneys, local education providers, local and regional public health administrators, and any local community based organization that have received state-level grants in the area of youth suicide, violence prevention and intervention, and reducing youth risk factors.

Special Education Services for Students in Foster Care: HB23-1089 specifies that students in foster care, including students with a disability, are residents of the school they attended at the time of placement into foster care, so long as the student continues to attend school. This bill also requires the Colorado Department of Human Services to convene a work group with the purpose of identifying issues related to foster youth education, transportation, stability, and to recommend any regulatory or legislative changes prior to the 2025 legislative session.

Reduce Justice Involvement for Young Children: HB23-1249 recognizes the importance of community-based alternatives to serving youth and serving youth through local collaborative management programs in order to reduce future victimization, specifically youth under the age of 13 years. Adds criteria for the Colorado Department of Human Services to include in their report to the work group for criteria for placement of juvenile offenders, Judiciary committees in both chambers, and other relevant committees such as: number of youth that received services from a county department. Requires a Local Collaborative Management Program (as defined in §24-1.9-101 CRS) to create one or more individualized service and support teams to refer youth to services and to establish a service and support plan for the youth after meeting with them, their family, and other relevant individuals.

Increase Economic Mobility

Employer Notice of Income Tax Credits: HB23-1006 recognizes the importance of targeted tax credits like the Earned Income Tax Credit, the Child Tax Credit, and the Child and Dependent Care Tax Credits. These are designed to uplift working Coloradans and children, but many qualifying families are losing out because of lack of information and awareness. This bill requires employers to notify all employees of the availability of the aforementioned tax credits.

Earned Income and Child Tax Credits: HB23-1112 recognizes the important roles The Earned Income Tax Credit (EITC) and the Child Tax Credit (CTC) have in reducing child and household poverty, boosting food security, incentivizing employment, and more. This bill will increase the state's EITC to 38% of the federal credit for tax year 2024 and permanently expand our state's CTC to include families with qualifying children who have low or no income to report.

Colorado Adult High School Program: SB23-003 creates the Colorado Adult High School Program in the Colorado Department of Education, which will be a pathway for adults in the state who have not earned a high school diploma to attend high school and earn a diploma and/or earn industry-recognized certificates or college credits. This program will operate through a partnership between the Department of Education and a local non-profit to provide these services at no cost.

Child Care Contribution Tax Credit Renewal: HB23-1091 renews the Child Care Contribution Tax Credit for an additional three years. Child care providers rely on the donations incentivized by this tax credit (an estimated $60 million yearly, statewide) to fund their core programs, increase quality and wages, improve access to care for families, expand their capacity, and provide professional training and career pathway support for staff.

III.C. Needs Assessment
FY 2024 Application/FY 2022 Annual Report Update

Colorado's MCH program continues to collect and analyze qualitative and quantitative data to augment the statewide needs assessment conducted in 2020 and inform state action planning and implementation. Preliminary work on the 2025 assessment has also begun. A description of these ongoing activities is included below.

On-going Needs Assessment Activities

Data to Action Priority Packages

The Colorado MCH program is approaching the data products for the 2021-2025 cycle differently than in the past. Instead of creating data products as separate items, there is now a more intentional effort to ensure individual products are aligned as a cohesive set of resources. The items that make up the "data to action priority packages" complement and reference different components of the package. The overarching goal is to integrate qualitative and quantitative data to tell the story of MCH in Colorado - both the processes and the outcomes are updated in the data packages throughout the five year cycle.

While the MCH Framework and MCH Snapshot are cross-cutting documents relevant to all priorities, the rest of the products are more specific. Items have continued to be added and, as part of the data package development, icons were created for each of the MCH priorities, strategic anchors and health impact areas. The icons (see table below) are now used in all MCH products and are also included throughout this application.

Colorado MCH Icons

MCH Priority Icons	Increase Economic Mobility 	Increase Prosocial Connection 	Reduce Racial Inequities 	Improve Access to Supports 
	Increase Social Emotional Wellbeing 	Promote Positive Child & Youth Development 	Create Safe & Connected Built Environments 	
Strategic Anchors		Racial Equity 	Community Inclusion 	Moving Upstream 
Health Impact Areas	Nutrition Security 	Behavioral Health 	Access to Care 	
Other Icons	Workforce Development Team 	Local Public Health Agency Stories 		

The most current versions of completed products are linked below and a more detailed description of some of the products follows:

- MCH Framework - A high level visual of the MCH program, the latest version more explicitly delineates the connection between strategies, outcomes and the measures used to track progress. Updated in FY2023.
- MCH Snapshot - An overview of data on the social determinants of health affecting the MCH population including geographical, social, and economic factors. Updated FY2023.
- Priority Overviews - A two-page high level summary of each priority. Updated in FY2023.
- Anchor Overviews - One to two-page high level summary of each strategic anchor.
- State Data Briefs - The Positive Child and Youth Development Brief was completed summer 2023. The rest of the briefs will be completed by December 2023.

- Evaluation Summaries - Annual assessment of progress by priority and strategic anchor. Updated in FY2023.
- Picturing Colorado MCH - An MCH Storytelling project. Updated in FY2023

State Data Briefs
The first data brief (Positive Child and Youth Development) was completed this year using a new template created for the current five year cycle/upcoming needs assessment. The data briefs include more data visualization and less text than previous versions. The data brief template includes state data for core measures and population-based data for related measures. Disaggregated data to highlight disparities and inequities is also included along with context that explains drivers of inequities. Anecdotal quotes from survey participants are integrated throughout as applicable.

The MCH program identified the need to be more explicit in ensuring that a racial equity lens is employed in reporting and analyzing data within the historical, social and structural systems that contributed to health disparities. This led to the creation of the *Racial Equity in Data Initiative (REDI).* The MCH Epidemiology and Evaluation team is working with the Racial Equity Specialist, MCH Priority Coordinators and the MCH Program Specialist to ensure this perspective is woven into data briefs from the onset. The MCH Epidemiologist drafted a brief that addressed racial equity within MCH data sources that includes underreporting, sample sizes that may be too small to disaggregate and other overall challenges to racial equity in data. In addition, the Racial Equity Specialist and MCH Priority Coordinators will identify specific areas within the state action plans where there is historical, structural or social context that has been directly linked to health disparities in the data, and will publish supplemental material to the data briefs to give the additional context. See ***Section III.E.2.b.iii. MCH Data Capacity, State Systems Development Initiative (SSDI)*** for an update on this part of the REDI project. The MCH Epidemiologist and MCH Program Specialist will also collaborate with the Racial Equity Specialist to publish best practices and lessons learned in using a racial equity lens in the development of MCH products, including MCH data reporting.

In the upcoming year, local data tables will be created to provide local (county or regional) data for the newly proposed national performance measures and identified emerging issues, where available. As part of the local evaluation planning process, state MCH staff compiled information on local epidemiology and evaluation capacity and data access and usage through surveys and local learning communities. This information provided the MCH program with a better understanding of which population-based data and data products will be most useful for local public health agencies. The local data tables will be integrated into the quantitative piece of the 2025 needs assessment and will assist local agencies in planning work under the 2026-2030 priorities.

Picturing Colorado MCH (PCMCH)
This project began as an idea for a photo story project and evolved to encompass many storytelling mediums including: written word, voice recordings, video, and visual art. Since September 2021, the PCMCH team has taken the project from an idea into the project pilot stage. The team developed project promotion/collection plans and materials, including a community ambassador model where a trusted community member is paid a stipend to help recruit and collect stories. The community ambassador model is being piloted this summer. There are already several stories in the PCMCH library collected through LPHAs and the CDPHE youth advisory board, and the first community ambassador will gather more stories as part of the pilot. Additionally, the PCMCH team is currently working on a temporary website, which will serve as a space to share stories and a tool for communicating about the project until the official website is complete, which is anticipated in fall 2023.

From the conception of the PCMCH Project, community voice has been centered. In the past year, the PCMCH team met with CDPHE's Community Advisory Board, Youth Partnership for Health Board, and created and conducted a community workgroup specifically for this project. Spanish interpreters were hired so that all attendees could fully participate in the discussions. The team presented ideas and project materials to the workgroups and made changes based on feedback received.

A goal of the PCMCH project is to use the collected stories to inform the Colorado MCH program, both as part of the upcoming MCH Needs Assessment and ongoing MCH evaluation. Stories will be coded and themed so that they can easily be accessed and included as qualitative data. PCHCH team members are working with the Needs Assessment Data Group to develop codes. The PCMCH team will work with MCH staff across the program to find other avenues where the stories can be used to inform MCH efforts.

Evaluation Summaries
Similar to previous years, priority evaluation reports were completed this year. This year's evaluation summaries cover FY2022 (October 2021 - September 2022). There is a cross-cutting summary on the overall performance of the block grant including the strategic anchors, and a summary for each priority highlighting data, successes and challenges. Two-year objectives were written, with the timeframe ending in FY23 (Sept 30, 2023). Status of objectives as of the end of FY22 (Sept 30, 2022) is reported. Of the 37 objectives in the action plans, 24 (65%) were completed, 10 (27%) are in progress, two (5%) were put on hold, and one (3%) was not measurable due to a change with the data source. Even though two years isn't sufficient time to show much change in performance measures, two NPMs are improving, two show no change, and one NPM (4A, 4B) is split, with one measure improving and the other showing no change. One SPM is improving, two SPMs show no change, and one SPM is getting worse.

Partnerships and Collaborations
Colorado's MCH program values and fosters relationships across CDPHE programs, local public health agencies, and other Colorado state agencies, as well as with other statewide and community-based organizations. Working across sectors and with local, regional and state partners brings a variety of perspectives that inform both the needs assessment process and program implementation. Colorado's MCH program included a broad purpose statement "To Increase Community and Family Resilience" in the MCH Framework for the 2021-2025 program cycle to acknowledge and make space for partners in the interconnectedness of MCH work across priorities and populations and the variety of partners who are adjacent to, involved in or, in some cases, leading related strategies towards the bigger MCH vision of community and family resilience. A summary of key partners by priority can be found in the Partners Infographic.

Organizational Structure and Leadership Updates
Colorado's MCH program uses a collaborative meeting infrastructure to best support the state and local implementation of MCH priorities. Colorado MCH entered the third and final stage of transition to the 2021-2025 MCH priorities in July 2022. Designated leadership positions coordinate state and local MCH planning and implementation. Lyz Sanders joined CDPHE in November 2022 as the MCH Section Manager/Title V Deputy Director. In this role, she oversees the state action planning process and supports communication and coordination amongst the priority coordinators throughout the state planning and implementation processes. MCH Priority Coordinators continue to serve as conveners of teams with content expertise that are responsible for the development and implementation of the state action plan. In addition to state planning and implementation, Lyz Sanders also oversees the contract monitoring and technical assistance for 14 local public health agencies that receive more than $50,000 in MCH funding annually and the technical assistance for 42 local public health agencies that receive less than $50,000 of funding through a combined contract with CDPHE's Office of Public Health Practice, Planning and Local Partnerships. There were no other structural state program staffing changes this year.

In October 2021, the MCH Local Support Team (Liaisons) piloted a new local support model developed collaboratively with priority coordinators, staff from the Workforce Development Section and other subject matter experts within the MCH program to support the first year of local implementation for agencies receiving more than $50,000 annually. The model included the pilot of a local support plan, created at the beginning of each grant year to provide a centralized space for agency-specific technical assistance needs. The local support plan is included in the local public health agency's quarterly reporting document for shared communication and collaboration between state and local MCH staff.

Team FAD (*Focus, Advise, Decide*) serves as the leadership team for the MCH program, with representation from staff with diverse perspectives and roles across the program. In addition, state MCH staff are invited to participate in monthly all-staff meetings that alternate between business meetings and learning communities. Local MCH staff are invited to participate in bimonthly MCH managers calls, with bimonthly local learning communities for all local MCH staff held in the alternate months.

2025 Needs Assessment Planning
Preparation for the 2025 MCH needs assessment to select 2026-2030 priorities has begun. The process design phase will

conclude in October 2023, culminating in the completion of a full data to action plan–including data collection and analysis, community and stakeholder engagement, and communication activities. The needs assessment leadership structure has also been determined, with the following groups slated to lead the process:

- **Team FAD+** - Team FAD (*Focus, Advise, Decide*) is an existing leadership team that has been expanded to include the strategic anchor leads and MCH Deputy Director, who is providing overall coordination for the needs assessment, to serve as the needs assessment leadership and decision making body.
- **Data Workgroup** - consists of epidemiology and evaluation staff and data subject matter experts who will create and implement a plan for quantitative and qualitative data collection and analysis.
- **Priority Coordinators** - MCH staff who develop and implement priority action plans and provide input into the needs assessment process.

In addition, the needs assessment leadership structure is enhanced by efforts and support of the MCH Community Advisory Board, local liaisons and agencies, the Youth Partnership for Health, and Parent to Parent of Colorado.

As shown in this timeline, the process design phase will ensure the ongoing communication between all workgroups, facilitate proper scoping of the assessment process, and will be followed by data collection and review.

Emerging Public Health Issues

The MCH public health issues that were prioritized through the 2020 needs assessment process remain as the top areas of focus for Colorado's MCH program. That said, two emerging issues that have not explicitly been included in MCH work are climate change and housing. The Built Environment team is currently exploring opportunities to more intentionally include strategies to address climate change moving forward. To explore the potential public health role in housing, staff from across the Prevention Services Division, have launched an internal learning community and submitted an abstract to the Public Health in Rockies Conference (September 2023) to share ideas and elicit input from public health partners statewide.

Click on the links below to view the previous years' needs assessment narrative content:

2023 Application/2021 Annual Report – Needs Assessment Update

2022 Application/2020 Annual Report – Needs Assessment Update

2021 Application/2019 Annual Report – Needs Assessment Summary

III.D. Financial Narrative

	2020		2021	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$7,403,844	$7,346,989	$7,397,625	$7,337,336
State Funds	$5,552,883	$5,510,242	$5,548,219	$5,503,002
Local Funds	$0	$0	$0	$0
Other Funds	$0	$0	$0	$0
Program Funds	$0	$0	$0	$0
SubTotal	$12,956,727	$12,857,231	$12,945,844	$12,840,338
Other Federal Funds	$545,000	$1,004,131	$920,000	$1,040,663
Total	$13,501,727	$13,861,362	$13,865,844	$13,881,001

	2022		2023	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$7,346,989	$7,403,131	$7,337,336	
State Funds	$5,510,242	$5,552,349	$5,503,002	
Local Funds	$0	$0	$0	
Other Funds	$0	$0	$0	
Program Funds	$0	$0	$0	
SubTotal	$12,857,231	$12,955,480	$12,840,338	
Other Federal Funds	$1,175,000	$1,299,024	$920,000	
Total	$14,032,231	$14,254,504	$13,760,338	

	2024	
	Budgeted	Expended
Federal Allocation	$7,403,131	
State Funds	$5,552,349	
Local Funds	$0	
Other Funds	$0	
Program Funds	$0	
SubTotal	$12,955,480	
Other Federal Funds	$2,288,800	
Total	$15,244,280	

III.D.1. Expenditures

Aligning MCH Resources with Need

Colorado's MCH program aligned resources to meet the prioritized needs for this reporting period, as identified through the statewide MCH needs assessment. Strategies and activities outlined in the state action plans for each priority were used to identify resource needs and scope annual budgets to support implementation.

MCH progress towards outcomes for each priority could not have been achieved without federal MCH block grant support. A summary of how the federal/state partnership resources were leveraged is included below and organized by the national and state performance measures selected by Colorado for this reporting year.

NPM 4a: Percent of infants who are ever breastfed was 94.0%. The annual objective for reporting year 2022 was 91.0%. The annual objective was met.

NPM 4b: Percent of infants breastfed exclusively through 6 months was 32.1%. The annual objective for reporting year 2022 was 32.0%. The annual objective was met.

For this reporting period, MCH funding supported staff time (0.4 FTE) to implement breastfeeding strategies in the Positive Child and Youth Development priority action plan. MCH leveraged funding from the Centers for Disease Control and Prevention State Physical Activity and Nutrition (SPAN-1807) grant to pay for staff time (0.35 FTE) and technical assistance and hospital recognition. Additional breastfeeding FTE (and associated strategy work) was funded through the USDA Special Supplemental Nutrition Program for Women, Infants and Children program (0.2 FTE) and the state-funded Cancer, Cardiovascular and Pulmonary Disease grant program (0.05 FTE).

NPM 6: Percent of children, ages 9-35 months, who received a developmental screening using a parent-completed screening tool in the past year was 39.6%. The annual objective for reporting year 2022 was 42.0%. The annual objective was not met. Note: The data for this measure has a wide 95% confidence interval (14.8 percentage points) as a result of the small sample size (340 children, ages 9-35 months).

For this reporting period, MCH Block Grant dollars were braided with state General Funds to support approximately 3.0 FTE on the CYSHCN team and .35 FTE on the Health Informatics and Telehealth and Digital Inclusion teams at CDPHE; implementation of strategies in the state action plan; and contracts with local public health agencies to implement local action plans that support the CYSHCN population and a contract with Assuring Better Child Health and Development (ABCD). The CYSHCN team leveraged additional MCHB grant funds (the Pediatric Mental Health Care Access Grant) to continue and/or expand several existing partnerships and to support state and local implementation efforts.

NPM 9: Percent of adolescents who are bullied on school property or electronically was 16.4%. The annual objective for reporting year 2022 was 19.5%. The annual objective was met.

For this reporting period, MCH Block Grant dollars funded approximately 2.0 FTE to implement the state prosocial connections action plan. MCH staff time was leveraged with additional state funding including: $400,000 of state General Funds to support gender sexuality alliances, staff mental health training and school and district policy development with Colorado schools and districts; and additional state funds from Tobacco and Marijuana programs for a public awareness campaign for youth.

NPM 11: Percent of children with special health care needs, ages 0-17, who have a medical home was 44.0%. The annual objective for reporting year 2022 was 42.0%. The annual objective was met.

For this reporting period, MCH Block Grant dollars were braided with state General Funds to support approximately 3.0 FTE on the CYSHCN team and .35 FTE on the Health Informatics and Telehealth and Digital Inclusion teams at CDPHE; implementation of strategies in the state action plan; and contracts with local public health agencies to implement local action plans that support the CYSHCN population. The CYSHCN team leveraged additional MCHB grant funds (the Pediatric Mental Health Care Access Grant) to continue and/or expand several existing partnerships and to support state and local implementation efforts that impact this NPM.

NPM 14a: Percent of women who smoke during pregnancy was 3.7%. The annual objective for reporting year 2022 was 4.9%. The annual objective was met.

MCH Block Grant dollars continued to fund a portion of a Tobacco program staff position (0.25 FTE) to serve as an MCH program liaison. Amendment 35 tobacco state tax revenue and a Centers for Disease Control and Prevention grant continued to provide annual funding for additional tobacco program staff and comprehensive Tobacco program efforts,

including MCH-related tobacco activities. Leveraging combined funds enabled CDPHE's Tobacco and MCH programs to extend the reach of strategic efforts that reduce the burden of perinatal tobacco use and exposure, increase positive birth outcomes and improve the health of families throughout the lifespan.

SPM 1: Percent of children ages 0-17 years who live in a supportive neighborhood was 57.2%.
The annual objective for reporting year 2022 was 54.5%. The annual objective was met.

MCH Block Grant funds continued to be braided with Centers for Disease Control and Prevention funding for physical activity, nutrition, comprehensive cancer prevention, violence and injury prevention, and state tobacco tax funds to develop and implement the state action plan for the built environment priority. Leveraging these funds enables CDPHE's Health Promotion and Chronic Disease Prevention Branch to extend the reach of implementation efforts to the MCH population. For this reporting period, MCH Block Grant dollars funded approximately 0.6 FTE in the Healthy, Equitable, Livable Communities Unit for action planning, implementation, technical assistance, and community engagement support to impact this SPM.

SPM 2: Percent of households that spend more than 30% of household income on housing costs was 32.6%. The annual objective for reporting year 2022 was 31.0%. The annual objective was not met.

For this reporting period, MCH Block Grant dollars funded 0.6 FTE Economic Mobility Program Manager to implement the strategies outlined in the state action plan, and also funded contracts with local public health agencies to implement economic mobility local action plans and strategies. To expand impact, MCH continues to leverage additional funding of $5.2 million to support tax credit outreach and communication efforts in 2022-24. Funding sources include private foundation funding from Gary Community Ventures, the U.S. Department of Labor, and federal pandemic recovery funds from the American Rescue Plan Act. This supplemental funding helped support 4.5 additional FTE to support contracting, grant coordination, evaluation and communication.

SPM 3: Number of points for racial equity related policy, practices and systems changes implemented at the program, division and department level was 9. The annual objective for reporting year 2022 was 6. The annual objective was met.

During this reporting period, MCH Block Grant dollars supported 1.0 FTE for the Racial Equity Specialist to develop and implement state action plan strategies and consult with internal and external partners to integrate racial equity approaches across programs and systems that serve the MCH population.

SPM 4: Percent of women of reproductive age (18-44 years) who report good mental health was 69%. The annual objective for reporting year 2022 was 72.0%. The annual objective was not met.

For this reporting period, MCH Block Grant dollars funded 1.0 FTE of the Maternal and Infant Wellness team at CDPHE across multiple positions for the implementation of strategies in the state action plan; and for contracts with local public health agencies to implement local action plans. To advance and expand impact, MCH aligned and leveraged funding from the CDC grant that supported the Colorado Perinatal Care Quality Collaborative, state General Funds to reduce maternal mortality, the ERASE Maternal Mortality grant through the CDC, and HRSA funding through the State Maternal Health Innovation and Data Capacity grant.

Colorado's MCH program monitors implementation of the strategies supported by Title V dollars through quarterly performance management reporting and progress towards meeting annual objectives for national and state performance measures through annual evaluation of state and local impact as captured in the Annual Evaluation Summaries.

Local Public Health Agency Funding
During this reporting period, all 56 local public health agencies in Colorado were awarded $5,203,339 of federal/state MCH partnership funding. Note: with the dissolution of Tri-County Health Department into three separate agencies, the number of local public health agencies increased from 54 to 56, starting January 2023. Local funding allocations are calculated by a formula based on the MCH population and poverty rates in each local public health agency's jurisdiction. Agencies receiving the largest awards (>$55,000) were required to implement an action plan for one or more of the MCH priorities and submit quarterly performance management reports based on the action plans. Smaller agencies were required to use their funding for core public health services that support the MCH population within their communities.

MCH Federal/State Partnership Match Requirement
For this reporting period, the Colorado MCH program received a Title V Block Grant award of $7,403,131. Colorado matched the federal Title V Block Grant award with $5,552,348 of state General Funds (as indicated in Form 2, line 3), meeting the 4:3 federal to state match requirement. These state General Funds are from the following three programs: Children and Youth with Special Needs ($2,460,157); Family Planning (contracts line, $1,546,095); and School Based Health Centers (contracts line, $1,546,096). A brief description of each match source is included in the budget section.

Colorado does not use any other funds as match, as reflected on Form 2, lines 3-6 (local, other or program income).

30%-30%-10% Requirement
For the past year, MCH expenditures (not including match) were allocated 41.4% to CYSHCN, 31.3% to preventive and primary care for children and 4.7% to Title V administrative costs (see Form 2). Specific to line 1C of Form 2, administrative costs include operating costs and personnel time for the division's centralized services that support the MCH program. This includes fiscal, contracting, compliance, communications and operations support. These costs have consistently remained between 5 - 9%. Annual variations are contingent upon the status of the Prevention Services Division's overall budget for centralized services, which is impacted by changes in Federally negotiated indirect rates, centralized services staffing and availability of resources from other funding streams.

To ensure adherence to federal population-specific budget requirements, the state MCH fiscal officer and MCH program staff track expenditures throughout the year by type of effort (direct versus enabling versus public health services and systems) and by population (CYSHCN, child/adolescent, women of reproductive age). Based on the Maternal and Child Health Bureau's definition of direct health care services, Colorado's MCH program does not fund any direct services with Title V dollars, nor does MCH fund any services that are eligible for Medicaid reimbursement. In addition to monthly fiscal meetings, a coded system of invoicing for contractors is employed, allowing for budgetary planning and tracking according to the three population categories. Spending on administrative services is tracked by the Fiscal Services Unit Manager in coordination with the MCH fiscal officer and the MCH Director.

The MCH Block Grant Expenditures infographic provides an overview of Colorado's MCH expenditures. The infographic includes programmatic and administrative expenditures, as well as icons to indicate coding by population. The infographic also reflects how Title V block grant funds are distributed across CDPHE's organizational structure and work units, along with a brief description of the work that was implemented with the allocated MCH resources. The infographic also includes match sources.

Expenditure data reported in Form 2 and Form 3 did not exceed a variation of 10% as compared to budgeted amounts.

Form 5
The methods for reporting the unduplicated count of individuals served under Title V in Form 5a and 5b are reviewed annually by the state MCH Director and state MCH Epidemiologist, in consultation with the Office of Epidemiology and Research at MCHB. The total numbers served in 5a was 34,946 which is down from 42,500 in the previous reporting year, due to the shift in the percent allocation of match sources and does not reflect an actual decrease in the total numbers served through match source programming. The total numbers served in 5b was 1,685,484 which is up from 1,544,440 that was reported the prior year. The majority of this increase is due to the inclusion of total live births receiving newborn hearing screening in the infants <1 year of age population count. See Form 5b notes for additional details on shifts for each population served by Title V. .

Form 5a field notes include a definition of each population count. Because Colorado is focused on predominantly employing systems level strategies to impact outcomes for the MCH population, Form 5a presents a challenge in that it captures direct and enabling services. Since Colorado's MCH program provides no direct services, the numbers are predominantly enabling services provided by match sources (CYSHCN care coordination, family planning and school-based health centers).

Field notes for Form 5b include a description of the methods used to determine reporting for each population group. For each population group, Colorado reported the number from the program(s) that have the largest reach in an effort to avoid duplication. Using this methodology, Colorado's estimates track closely to the overall state population for most of the six population groups (see form 5 field notes).

Audit of Expenditures
Colorado implements a state single audit, which meets the requirement of Section 506(b)(1). Please click here for the most recent single state audit.

III.D.2. Budget

Aligning MCH Resources with Need

In the upcoming year, Colorado's MCH program will continue to align resources to meet the prioritized needs for this reporting period, as identified through the statewide MCH needs assessment. Strategies and activities outlined in the state action plans for each priority were used to identify resource needs and scope annual budgets to support implementation that begins October 2023.

Progress towards MCH outcomes for each priority is not achievable without the federal Title V MCH Block Grant award that also leverages additional resources. A description of how Colorado is braiding resources to impact the priorities is included below and organized by the national and state performance measures selected by Colorado for the upcoming year.

NPM 4a: Percent of infants who are ever breastfed.
The annual objective for reporting year 2023 is 91.5%.

NPM 4b: Percent of infants breastfed exclusively through 6 months.
The annual objective for reporting year 2023 is 36.0%.

For the upcoming reporting period, MCH funding will continue to support staff time to implement breastfeeding strategies in the positive child and youth development priority action plan. MCH will continue to leverage funding from the Centers for Disease Control and Prevention State Physical Activity and Nutrition (SPAN-1807) grant to pay for staff time and technical assistance and hospital recognition. Additional breastfeeding FTE (and associated strategy work) will be funded through the USDA Special Supplemental Nutrition Program for Women, Infants and Children program and the state-funded Cancer, Cardiovascular and Pulmonary Disease grant program.

NPM 6: Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year. The annual objective for reporting year 2023 is 42.5%.

For the upcoming reporting period, MCH Block Grant dollars will be braided with state General Funds to support approximately 3.0 FTE on the CYSHCN team and .35 FTE on the Health Informatics and Telehealth and Digital Inclusion teams at CDPHE; implementation of strategies in the state action plan; and contracts with local public health agencies to implement local action plans that support the CYSHCN population and a contract with Assuring Better Child Health and Development (ABCD). The CYSHCN team will continue to leverage additional MCHB grant funds (the Pediatric Mental Health Care Access Grant) to continue and/or expand several existing partnerships and to support state and local implementation efforts.

NPM 9: Percent of adolescents who are bullied on school property or electronically. The annual objective for reporting year 2023 is 19.0%.

MCH Block Grant dollars will continue to fund approximately 2.0 FTE to implement the state action plan for the Prosocial Connections priority. In addition, MCH staff time will be leveraged with additional state funding including: $400,000 of state General Funds to support gender sexuality alliances, staff mental health training and school and district policy development with Colorado schools and districts; and state funds from tobacco and marijuana programs for a public public awareness youth campaign.

NPM 11: Percent of children with special health care needs, ages 0-17, who have a medical home. The annual objective for reporting year 2023 is 44.0%.

For the upcoming reporting period, MCH Block Grant dollars will be braided with state General Funds to support approximately 3.0 FTE on the CYSHCN team and .35 FTE on the Health Informatics and Telehealth and Digital Inclusion teams at CDPHE; implementation of strategies in the state action plan; and contracts with local public health agencies to implement local action plans that support the CYSHCN population. The CYSHCN team will continue to leverage additional MCHB grant funds (the Pediatric Mental Health Care Access Grant) to continue and/or expand several existing partnerships and to support state and local implementation efforts. In partnership with the Pediatric Mental Health Institute, MCH will also be leveraging the $4.6 million in pandemic relief funds associated with the SB22-147 that was passed during the 2022 Legislative Session to expand the program funded through the Pediatric Mental Health Care Access Grant to more rural areas of the state and extend implementation efforts through 2024.

NPM 14a: Percent of women who smoke during pregnancy. The annual objective for reporting year 2023 is 4.5%.

MCH Block Grant dollars will continue to fund a portion of a Tobacco program staff position (0.25 FTE) to serve as an MCH program liaison. Amendment 35 tobacco state tax revenue and a Centers for Disease Control and Prevention grant will continue to provide annual funding for additional Tobacco program staff and comprehensive Tobacco program efforts, including MCH-related tobacco activities. Leveraging combined funds enables CDPHE's Tobacco and MCH programs to extend the reach of strategic efforts that reduce the burden of perinatal tobacco use and exposure, increase positive birth outcomes and improve the health of families throughout the lifespan.

SPM 1: Percent of children ages 0-17 years who live in a supportive neighborhood. The annual objective for reporting year 2023 is 55.0%.

For the upcoming reporting period, MCH Block Grant funds will continue to be braided with Centers for Disease Control and Prevention funding for physical activity, nutrition, comprehensive cancer prevention, violence and injury prevention, state tobacco tax funds, and state general funds to implement the state action plan for the built environment priority. MCH Block Grant dollars will continue to support approximately 0.6 FTE in the Healthy, Equitable, Livable Communities Unit for action planning, implementation, technical assistance, and community engagement support to impact this SPM.

SPM 2: Percent of children in poverty according to the supplemental poverty measure (New measure in 2023).

For the upcoming reporting period, MCH Block Grant dollars will continue to support staff time to implement the program, including partial FTE for the Economic Mobility Program Manager. The program will continue to leverage multiple funding streams, including private foundation funds, the FARE grant through the U.S. Department of Labor, and federal pandemic recovery funds received through the American Rescue Plan Act. Braided funding will support a portion of the FARE Grant Coordinator, a Tax Credit Outreach and Navigation Specialist, contracting staff and evaluation and communications staff to support continued implementation of the MCH state action plan and FARE grant activities. These funds will also continue to support contracts with local public health agencies, free tax assistance site partners, and community-based organizations. Funding will also continue to support the GetAhead Colorado media campaign.

SPM 3: Number of points for racial equity related policy, practices and systems changes implemented at the program, division and department level. The annual objective for reporting year 2023 is 9.

For the upcoming reporting period, MCH Block Grant dollars will continue to support the implementation of the reducing racial inequities priority. The funding will support 1.0 FTE for the Racial Equity Specialist to develop and implement state action plan strategies and consult with internal and external partners to integrate racial equity approaches across programs and systems that serve the MCH population.

SPM 4: Percent of women of reproductive age (18-44 years) who report good mental health.
The annual objective for reporting year 2023 is 73.0%.

For the upcoming reporting period, MCH Block Grant dollars will continue to support 1.0 FTE of the Maternal and Infant Wellness team at CDPHE across multiple positions for the implementation of the strategies outlined in the state action plan; and contracts with local public health agencies to implement social emotional wellness local action plans. To advance and expand impact, MCH will align with and leverage funding from the Centers for Disease Control and Prevention grant that supports the Colorado Perinatal Care Quality Collaborative, state General Funds to reduce maternal mortality and the ERASE Maternal Mortality grant through the Centers for Disease Control and Prevention.

Throughout the upcoming year, Colorado's MCH program will continue to monitor implementation of the strategies supported by Title V dollars through quarterly performance management reporting and progress towards meeting annual objectives for national and state performance measures through annual evaluation of state and local impact that will be submitted with Colorado's annual application/report.

Local Public Health Agency Funding
In the upcoming year, all 56 local public health agencies in Colorado will continue to receive funding from Colorado's MCH Block Grant, totalling approximately $5,203,339 of federal/state partnership funding. Local funding allocations are calculated by a formula based on the MCH population and poverty rates in each local public health agency's jurisdiction. Agencies receiving the largest awards (>$55,000) are required to implement an action plan for one or more of the MCH priorities and submit quarterly performance management reports based on the action plans. Smaller agencies use their funding for core public health services that support the MCH population within their communities.

MCH Federal/State Partnership Match Requirement
Based on Colorado's current Title V Block Grant award, the MCH program anticipates receiving $7,403,131 for the application year. Colorado will match the federal Title V Block Grant award with $5,552,348 of state general funds (as

indicated in Form 2, line 3) to meet the 4:3 federal to state match requirement. These state general funds are from the following three programs: Children and Youth with Special Needs; Family Planning; and School Based Health Centers. A brief description of each match source is included below.

Children and Youth with Special Needs: Pursuant to Colorado Revised Statute §25-1.5-101(1)(r). CDPHE will continue to contract with local public health agencies throughout the state to provide services for the children and youth with special needs population, such as MCH funded care coordination, and to implement local action plans to support children and youth with special needs.

Family Planning: Pursuant to Colorado Revised Statute §25-6-102, CDPHE will continue to contract with family planning programs throughout Colorado, which serve the MCH population. Family Planning clinics continue to play a critical role in ensuring access to a broad range of family planning and related preventive health services for millions of low-income or uninsured individuals throughout the state. In addition to contraceptive services and counseling, these clinics provide a number of important preventive health services such as patient education and counseling, pelvic examinations, breast and cervical cancer screening according to nationally recognized standards of care, sexually transmitted disease and Human Immunodeficiency Virus prevention education, counseling, testing and referral and pregnancy diagnosis and counseling.

School Based Health Centers: Pursuant to Colorado Revised Statute 25-20.5-501-503, CDPHE will continue to contract with school-based health centers, which serve the MCH population. Priority is given to centers that serve a disproportionate number of uninsured or underinsured children and youth (defined as birth to < 21 years of age), a low-income population or both and may award grants to (1) establish new school-based health centers; (2) expand primary health, behavioral health and oral health services offered by existing school-based health centers; (3) expand public and private health insurance enrollment; and/or (4) provide support for ongoing operations of school-based health centers.

Colorado does not use any other funds as match, as reflected on Form 2, lines 3-6 (local, other or program income).

30%-30%-10% Requirement
MCH budgets will be finalized in September 2023 to meet the allocation requirements of at least 30% to CYSHCN, 30% to preventive and primary care for children and no more than 10% to Title V administrative costs (see Form 2). Specific to line 1C of Form 2, administrative costs include operating costs and personnel time for the division’s centralized services that support the MCH program. This includes fiscal, contracting, compliance, communications and operations support. These costs consistently remain between 5 - 9% over time. Annual variations are contingent upon the status of the Prevention Services Division's overall budget for centralized services, which is impacted by changes in Federally negotiated indirect rates, centralized services staffing and availability of resources from other funding streams.

To ensure adherence to federal population-specific budget requirements, the state MCH fiscal officer and MCH program staff will continue to track expenditures throughout the year by type of effort (direct versus enabling versus public health services and systems) and by population (CYSHCN, child/adolescent, women of reproductive age). Based on the Maternal and Child Health Bureau’s definition of direct health care services, Colorado’s MCH program will not be funding any direct services with Title V dollars, nor will MCH fund any services that are eligible for Medicaid reimbursement. In addition to monthly fiscal meetings, a coded system of invoicing for contractors will continue to be used, allowing for budgetary planning and tracking according to the three population categories. Spending on administrative services will be tracked by the Fiscal Services Unit Manager in coordination with the MCH fiscal officer and the MCH Director.

III.E. Five-Year State Action Plan

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

State: Colorado

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

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

III.E.2. State Action Plan Narrative Overview

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

Colorado's Title V program is designed in alignment with Brownson's Evidence-based Public Health Framework of assessment, planning, implementation and evaluation. Funded implementation strategies are 81.9% public health services and systems and 18.1% enabling; no currently funded strategies are categorized as direct service provision. Both needs assessment and resulting priority implementation strategies are informed by the following models of investigating and improving health status:

- Life course theory and model
- Two-generation approach, aka 2Gen
- Resilience-focused approaches informed by research in protective factors and adverse childhood experiences
- Social determinants of health models, including the BARHII Framework, emphasizing social and structural influencers of health status
- National Public Health Accreditation Board standards and measures for public health practice Colorado Public Health Improvement Act (SB 08 194)
- The Public Health Foundation's performance management framework

As a result of the Needs Assessment for the 2021-2025 Colorado MCH priorities, the Title V program in Colorado changed the fundamental programmatic approach to impacting the priorities, which is captured in the MCH Framework. An additional suite of materials, including priority overviews and data packages, serve as valuable communication tools that are described in section ***III.C. Five Year Needs Assessment Summary*** of this application.

The needs assessment process that determined the 2021-2025 Colorado MCH priorities began with workgroups originally focused on the MCH population groups. Each workgroup reviewed current literature, convened community partners, used MCH, CDPHE and supplemental evaluation data and reviewed state plans developed by other Colorado programs to aid in priority needs selection. Early in the process, coordinators of the population-specific groups identified that similar themes were emerging across the lifecourse in MCH populations.

Access to care, behavioral health (defined to include both mental health and substance use) and nutrition security were identified as needs for each MCH population group. These became the Colorado MCH health impact areas, with strategies to address these common needs, and associated measures, identified across the seven priorities. In preparation for program implementation for the new priorities, the MCH program developed three strategic anchors: racial equity, community inclusion, and moving upstream. These strategic anchors tether the seven MCH priorities to a shared vision. They also provide a lens through which every decision is viewed to ensure consistency in decision making.

As people from across the Colorado MCH program met, collaborated and created a shared vision for MCH through the identification of the 2021-2025 priorities, it became important to both maintain the strength of the evidence-based practices and population-specific focus areas that the program has cultivated in the past, as well as to make space for innovative approaches to maximizing MCH impact. The result is seven broad, interconnected priorities that were selected with the intention of implementing strategies that could directly, as well as indirectly, impact multiple priorities. The challenge then became how to represent broad, interconnected work in Colorado's state and local action planning processes to reflect the cross-cutting nature of the MCH priorities in how teams work together both internally and across systems.

The overarching goal for MCH, as stated in the Framework, is "to increase community and family resilience," which has expanded opportunities for the MCH program to communicate, connect and collaborate with partners in human services, health care delivery systems and now economic development - an area in which public health has not always been engaged. Using this framework allows Colorado's MCH program to create a strong foundation for programs impacting the health of families and children, grow connections and ultimately impact outcomes that are shared across the systems that support the MCH population in Colorado.

State Action Planning and Implementation Process:
Colorado's MCH Program followed the Implementation Science framework to guide the development of the state action plans. While the needs assessment process served as the "exploration" stage, starting in December 2019 through September 2020 the program moved into the "installation" stage to get ready for "initial implementation" of the new state action plans in October 2020. MCH is now in "full implementation" with annual updates to state action plans occurring in the summer for implementation October through September. The strategic anchors are used by staff as guideposts as they update their action plans and logic models to ensure the inclusion of strategies and activities that advance racial equity, community inclusion and moving upstream. The action plans for the upcoming year are summarized here. Priority Coordinators continue to lead implementation teams for each priority. A collaborative performance reporting tool is completed quarterly by priority coordinators and reviewed by the MCH program's leadership team. The qualitative and

quantitative data collected in the tool is a mechanism to monitor progress, learn from each other's implementation efforts, make adjustments to program implementation as needed, highlight successes and address challenges.

The collaborative infrastructure for implementation includes a Priority Coordination Team, which meets monthly to provide an opportunity for priority coordinators to collaborate around implementation of state action plans, support for local action plans and challenges experienced with the intent of learning and adapting the work. Each priority has developed a team to guide the overall implementation of the priority-specific state MCH action plan through regular, active implementation of strategies and activities. The MCH leadership team, known as "Team FAD" (ie focus, advice and decision-making) directs the program's strategic focus, provides advice as needed and guides programmatic decision making. All MCH staff continue to meet on a monthly basis for either an all-staff meeting or learning community. These all staff convenings provide an opportunity for staff throughout the program to connect and collaborate through sharing of information and/or input gathering, or to bring topic specific discussion on areas of shared interest to expand understanding and growth.

The culmination of these planning efforts from the installation stage into the initial implementation stage to what is now full implementation has resulted in more thoughtful collaboration across MCH staff, as well as an increase in shared decision making throughout the program. A more in-depth overview related to implementation efforts for each priority is included in the narrative section for each population domain, along with a link to the state action plan for each priority. The narratives include an overview of the MCH role in addressing the prioritized need, the MCH resource investment, other funding being leveraged to support the work, a description of the population health strategies to impact each priorities' national and/or state performance measure(s), as well as areas of innovation and cross-cutting issues being addressed through MCH efforts.

Local Action Planning and Implementation Process:
Beginning in October 2020, to support local public health agencies with their initial planning and implementation, priority coordinators developed examples of potential local strategies that could complement and augment state efforts and created adaptable local logic model templates for agencies to customize. Beginning in January 2021, Priority Coordinators, in partnership with the local MCH and CYSHCN teams, supported local public health agencies in the development of local logic models and action plans tailored to their specific community needs and agency capacity. Local public health agencies are expected to align their work with the state priorities, and the development process followed many of the same steps taken to establish state logic models and action plans. By using a co-creation approach, the local public health agencies have the opportunity to select activities that align with the relationships they have in place, the political and public will in their community and the needs they have identified through their local community health assessments and public health improvement plans. Local agencies were able to choose from the national and state performance measures selected by Colorado MCH or create local performance measures that they measure and report independently. All local plans were approved by the state MCH priority coordinators, CYSHCN staff and the MCH local support team. The plans are incorporated into local contracts, and agencies submit quarterly reports and are monitored based on the plans and budget they submit. Local public health agencies convene monthly for peer to peer support and the MCH Local Support team coordinates fall, winter and spring progress check-ins between state and local MCH staff to allow for additional communication channels to identify barriers, transition/onboard new staff and support the implementation of the local action plans.

Performance Management
Colorado's MCH program has an infrastructure to support performance management. Performance management has been institutionalized across priority efforts through the use of consistent data collection tools, required reporting, meeting structures, and quality improvement resources. Because long-term outcomes at the population level can take multiple years to achieve, MCH performance management provides a mechanism for monitoring, supporting, and realizing incremental wins so that staff know when work is on track and when it's not, allowing for proactive and timely adjustments. Core components of MCH state and local performance management include:

- Logic model and action plan development for each priority.
- Quantitative and qualitative quarterly state progress reports on each priority (progress on objectives and strategic anchors, successes, challenges, and areas where additional assistance may be needed).
- Review of quarterly reports by Team FAD (Focus, Advise, Decide) and the MCH evaluation team. This review includes highlighting successes, as well as clarifying challenges or reasons why progress is impeded. When needed, additional feedback and/or support is provided for priority implementation teams.
- Successes and challenges are documented with each review of the quarterly report.
- Local public health agencies submit quarterly reports on progress through a template that is reviewed by the MCH local support team and relevant subject matter experts from the state MCH implementation teams.
- The MCH Epidemiology and Evaluation team use the state and local quarterly reports to help inform annual evaluation summaries for each priority, as well as a cross-priority evaluation.
- Ensuring linkages between performance management, performance measures and program evaluation.
- Embedding quality improvement into routine program monitoring and implementation.
- Hosting interactive learning communities to foster growth and identify areas for improvement across priorities.

- Coordinating ad hoc workgroups to provide input into new or evolving processes when change is needed.

Overall, MCH performance management has improved state and local action plan implementation; documentation of impact; and enabled leadership to understand and respond to barriers identified by staff.

MCH Evaluation
Each year, the MCH evaluation team uses multiple sources to develop annual evaluation summaries to capture ongoing progress towards goals, track completion of objectives, and monitor national and state performance measures, as well as evidence informed strategy measures. Action plan objectives are developed based on short-term or intermediate outcomes from the corresponding logic model.

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

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

Workforce Development Infrastructure

In June 2019, the MCH program launched an MCH Workforce Development Section within the Children, Youth and Families Branch. This team was established to support training, consultation, coaching and communities of practice for Colorado's MCH state and local public health workforce on cross-cutting knowledge and skills, fundamental to MCH program implementation.

The MCH Workforce Development Section is currently home to the following positions: Racial Equity Specialist, Community Inclusion Specialist, Change Specialist, Youth Development Specialist and a Section Manager. Current staff hold content expertise in racial equity, community engagement, positive youth development, change management, behavioral insights, project management, emotional intelligence, facilitation, coaching and fostering trauma-informed environments. Collectively, the staff have extensive experience providing training, consultation and applying adult learning best practices.

The Workforce Development Section developed a learning infrastructure for the MCH program based on an MCH learning framework, which captures the current state of the MCH workforce, the future state (ie vision) and the approach to fulfilling the vision. The team established shared language, processes and expectations for the provision of workforce support and a process for accessing the team through a workforce development request system. Workforce Development staff also provide leadership for a Branch Culture Team within the Children, Youth and Families Branch. Having staff with expertise in facilitation and navigating differences, has been beneficial in fostering a positive workplace culture and has helped branch staff continuously strive to live into five branch values: growth mindset, cultural humility, anti-racism, connectedness and accountability. Additionally, Workforce Development staff are piloting a six-part series with branch supervisors focused on the importance of "regulating to relate."

Workforce Development Needs

The Workforce Development Section has continued to partner with the Office of Public Health Practice, Planning and Local Partnerships to annually survey the workforce learning needs for all Colorado local public health agencies. This annual survey has been embedded as a part of the contract requirements, and as such, the MCH Workforce Development Section can now track changes to workforce development learning needs over time. Based on survey responses from 2020-2023, the MCH Workforce Development Section has identified the greatest learning needs to be:

- Communicating the value of public health's role across sectors
- Community Inclusion
- Racial Equity
- Influencing Partners and Leaders
- Navigating Change
- Moving Upstream

In addition to highlighting local public health agencies' top learning needs, the survey also painted a picture of significant local staff shortages, burnout and overwhelm. This is critical to understand, since neuroscience demonstrates that cognitive learning cannot happen while in a state of pervasive stress and overwhelm. This undoubtedly poses an operational challenge for a team charged with supporting the learning and development of public health staff. To address this barrier in a neurobiologically sensitive way, MCH Workforce Development team has prioritized the intentional integration of "stress-responsive and trauma-informed" strategies into processes and communications, as well as grounding staff in the science of both stress and regulation.

Strategic Anchors

To support alignment and cohesion across implementation efforts for the seven MCH priorities, Workforce Development staff facilitated the process to identify three strategic anchors for the MCH program. The strategic anchors of racial equity, community inclusion and moving upstream are fundamental to all aspects of the MCH program and guide MCH priority co-leads and implementation teams in selecting and implementing strategies, as well as measuring impact.

The following are examples of how the MCH Workforce Development team has supported the knowledge, understanding and operationalizing of the three strategic anchors:

- Community Inclusion Learning Community
- Community Inclusion presentation "The Sole Effort of Community Connection"
- Strategic anchor intro presentation at Local Planning and Partnership Call
- Moving Upstream Learning Community
- MCH Digest Strategic Anchor article
- Racial Equity Learning Community

- Local learning community anchor discussion
- Language Justice state learning community
- An overview of the MCH Strategic Anchors
- A Moving Upstream Matrix tool
- Strategic Anchor evaluation Final Report (pp. 6-12)
- PSD Community Engagement Toolkit
- Community Engagement 101 Training
- State-level Strategic Anchor planning guidance
- Racial Equity in Data Initiative (REDI) Project

These resources, and others, are available via the MCH Workforce Development webpage.

In an effort to promote continuous quality improvement, the anchor leads began conducting an annual process evaluation of the strategic anchors in 2021. Process changes that were a result of the evaluation include:

- Anchor leads review and provide input on local action plans and 4-square progress reports
- Anchor leads review and provide input on state action plans
- Anchor leads provide more proactive analysis, feedback, direction, and learning opportunities for state MCH staff
- Anchor leads launched the REDI initiative
- Anchor leads and the MCH Local Support Team partner more intentionally to determine local public health agency needs and pathways to offer support (e.g. creation of WDS email address and request form)
- Anchor leads created a 30-minute orientation video specific to the strategic anchors for new state and local MCH staff

Positive Youth Development

The MCH Youth Development Specialist, who also serves as the state's designated MCH Adolescent Health Coordinator, developed a statewide positive youth development statewide training system. In partnership with other funding opportunities, there are now over 160 trainers across the state. These local and regional trainers, which include MCH and other CDPHE staff, have provided training around the state since 2013. In response to the pandemic, CDPHE trainers successfully transitioned to hosting online trainings and found ways to better reach communities virtually. In addition to communities hosting their own local PYD trainings, CDPHE provided 12 virtual PYD 101 training to over 120 participants across the state. In addition, the demand for the PYD Training of Trainers increased and the Youth Development Specialist met this need by hosting eight virtual PYD Training of Trainers sessions. The adaptations made to both of these trainings over the past two years have increased accessibility for small organizations, especially those outside of the Denver Metro area, and assisted MCH staff in effectively meeting the on-going demand.

In the fall of 2022, following extensive discussions with state and community partners, the MCH Youth Development Specialist executed a three year interagency agreement to support the transition of the statewide training system to the Colorado Department of Human Services. This agreement leverages the statewide infrastructure of the Tony Grampsas Youth Services program and enable the program to hire a Positive Youth Development Specialist to support local trainers, update and maintain the website for the statewide training system, and expand the positive youth development learning opportunities to include more robust content in topics such as racial equity and inclusion strategies for LGBTQ+ youth. The MCH Youth Development Specialist will continue to support the transition of the training system over the next three years to ensure successful integration, implementation and sustainability of the program.

Stress-Responsive, Trauma-Informed Environments

In response to the annual workforce survey feedback indicating staff overwhelm and burnout, the Workforce Development Section received training from the Neurosequential Network in the spring of 2022 on their trauma-informed framework. The information gleaned from the training was used to develop and integrate a stress-responsive, trauma-informed systems approach into the MCH program. After vetting numerous organizations and frameworks, the Neurosequential Model in Education framework was determined to have the most user-friendly and accessible content. Additionally, the framework was already familiar to some of Colorado's local public health agency partners. MCH Workforce Development staff contracted with the Educational Access Group to adapt the content for increased relevance to the public health sector and workplace settings. This past year, the Workforce Development team integrated this content and began training state and local MCH staff in operationalizing a trauma-informed approach into program policies and practices. This training enables the MCH workforce to understand stress and trauma and recognize how it can be reduced or reinforced, in both subtle and overt ways. Integration of the approach serves as a mechanism for the MCH program to support psychologically safe, diverse, inclusive and engaging environments. These environments will ultimately support the retention of staff and lead to more meaningful and relevant state and local MCH program implementation.

During this reporting period, the MCH Racial Equity Specialist and MCH Workforce Section Manager have hosted 36 workshops on the individual and interpersonal skills necessary for building a stress-responsive, trauma-informed and staff-resilient workforce. The audiences for these workshops have varied, and included MCH staff and partners from the Children, Youth and Families Branch, the Health Promotion and Chronic Disease Prevention Branch, the Department's BIPOC Employee Resource Group, the Children's Hospital Colorado Pediatric Residency Program, a statewide juvenile justice convening conference, grantees from CDPHE's Community Organizing For Prevention Program, and multiple programs within two large local public health agencies. The evaluations of these initial workshops continue to demonstrate a high need and interest in staff having the time to understand the science of stress that they are so intimately familiar with, learn and practice regulation strategies and be given the time to slow down to promote self-care, as well as integrate strategies for organizational change. Due to the ongoing demand for workshops, the MCH Racial Equity Specialist and MCH Workforce Development Section Manager will be designing and launching a cohort model for workshop participation in the fall of 2023. This will support focused learning,dedicated support, and sharing of implementation practices across local public health agencies and community coalitions. In addition, the workforce team continues to develop relevant content and processes for adapting the Neurosequential Model framework for workplaces. By bridging existing MCH Workforce Development consultation model practices and having a plethora of content developed, the team is able to begin curating organization/team specific workshop series proposals that are specific to meeting their individual needs related to creating cultures of care and belonging. The Racial Equity Specialist and Workforce Development Section Manager continue to contract with an external organization, Educational Access Group to receive consultation support on adapting the Neurosequential Model training and resource content. This support includes observation of workshops with growth-focused feedback and recommendations, the development of an evaluation plan to measure progress and practice changes within implementation teams, and monthly coaching sessions

Navigating Change and Moving Upstream

The ability to navigate change is not only a strategic public health skill, but also a critical skill for navigating and mitigating stress. The MCH Change Specialist possesses a deep understanding of the intersections of change management, behavioral insights and project management, and has developed tools and processes to support MCH staff with navigating change and complex issues with greater ease. One example is the Project Exploration Workbook that integrates the three frameworks, in addition to the MCH Strategic Anchors to help staff apply the concepts in their implementation efforts. The MCH Change Specialist also uses a planning template to guide programmatic change management efforts.

The MCH Change Specialist serves as the programmatic lead for the moving upstream strategic anchor. She drafted this resource to describe the Root Cause Analysis Process and developed a Moving Upstream Matrix tool that has been shared and used in consultation with numerous stakeholders, including the Rocky Mountain Public Health Training Center's SDOH courses, the University of Colorado's School of Public Health, the PHIT conference 2022, an MCH State Learning Community, and during the 2023 AMCHP conference virtual poster presentation.

The concept of Targeted Universalism has also become a topic of exploration in MCH priority implementation. As a result, the Racial Equity Specialist and Change Specialist coordinated an MCH targeted universalism learning community with MCH state staff to create a baseline understanding of the concept and to begin exploring opportunities for application in future MCH action planning.

Holding Difference and Embedding Equity

The ability to recognize, hold and navigate difference, is a critical skill in moving towards equity and creating a culture of care and belonging. The Racial Equity Specialist completed a certification process to become a Qualified Administrator of the Intercultural Development Inventory (IDI) and Intercultural Conflict Style (ICS). These tools help create awareness in individuals and teams regarding the ability to understand, honor and navigate differences. The Racial Equity Specialist embedded the use of the assessments into the stress-responsive, trauma-informed learning series and normalized the use of racial equity tools, such as these assessments, with local public health agencies and community-based partners. During this reporting period, the Racial Equity Specialist has administered 35 assessments and individual debriefs. In addition, the Racial Equity Specialist developed questions to vet potential contractors for values and expertise alignment. MCH staff piloted these questions when seeking contractors to facilitate the Maternal Mortality Review Committee Retreat, as well as to select a vendor to facilitate upcoming race-based affinity groups within the Children, Youth and Families Branch.

Facilitation

The Workforce Development team continues to receive internal and external requests to support teams and processes through thoughtful facilitation. Being able to hold differences, simultaneously address power dynamics, and serve as an engaging yet neutral facilitator, is a critical public health skill, especially when there is a prioritized focus on equity, diversity and inclusion. The Youth Development Specialist, will begin to transition her skill sets currently utilized in the Positive Youth Development Trainings and Training System, and focus on building the capacity of others to facilitate dialogue and engagement across sectors and with communities. As an MCH Facilitation Specialist, she will not only build the capacity of others through training, consultation and coaching, but will also be available to serve as a neutral facilitator for MCH staff and

partners, including support for, and facilitation of, the upcoming MCH Needs Assessment process.

Collaboration/Coordination

MCH Workforce Development staff continue to connect and collaborate with organizations, such as the de Beaumont Foundation and the National MCH Workforce Development Center for purposes of both learning and alignment. The Workforce Development Team continues to strategically connect the dots between MCH-specific workforce development and the Prevention Services Division's, as well as CDPHE's equity and community engagement efforts. The Workforce Development Section has also begun to leverage training areas of focus promoted by the Colorado Department of Personnel Administration, such as Creating Psychological Safety in the Workplace. These areas of connection are critical for all state and local MCH to know and understand in order to drive systemic change towards meaningful programmatic impacts. The following are examples of the team's collaboration and connections across the Division and Department:

- The Change Specialist participates in CDPHE's Behavioral Insights Community of Practice, which has since expanded to include statewide engagement.
- The Community Inclusion Specialist continues to co-lead the Community Engagement Subcommittee for Colorado's Health Equity Alliance coordinated through CDPHE's Office of Health Equity. This group previously adopted the MCH Community Inclusion slidedeck as their onboarding tool for the subcommittee.
- The MCH Facilitation Specialist continues to co-lead one of CDPHE's Employee Resource Groups, which creates and facilitates the leadership networking series, Table of Ten.
- Workforce Development Staff engaged in the Prevention Services Division's Community Engagement workgroup, and provided leadership in developing the Division's Community Engagement Toolkit, which has since been adopted by the entire Department and utilized externally at both state and local agencies.
- The Workforce Development Team is currently partnering with the Office of Human Resources, the Director of Culture, Strategy, Equity and Innovation, and the Department's Senior EDI Officer to coordinate and leverage MCH learning opportunities and expertise to inform, influence and engage with CDPHE's workforce revitalization efforts.
- The MCH Workforce Development Section Manager has begun facilitating monthly Emotional Intelligence workshops, as well as individualized EQ-i 2.0 assessments for CDPHE's Human-Leadership Cohorts; a collection of comprehensive leadership development training for managers across the department.
- The Racial Equity Specialist and Workforce Section Manager facilitated workshops for the Colorado Department of Human Services, including their Extended Executive Leadership Team and the Office of Community Partnerships.
- The Racial Equity Specialist and Workforce Development Section Manager have begun facilitating and evaluating monthly Stress-Responsive, Trauma- Informed workshop series with four groups, including two local public health coalitions, the Children, Youth and Families Supervisors, and a team within the Colorado Judicial Branch.
- The Community Engagement Specialist led a Community Engagement skills-building session at the 2022 annual AMCHP conference.
- The Change Specialist hosted a virtual poster session on Moving Upstream at the 2023 annual AMCHP conference.
- The Workforce Development Team led a skills-building workshop at the 2022 Public Health Improvement Training's annual conference on building workforce capacity.
- The Community Inclusion Specialist leads the CDPHE's strategic plan priority #4 related to community engagement and created a baseline survey to identify areas of strength and struggle to inform future learning opportunities and resource development.
- The Change Specialist, engages in the PSD Strategic Plan Culture and Behavior Norms Priority and prioritizes the integration of trauma-informed practices as well as behavioral insights.
- The Change Specialist partnered to inform CDPHE's PMQI plan and proposed equity be integrated into the plan, of which most proposals were accepted
- The Change Specialist developed and led the department wide Behavioral Insights Community of Practice group and continues to partner with experts in change management across state and local agencies, as well as private sectors.
- The Workforce Development Section Manager co-leads the AMCHP Workforce Leadership Development Committee including informing AMCHP's strategic planning for the workforce development pillar.
- The Workforce Development Section Manager participates on the Advisory Committee for the Rocky Mountain Public Health Training Center.

Moving Forward

To meet the increasing needs of the MCH workforce, the MCH Workforce Development Team will continue to grow their expertise in their specific content areas of focus, as well as complementary areas, including:

- Trauma-Informed Systems
- Creating Psychological Safety in the Workplace
- Story-telling (as a mechanism for qualitative data collection and dissemination)
- Embodiment and mindfulness practices

- AORTA's Facilitate for Freedom Fundamentals Training - a training to develop anti-oppression facilitation skills
- Targeted Universalism

Over the course of the next year, the MCH Workforce Development Team will continue curating resources and learning opportunities for MCH staff and partners to deepen their learning, skills and abilities to operationalizing the prioritized A few of these opportunities include:

- Plan and coordinate MCH program learning communities.
- Coordinate Children, Youth and Families Branch culture-building efforts to support the development of an inclusive workplace.
- Host ongoing strategic anchor learning opportunities for local public health agencies about how to apply the anchors to MCH work.
- Host learning cohorts that engage in a series of workshops focused on the individual, interpersonal and systems strategies needed to create and practice a stress-responsive, trauma-informed and staff resilient workplace culture.
- The Strategic Anchor leads will partner with the MCH evaluation team to coordinate evaluation processes, embedding the strategic anchor evaluations into the annual MCH evaluation.
- Provide individualized consultation on the MCH strategic anchors for state and local staff implementing MCH action plans.
- Curate a Community Inclusion series to support MCH staff and partners in developing the engagement skills necessary for authentic community engagement.
- Curate a Moving Upstream series to support MCH staff and partners in developing the skills necessary for implementation of moving upstream strategies.
- Develop facilitation expertise and learning opportunities and resources focused on building skills for anti-oppression facilitation skills.
- Develop a more comprehensive assessment process for not only understanding the needs of the workforce, but one that also allows for evaluation of growth and change related to knowledge and skill development.

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

One of the three MCH strategic anchors is community inclusion. Community refers to the people who are most impacted by inequities resulting from geography, race and ethnicity, immigration status, language, sexual orientation, gender identity, socioeconomic status, and other structurally marginalized identities. Colorado uses the de Beaumont Foundation's definition of community inclusion as "an authentic, mutually beneficial, and collaborative process of working to address issues that affect the health and well-being of particular communities, which often involves prioritizing health equity. Community engagement exists on a continuum; involves equitable distribution of decision-making power and a focus on community partnering and collaboration; and is rooted in trust and respect." Colorado's MCH program implements multiple strategies to support inclusion amongst youth, families and community members who reflect the MCH population in achieving positive outcomes across the life course. This includes dedicating MCH resources to support:

- MCH Community Inclusion Specialist
- CDPHE Community Advisory Board
- Youth Partnership for Health
- Family leader engagement

CDPHE Community Advisory Board

In 2018, Colorado's MCH program identified that a formal infrastructure for community inclusion and engagement would strengthen MCH priority implementation. As a result, the Community Advisory Board was developed and launched in October 2019. Primarily funded by MCH, the Colorado tobacco program also contributed funding during the 2022/2023 year. The advisory board's membership is reflective of the communities that are most impacted by MCH priority work and is composed of individuals who have a wide range of expertise, including lived and professional experience. Members represent varying sexual and gender identities, both native and immigrant experiences, as well as different languages, races, and ethnicities. Processes for facilitation include simultaneous interpretation in both Spanish and American Sign Language. The Advisory Board meets monthly from September through May. All meetings are planned and co-facilitated by the MCH Community Inclusion Specialist and advisory board members. Staff representing the following programs, initiatives or projects, who have sought feedback from the advisory board include:

- Economic Mobility MCH Priority
- Positive Child and Youth Development MCH Priority
- Child Fatality Review Program
- Reducing Racial Inequities MCH Priority
- Maternal Mortality Prevention Program
- Community Inclusion MCH Strategic Anchor
- Colorado Early Childhood Comprehensive Systems
- Colorado Family Leadership Training Institute
- MCH Needs Assessment
- MCH "Picturing Colorado" project
- CYSHCN Family Delegate

The variety and volume of programs that access the advisory board consistently highlights its value, integrating feedback into program development, implementation and evaluation, as well as policy recommendations.

Throughout the past two years, the advisory board developed and launched a storytelling project in an effort to highlight community expertise and develop personal stories related to MCH that have the potential to influence program, practice and policy change. This storytelling project resulted in numerous member-led, member-driven, and member-authored stories. Within the MCH program, these stories were utilized to increase the capacity of MCH staff to more effectively engage in race equity work through a lens of cultural humility. In addition, these recorded and professionally produced stories will be combined into a short video which has been disseminated widely as a tool for demonstrating the impact of community inclusion efforts. The videos include: the Community Advisory Board Video, as well as individual videos of LaTerrell, Mariana, Reyna, and Sara.

The MCH Community Inclusion Specialist, in partnership with advisory board members, continues to update practices and board infrastructure with tools, such as Presenter Onboarding for Presenters, and Onboarding for Members to support effectiveness, as well as sustainability and replication. The Community Advisory Board's infrastructure and practices have been shared within CDPHE and across state agencies, as well as presented nationally at the 2022 AMCHP conference. Most recently, the Community Advisory Board process was updated to help support the pending transition of onboarding a new Community Inclusion Specialist in the summer of 2023.

Like any initiative there are successes and challenges. Current successes include: most stakeholders report revising their work based on the feedback they received from advisory board members and that the feedback they received helped them to re-center their work to focus more on community. Challenges include scheduling and the high demand for advisory board

feedback and insights. This demand has resulted in presenters either being turned away or needing to be scheduled months away from their request date.

Youth Partnership for Health
For the past 21 years, the Youth Partnership for Health has met monthly during the academic year to provide feedback and recommendations to programs and initiatives. Members receive training on topics related to public health, such as the MCH core competencies, the ten essential services of public health, social determinants of health, health equity and positive youth development. Maintaining a diverse group of youth continues to be a priority. Members range in age from 13-19, represent urban, mountain and rural experiences, varying sexual and gender identities, both native and immigrant experiences, as well as different races and ethnicities. The Youth Partnership for Health is coordinated by the Community Inclusion Specialist and continues to receive financial support from numerous CDPHE programs, including state-funded tobacco and marijuana programs, to sustain this mechanism for soliciting youth input.

Despite the ever-changing demands of the COVID-19 pandemic, the council continued to meet both virtually and in-person, and provide feedback to interested programs and initiatives. Partners that have utilized their expertise include:

- HIV/STI Prevention, Public Health Institute at Denver Health
- CDPHE Comprehensive Health Sex Education Program
- Young Driver Safety Alliance: Safe Driving Campaign and the Alliance's Strategic Plan
- MCH "Picturing Colorado" project
- CDPHE Family Planning Program
- Children's Hospital Colorado
- MCH Positive Child and Youth Development priority
- HIV/STI/Hepatitis Campaign (Disease Control and Environmental Epidemiology Division)
- Youth Photovoice Project, Denver Department of Public Health and Environment
- MCH Built Environment priority
- Office of Research, Denver Department of Public Health and Environment
- State Health Assessment, CDPHE's Office of Public Health Practice, Planning and Partnerships

Like the Community Advisory Board, the value of the Youth Partnership for Health is reflected by the variety of entities that seek input on their program and/or policy development, implementation and evaluation.

In the fall of 2022, the MCH Community Inclusion Specialist onboarded 17 youth, including 8 returning members and updated practices and program infrastructure for the Youth Partnership for Health, including Onboarding for Presenters and Onboarding for Members resources.

YPH continues to experience both successes and challenges. Successes include continued feedback that every presenter that attended YPH found their time to be valuable. "It's so valuable to be welcomed into a space that is facilitated by young people and where youth voices are driving the conversation. I am so thankful that this group exists and that the young people involved with YPH are so willing to meet with community, local-level and state partners to improve efforts that and for, and impact, them." Challenges include the virtual nature of YPH meetings. Some members have expressed not wanting to speak up due to their discomfort with the virtual space. To create a more inclusive environment, the Community Inclusion Specialist leads team building activities and has also prioritized scheduling an in-person meeting so members can connect with each other in person.

Family Leaders
The MCH program contracts with Parent to Parent of Colorado to increase engagement of family leaders in the implementation of MCH program efforts, with a focus on families of children and youth with special needs. Lisa Franklin has served as Colorado's designated Family Leader for the Title V block grant, drawing on her lived experience as a parent and grandparent of a child with special health care needs, as well as extensive experience establishing and participating in family advisory councils to provide consultation, technical assistance and expertise to support meaningful community engagement. Lisa has been an active participant in AMCHP's Family Engagement Community of Practice and Region VIII meetings. In June 2023, Lisa retired after a nearly year-long transition and onboarding of Nichole Arp as the new Executive Director. MCH's current contract with Parent to Parent of Colorado continues through September 2024. Current Parent to Parent of Colorado activities include:

- Build the capacity of MCH state staff to engage parents and caregivers of children and youth with special healthcare needs.
- Inform the development of MCH family engagement strategies that are included in MCH priority implementation efforts with a focus on the CYSHCN population.

- Act as a liaison between the MCH program at CDPHE and existing family leadership organizations.
- Help Colorado's MCH program infuse the CYSHCN caregiver experience into health care, human services and early childhood systems initiatives.
- Serve as Colorado's designated Family Leader for the Title V MCH Block Grant and AMCHP family leader delegate. This includes providing and/or ensuring the provision of family perspective(s) to inform the strategic direction of the MCH program; contributing relevant content to the MCH Block Grant annual report and application for the upcoming year and participating in the annual in-person block grant review with federal partners; and participating in the annual AMCHP conference on behalf of Colorado's MCH program.
- Represents Title V in the Children's Disability Advisory Committee, which makes recommendations to Colorado's state Medicaid agency.

MCH Collaboration with CDPHE Community Inclusion Efforts

In 2018, a department-wide community participation policy was created, requiring all CDPHE programs to engage the community to inform their work. CDPHE staff are also expected to operationalize the Colorado Equity Alliance's Community Partnership Principles into their business practices in order to reduce barriers to effectively engage community members, as well as to identify and inform systems improvements that support effective community engagement. To support uptake and implementation of these principles, MCH staff co-led and participated in the Prevention Services Division's Community Engagement Workgroup. The workgroup prioritized areas of focus for expanding and strengthening internal practices that support community engagement. This led to the Prevention Services Division removing two provisions in the request for applications procurement process to reduce the administrative burdens on smaller, grassroots organizations, which are often led and/or staffed by people of color. The work group also held internal information sessions to educate program staff on the role that Financial Risk Assessments for external contracting can play in equity and engagement. As part of the goal to embed community perspectives in CDPHE's grant application processes, the work group developed a common definition of "community" for consistency across the division. The work group developed a robust Community Engagement Toolkit, approved by CDPHE's Executive Leadership Team for use across CDPHE in spring of 2022. This toolkit outlines a shared approach and best practices for providing incentives to support community participation, as well as guidance on how to systematically embed costs for language services as part of standard, program budgeting.

Beyond CDPHE, the MCH Community Engagement Specialist co-leads the community engagement subcommittee of the Colorado Equity Alliance. This group is focused on sharing best practices and aligning policies for engaging family and community. This group has adopted the MCH Community Inclusion 101 slidedeck as an onboarding tool for the subcommittee itself, as well as a tool for other state agency staff to promote community engagement and inclusion internally to their respective agencies.

During this reporting period, the MCH Community Inclusion Specialist provided leadership for an RFP to increase department-wide access to language services. As a result of this formal solicitation process, in April 2022, a list of ten approved language services vendors were selected. This list allows CDPHE staff to select from and expedite the procurement process, and ultimately reduce barriers to effectively engaging the community in programmatic and departmental efforts.

Throughout this reporting period, the Community Inclusion Specialist has led the Prevention Services Division's strategic plan workgroup for Priority #2 that is focused on community inclusion. This committee is tasked with understanding the current scope of community inclusion efforts across the division and developing tools/resources for improvement.

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

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

The Colorado MCH program is dedicated to evidenced-based practices and measurement of progress towards the selected priorities through the use of core measures, which include National Performance Measures, Evidence-based or -informed Strategy Measures, State Performance Measures and State Outcome Measures. These measures are applied to both state and local action plans and are tracked through a performance dashboard that includes state and local quarterly reporting by priority.

MCH epidemiology and evaluation are performed by an MCH Epidemiologist (1.0 FTE) and an MCH Evaluation Manager (0.6 FTE) who work in CDPHE's Center for Health and Environmental Data (CHED) and whose work is overseen by the MCH Section Manager/Title V Deputy Director. Locating these two positions in CHED enables the epidemiologist and evaluator direct access to population-based data sources, as well as collaboration opportunities with fellow epidemiologists and evaluators who serve other programs across CDPHE. Although the MCH Epidemiologist and MCH Evaluation Manager sit in a different division at CDPHE, they are integrated within the Title V program. They attend quarterly MCH Section and MCH All Staff meetings and are ad hoc participants in the MCH leadership team meetings. They also participate on the MCH Data Workgroup that is developing the process design for the next needs assessment. All MCH team members and local public health agencies have direct access to the MCH Epidemiologist and MCH Evaluation Manager to meet their data and evaluation needs.

The MCH Epidemiologist has an MSPH with an emphasis in epidemiology and more than 14 years of experience in applied public health epidemiology. The position supports team members across the division and department and local public health agency staff in using MCH surveillance data to drive strategic planning and program improvement. This includes the following responsibilities:

- leads annual measurement and data reports for the MCH block grant and SSDI grant;
- develops state and local data tools such as data briefs, state and local data tables and other relevant materials;
- provides technical assistance for collection, analysis, interpretation, and dissemination of population-based data; and
- coordinates data collection and analysis for multiple population-based MCH surveillance systems.

The MCH Evaluation Manager has an MSPH and more than 25 years of experience in public health and quality/performance improvement with emphasis in the areas of program planning and evaluation, quality improvement, consultation and facilitation.This includes the following responsibilities:

- designs and implements the statewide MCH evaluation system in alignment with Public Health Accreditation Board, MCHB, and in coordination with performance management practice;
- provides expertise and leadership for MCH-related state and local level evaluation efforts, and evaluation-related technical assistance to state and local MCH staff; and
- supports team members across the division and department in using MCH evaluation data to drive strategic planning and program improvement.

Performance management and evaluation efforts were further supported by the Evaluation Specialist (1.0 FTE), from the CYSHCN team, and the Workforce Development Section's Change Management Specialist (1.0 FTE), who used Behavioral Insights methodology to enhance, improve and design reporting dashboards that reflect the values of the MCH program and include meaningful context for the data entered to assist in continuous process and quality improvement. These positions are housed in the Children, Youth and Families Branch. All of these positions are 100% funded by Title V, SSDI funds and/or state general funds for CYSHCN (Title V state match).

To assist with development of the state and local logic models and action plans for year one, the MCH Evaluation Manager increased her availability from 0.3 FTE to 0.6 FTE and maintained this schedule in FY22 to allow her to lead state and local staff in logic model and action plan training, provide planning support, and develop an evaluation plan. As planning and implementation of a more robust local evaluation expanded in FY23, the MCH Evaluation Manager maintained her hours at .6 FTE. She will continue at .6 FTE for FY24.

The MCH Epidemiologist, MCH Evaluation Manager, and Evaluation Specialist formed an MCH Data and Evaluation Implementation Team to increase communication, collaboration, and support. The team drafted a year two and year three data plan which lists all epidemiology and evaluation needs for the Title V block grant. The data plan includes activities listed in the state action plans in addition to planned epidemiology and evaluation activities that support the overall work. The team meets monthly to review progress on the data plan, troubleshoot issues, and discuss current work. The team also meets with priority coordinators and implementation team members as needed. This new model of collaboration amongst the data

experts has enhanced communication and alignment, as well as cross-training.

Challenges facing the data team include reductions in survey response rates, disruptions in population-based data collection systems, increased demand for disaggregated data reflecting demographics and geographic areas, and need for upstream data measuring the social determinants of health. Survey sample sizes are on the decline as response rates are dropping. Surveillance costs are on the rise as materials and postage increase in price and efforts to improve response are implemented. These surveillance changes negatively impact the depth of analysis and interpretation that epidemiologists and evaluators can provide as the amount of data available to analyze shrinks. Small sample sizes limit our ability to disaggregate the data to assess experiences, behaviors, and outcomes for various demographic and substate groupings. Population-based public health work is shifting upstream, and public health data collection systems are slow to shift course to measure social and structural determinants of health. As a result, public health epidemiologists and evaluators explore population-based data outside of traditional public health to measure these upstream factors. In order to do that well, they are tasked with learning methodologic details about each new data collection system, which takes time and attention to detail.

Colorado MCH took three steps forward in addressing some of these challenges. The MCH Epidemiologist applied for and received funding from the Council of State and Territorial Epidemiologists to support the implementation of a social determinants of health supplement on the Pregnancy Risk Assessment Monitoring System questionnaire. The supplement went into the field in May 2022. Over 1,100 participants completed the supplement. The weighted dataset will be available for analysis by late 2023. In addition, the Health eMoms surveillance system was codified in state statute in May 2022. This ongoing funding supports a program coordinator (1.0 FTE), program analyst (1.0 FTE), and part time program assistant (0.5 FTE). The coordinator was hired in August 2022 and the analyst was hired in April 2023. The next iteration of the panel survey, rebranded as the Baby & You Survey, will oversample groups that make up a smaller percentage of the population and disproportionately experience health inequities, including African Americans and Native Americans. Baby & You launched with Survey 1.1 during summer 2023. Finally, the MCH Epidemiologist worked with the Rocky Mountain Research Data Center to gain approval of a proposal to the U.S. Census Bureau to access the sub-state variables for regional analysis of the 2020 and 2021 NSCH substate oversample datasets. Once a third year of data becomes available in Fall 2023, the regional data will be analyzed, reviewed, and released.

Demand is increasing for data visualizations that allow for quick, broad access to overall and disaggregated data. The Maternal and Child Health Analyst received advanced training in Tableau, which enabled her to create two Tableau data dashboards in support of the economic mobility MCH priority. The MCH Epidemiologist completed an introductory training in Tableau in June 2023. In addition, the MCH Data and Evaluation Implementation Team created an internal dashboard that displays trend data for all performance measures. This dashboard supplements the annual evaluation summaries and is updated as new data become available. The MCH Epidemiologist is also investigating the utility of the R Shiny package to create dashboards that can analyze weighted datasets (since Tableau does not have this capability). These dashboards support internal staff with their data needs and improve access to MCH data for local partners, other MCH stakeholders, and the broader community.

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

SSDI FY2022: Finishing up the FY2018 - FY2022 Cycle

SSDI funding in Colorado is used to expand and enhance the MCH-related data system in the state in order to better collect and interpret data to comprehensively describe the health of reproductive-age women, children, and youth, including children and youth with special health care needs. The three main goals of the previous SSDI project (FY2018 - FY2022) were to build and expand MCH data capacity to support Colorado's MCH program activities and contribute to data-driven decision making, including assessment, planning, implementation, and evaluation; advance the development and utilization of linked information systems between key MCH datasets in the state; and support program evaluation activities that contribute to building the evidence base for the MCH program.

In FY2022, The MCH Epidemiologist updated the performance measure tracking sheets with the newest data as it became available. New data was shared with priority coordinators to assess progress and evaluate annual performance objectives. Year one (FY2021) evaluation summaries were completed for each priority, used to refine action plans, and submitted with the Block Grant. A revised format for Year two (FY2022) evaluation summaries was developed, focusing more on successes and challenges related to each objective. Based on local public health agency (LPHA) feedback, and ensuring a connection to the overall state evaluation, a local evaluation plan was developed. This plan included conducting interviews with local agencies to better understand their successes and challenges. The MCH Epidemiologist drafted the first three data briefs for three priorities. The Colorado Maternal Mortality Review Committee continues to review the Prescription Drug Monitoring Program report for every maternal death.

Current SSDI (FY2023 and FY2024)

In August 2022, the application and work plan for the current SSDI five year cycle (FY2023 - FY2027) was submitted. For this new cycle, there are four main goals each with their own set of objectives:

- **Strengthen capacity to collect, analyze, and use reliable data for the Title V MCH Block Grant to assure data-driven programming**
    - *Objective 1: Provide support for ongoing data monitoring, objective setting and achievement of the NPMs, ESMs, SPMs, and SOMs.*

    One focus of SSDI is to provide ongoing data support related to the MCH measures: NPMs, ESMs, SPMs and SOMs. Progress on this objective will be measured by completion and submission of the Title V Block Grant report and application each year.

    - *Objective 2: Use data to inform updates to state and local action plans and state and local logic models using a racial equity and community inclusion lens.*

    Annually, state and local staff create action plans in each priority area to build on previous work and determine the next year's efforts to achieve the short, intermediate and long term outcome measures identified in the logic model. The annual planning process occurs from April through July.

    For both state and local planning and implementation, MCH staff engage in a process to create or update their logic models using data and practice-based evidence to determine short-term, intermediate, and long-term measures. The development of state and local action plans takes place in close partnership between priority coordinators, local MCH staff, and CDPHE evaluation staff to ensure that the objectives, strategies, and activities selected are data informed and measurable. Throughout implementation of the action plans, data is collected and reviewed to check progress and course correct, if necessary. By leveraging lessons learned and available date resources, barriers can be addressed, successes celebrated, and upstream impact can be made.

    State priority coordinators finalized priority-specific action plans in June 2023. MCH staff leveraged relevant data to update their logic models and are working with MCH evaluators to craft racial equity in data initiative (REDI) data resources to enhance data briefs with crucial information. Priority coordinators will identify specific areas within the state action plans where there is historical, structural or social context that has been directly linked to health disparities in the data.

    MCH evaluators and priority coordinators also work closely with the 12 local agencies that receive more than $50,000 in MCH funding annually to update their local action plans, which were completed in June 2023.

    - *Objective 3: Provide quantitative data collection and analytic support for the selection of Colorado's Title V priority needs, strategic anchors (currently racial equity, community inclusion, moving upstream), the NPMs, ESMs, and SPMs as part of the 2025 MCH Needs Assessment.*

    One major focus of Colorado SSDI will be designing and completing the 2025 MCH needs assessment. Preparation for the assessment will ramp up in early 2024. Progress on this objective will be measured by completion of each component of the assessment, finalizing the new set of MCH priorities, and submitting the FY2026 Title V Block Grant Report and Application, including the MCH Needs Assessment. So far this year, the

MCH Snapshot was updated and one data brief was completed. A needs assessment data work group has been launched and is made up of the MCH program's director and deputy director, epidemiologist, evaluators, program specialists and one of the local liaisons. The work group began meeting monthly in April 2023 and will continue to meet regularly until the needs assessment is submitted. One outcome from the first three work group meetings includes a plan to review the data for the newly proposed NPMs. A subset of the data work group will develop data overviews for select NPMs listed in the revised grant guidance. These data overviews will complement the data briefs to inform priority selection during the 2025 needs assessment.

- *Objective 4: Annually evaluate progress on all seven MCH priorities and the strategic anchors (racial equity, community inclusion, moving upstream).*
  Similar to previous years, priority evaluation reports were completed this year. This year's evaluation summaries cover FY2022 (October 2021 - September 2022). There is a cross-cutting summary on the overall performance of the block grant including the strategic anchors, and a summary for each priority highlighting data, successes and challenges. Two-year objectives were written, with the timeframe ending in FY23 (Sept 30, 2023). Status of objectives as of the end of FY22 (Sept 30, 2022) is reported. Of the 37 objectives in the action plans, 24 (65%) were completed, 10 (27%) are in progress, two (5%) were put on hold, and one (3%) was not measurable due to a change with the data source. Even though two years isn't sufficient time to show much change in performance measures, two NPMs are improving, two show no change, and one NPM (4A, 4B) is split, with one measure improving and the other showing no change. One SPM is improving, two SPMs show no change, and one SPM is getting worse.

- **Strengthen access to, linkage of, key MCH datasets to inform MCH Block Grant programming and policy development, and assure and strengthen information exchange and data interoperability**
  - *Objective 1: Identify and support use cases about various data interoperability activities to increase equitable access and resources.*

The Colorado MCH program values linking MCH datasets in meaningful ways that can help improve MCH-related needs assessments, program development and evaluation. Several new data linkages are included in the new SSDI work plan and monitoring of other potential linkages will occur on an ongoing basis. The developmental screening and e-Referral project is a data linkage project that is highlighted in the ***III.A.3 MCH Success Story*** section in this year's MCH annual report.

- **Enhance the development, integration, and tracking of health equity and social determinants of health metrics to inform Title V programming**
  - *Objective 1: Plan and implement the Racial Equity in Data Initiative to better frame and interpret racial inequities identified in the data briefs and other data products.*

  MCH program staff recognized the need to be more explicit in providing context that accompanies data deliverables (e.g. priority data briefs) to ensure that a racial equity lens is employed in reporting and analyzing data within the historical, social, and structural systems that contribute to health inequities. For example, the initial draft of the positive child and youth development data brief did not have sufficient information about how systemic racism contributes to lower breastfeeding rates amongst Black people (e.g. provider bias, historical mistrust of healthcare institutions, the practice of wet nursing, etc.). The data briefs by themselves did not paint a complete picture and MCH program staff realized this was an opportunity to contextualize the data. Priority coordinators, with support from strategic anchor leads, agreed to develop a one-page document to accompany each priority's data brief with concrete examples related to the race equity, community inclusion, and moving upstream strategic anchors that would be helpful foundational knowledge for someone reading the data brief. Priority coordinators will research and review existing materials, receive consultation from the strategic anchor leads, and create one-pagers with additional historical, social, and systemic context to supplement the data briefs. Priority coordinators will have the one-pagers completed by December 2023. Several priority coordinators have already begun research/review, and/or have had consultations. However, none of the one-pagers have been fully completed as of the block grant submission date.

  The MCH Epidemiologist drafted a brief currently titled Guidance for Interpreting Data on Racial Inequities. This three-page brief provides guidance on interpreting data on racial inequities specifically related to the MCH data briefs. The brief is currently under review and once finalized and formatted, the brief will be released with the priority data briefs and the one-pagers mentioned above.

  - *Objective 2: Improve the availability of social determinants of health data in population-based data collection systems and integrate the measures into programmatic implementation and evaluation.*

  The new MCH priorities include varying levels of upstream work to improve the social determinants of health (SDoH). The MCH data team has been assessing SDoH data availability related to living conditions since selecting the new priorities and determining what else needs to be collected. The SDoH supplement added to the

2022 Colorado Pregnancy Risk Assessment Monitoring System (PRAMS) questionnaire includes questions on financial stability, food security, transportation, provider treatment, and stress. The tax credit team has been learning about tax return data available for analysis on an annual basis, and hopes to access provisional data for more real time program evaluation. The community vitals signs dashboard will be updated with new SDoH data for use with 2020 maternal mortality case review. This will all be completed by the end of 2024.

- **Develop systems and enhance data capacity for timely MCH data collection, analysis, reporting and visualization to inform rapid state program and policy action related to emergencies and emerging issues/threats, such as COVID-19.**
    - *Objective 1: Link maternal deaths (starting with 2021) to COVID-19 case data to inform rapid data analysis during emergencies and future programs and policies.*

  In January 2023, 47 maternal mortality cases (from 2021) were sent to the COVID-19 data team for matching. Eleven cases were identified as having tested positive for COVID-19 at some point prior to the death. This information was then incorporated into the case narratives for the Maternal Mortality Review Committee.
    - *Objective 2: Support surveillance systems to collect data in emergency situations through development of protocols for data collection and analysis and dissemination of COVID-19 data with a focus on marginalized populations.*

  The Health eMoms COVID-19 survey, conducted in early 2021, has been providing rich qualitative data through free text fields. Quotes from participants referencing a wide variety of situations during the pandemic are being integrated into various data products including the MCH Snapshot, the Areas of Well-being Reports, and the MCH Data Briefs.

  The Colorado Health Institute requested aggregated data from the CYSHCN COVID-19 Survey in May 2023 to support work of the Colorado Department of Early Childcare.

See the full Colorado FY2023 - FY2027 SSDI work plan for more details.

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

Child Fatality Prevention System
The Child Fatality Prevention System is a statewide network that focuses on preventing child deaths. Administered through CDPHE, Colorado's Child Fatality Prevention System consists of local review teams covering all 64 counties in Colorado, a State Review Team, and the state support team at CDPHE. Local teams include community members and field experts. These teams complete case reviews of infant, child, and youth deaths in Colorado due to undetermined causes, unintentional injury, violence, motor vehicle and other transportation, child maltreatment, sudden unexpected infant death, and suicide. These case reviews show trends and patterns in these deaths, and help identify strategies to prevent future deaths. The State Review Team develops recommendations for how to prevent child deaths in an annual legislative report. The leading causes of death among infants, children, and youth under age 18 reviewed by the Child Fatality Prevention System for the years 2017-2021 were suicide, motor vehicle and other transportation deaths, sudden unexpected infant death, child maltreatment, and firearm deaths. The Child Fatality Prevention System also maintains a Data Dashboard.

Maternal Mortality Prevention Program
The Maternal Mortality Prevention Program is in the process of developing a legislatively-mandated report that covers 2016-2020 maternal deaths to be published in July 2023. This report includes 13 overarching recommendations generated by the Maternal Mortality Review Committee addressing the following: equity, bias, and discrimination, community-based solutions and engagement, clinical quality, screening and follow-up, care coordination and transitions, overdose prevention, firearm violence prevention, capacity and access, workforce diversification and expansion, provider training, education and public awareness, reproductive autonomy, and equitable reimbursement and insurance coverage. Quantitative data in the report addresses racial inequities and discrimination, causes of death, the role of mental health and substance use, and additional demographic data. Data from 2016-2020 show that American Indian/Alaska Native pregnant and postpartum people were 2.9 times more likely to die during pregnancy or within one year postpartum than the overall population of people giving birth, and Black pregnant and postpartum people were 2.1 times more likely to die of pregnancy-related causes than the overall population in Colorado. The leading causes of pregnancy-associated deaths continue to be suicide, unintentional drug overdose, and obstetric complications. In addition to the Maternal Mortality Review Committee legislative report, the Maternal Mortality Prevention Program also completed a legislatively-mandated report to assess the state's gaps in maternal health data.

Pregnancy Risk Assessment Monitoring System
CDPHE has been collecting data on postpartum people two to four months after delivery via the Colorado Pregnancy Risk Assessment Monitoring System (PRAMS) since 1997. PRAMS collects data on maternal behaviors and experiences before, during, and immediately after pregnancy. Colorado has annual weighted data sets through 2021. That year, 1,261 postpartum people completed the survey, which was administered by mail and telephone, for a weighted response rate of 60%. The Phase 8 questionnaire was fielded for the last year in 2022 along with the twelve question social determinants of health supplement. The weighted 2022 dataset should be available around the end of 2023. The new Phase 9 questionnaire was finalized in early 2023 and fielded in June 2023. CDC PRAMS delayed the start of Phase 9 data collection by two months to accommodate the final stages of programming and testing of the new questionnaire. In addition to the Phase 9 questionnaire, 2023 data collection also marks the implementation of the web-survey module for Colorado. With each mailing, the sampled postpartum person is provided a QR code, web address, user ID and passcode to access the web version of the questionnaire. Now there are three options to complete PRAMS - mail, web, or phone. PRAMS data are provided to CDPHE programs and partners for planning, policy and programming, evaluation, and research. The MCH Epidemiologist coordinates the Pregnancy Risk Assessment Monitoring System for Colorado and MCH contributes funding to support PRAMS data collection each year.

Health eMoms/Baby & You
Health eMoms and Baby & You are online, longitudinal survey programs that CDPHE created to collect novel perinatal and early childhood data. State MCH staff were critical in the development and oversight of both programs.

Health eMoms operated from 2018-2021, drawing a monthly simple random sample of 200 Colorado-resident postpartum people from live birth certificates and recruiting these people by mail to join an online survey platform. Enrolled participants received four to six, 10-minute online surveys by email and text from shortly after birth up until their baby's third birthday. In January 2021, an additional survey was sent to the full enrolled cohort in order to provide understanding of the impacts of the pandemic on families. All surveys were developed in collaboration with CDPHE programs and partners.

Health eMoms sunsetted in August 2021 due to funding instability, and data collection ceased in January 2022. Prior to the sunset, Health eMoms collected data via six surveys from the 2018 birth cohort, four surveys from the 2019 birth cohort, two surveys from the 2020 birth cohort, and one survey for half of the 2021 birth cohort. Enrollment rates ranged from 45-47%, resulting in enrollment and first survey sample sizes of 1000-1100 postpartum people annually. Response rates for subsequent surveys (2-6) ranged from 75-80% with sample sizes of 800-880. The COVID-19 survey had 1844

respondents. Survey responses were weighted to represent the eligible birth population for each birth cohort. The results for all surveys and birth cohorts were shared broadly with partners and can be viewed on CDPHE's Center for Health and Environmental Data's website.

As a testament to Health eMoms' value to partners, the Colorado Children's Campaign and other stakeholders advocated to integrate the survey into HB22-1289. The legislation passed in May 2022, codifying the program into state statute and funding it with state General Funds. The new program, rebranded as Baby & You to be more gender inclusive, is tasked with collecting data to inform programs and policies that advance health equity for birthing people. To this end, the program is required to conduct an oversample of groups that make up a small percentage of the population and that disproportionately experience health inequities, including African Americans and Native Americans. In order to balance the sample across all groups, Baby & You will also oversample Asian Americans/Pacific Islanders.

Baby & You will begin collecting data in June 2023 and will sample 3,400 people annually. Due to the shift towards harder to reach populations, we anticipate 1,200-1,300 respondents on the first survey annually. Participants will receive four surveys over the first three years postpartum (at 3-6 months, 1 year, 2 years, and 3 years). Baby & You is in the process of redesigning its advisory structure to balance community and professional partners. MCH staff remain an integral part of the Baby & You Steering Committee and Advisory Board.

National Survey of Children's Health Oversample
MCH funded the first NSCH sub-state oversample in 2020, with a goal of 1,200 completes among children ages 0-17 years from eight regions of the state. The first year (2020) of oversample exceeded that goal with 1,609 completed interviews. The second year (2021) of the oversample also exceeded that goal with 1,737 completed interviews. The third year (2022) of the oversample will be released in October 2023. Data collection for the fourth year (2023) of the oversample commenced in June 2023. The MCH Epidemiologist worked with the Rocky Mountain Research Data Center to gain approval of a proposal to the U.S. Census Bureau to access the sub-state variables for regional analysis. Once the proposal was approved, two researchers from Colorado secured special sworn status to access the Research Data Center. Upon receiving access, the researchers analyzed regional data for several MCH indicators. Two indicators were submitted for disclosure avoidance review, which was granted in May 2023. The MCH Epidemiologist presented on Colorado's NSCH oversample journey, including accessing the Research Data Center, at the 2023 Association of Maternal and Child Health Programs Annual Conference in May 2023. Upon consultation with the MCHB Senior Epidemiologist who reviewed the first set of regional estimates, Colorado decided to include a third year of the oversample before releasing regional estimates. Additional analysis will be completed after the release of the 2022 oversample dataset. Since this is a federal surveillance system, states are not currently allowed to add state-specific questions of interest, which is a drawback for some programs that previously relied heavily on Colorado's Child Health Survey, which was customizable. The MCH Epidemiologist coordinates the contract for the oversample with the U.S. Census Bureau plus data access and analysis for the NSCH oversample and MCH continues to fund the NSCH oversample each year.

Healthy Kids Colorado Survey
The Healthy Kids Colorado Survey is Colorado's most comprehensive survey focussed on the health and well-being of middle school and high school students in Colorado. It's aligned with the CDC's Youth Risk Behavior Survey and is conducted on a biannual basis in the fall of odd years. The purpose of the survey is to better understand youth health and which factors support youth to make healthy choices. The survey covers numerous topics such as substance use, alcohol, tobacco, mental health, suicide, physical activity, nutrition, sexual health, safety, and other risk/protective factors, in order to develop interventions and supports to keep Colorado's youth healthy and safe. Statewide and regional survey data are compiled and disseminated after each survey. Colorado's 2021 Healthy Kids Colorado Survey had responses from 106,799 students (38,518 middle school students and 68,281 high school students). A total of 340 schools participated in the 2021 survey (161 middle schools and 179 high schools), with data released in June 2022. The next survey will be administered beginning in the fall of 2023, with data available in 2024.

Colorado has received representative results for the CDC's Youth Risk Behavior Survey six times in 30 years (2005, 2009, 2011, 2017, 2019, and 2021) of participation. In order to focus on the administration of the Healthy Kids Colorado Survey and to reduce local burden on schools who are invited to participate in both surveys, CDPHE has decided to pause participation in the CDC's Youth Risk Behavior Survey. An additional factor is that the Youth Risk Behavior Survey only yields statewide results, while the Healthy Kids Colorado Survey yields school, district, regional, and statewide results. Colorado remains committed to collaborating with the CDC to enhance national youth surveillance efforts and share innovations.

Data Products
In addition to ensuring access to various population-based data sets, the MCH data team created data products to support the 2021-2025 MCH priority work. The MCH Data Inventory organizes surveillance questions and indicators by MCH priority for the following data sources: birth certificate, PRAMS, Health eMoms, NSCH, HKCS, and a few other surveys that are focused on adults. The NOM, SOM, NPM, ESM, SPM Trends 2021-2025 is an internal tracking sheet that includes trend

indicators and annual objectives for each of the core measures. The data in this tracking sheet link to data figures in the MCH program's quarterly reporting document and to the annual evaluation summaries. The MCH Snapshot was updated this year and will be included in the data to action packages (see section ***III.C. Needs Assessment Summary Update***). A Council of State and Territorial Epidemiologists Applied Epidemiology Fellow led the development of six Health eMoms areas of wellbeing reports released in summer 2022. These reports showcase Health eMoms data in the areas of access to care, behavioral health, nutrition security, economic mobility, and child and youth development. A summary, the sixth report, connects the five other reports. MCH has a specific tab on the Colorado Health Information Dataset website to direct users to various online MCH data sources. The first MCH data brief was completed this year and the rest will be finished by the end of 2023.

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

On September 30, 2019, Governor Jared Polis signed the 2019 State Emergency Operations Plan. The purpose of the Colorado State Emergency Operations Plan is to outline general guidelines on how the state carries out its response and recovery responsibilities to address an emergency or disaster event. This plan can only be activated through the issuance of a Gubernatorial Executive Order. Adoption of the plan through this order identifies that the director of the Office of Emergency Management within the Colorado Department of Public Safety's Division of Homeland Security and Emergency Management will lead state disaster or emergency response and recovery efforts. Once the plan is activated, all state departments and offices are mandated under the authority of the Colorado Disaster Emergency Act (C.R.S. 24-33.5-701) and this plan to carry out assigned activities related to mitigating effects of an emergency or disaster and to cooperate fully with each other, the Office of Emergency Management, and other political subdivisions in providing emergency assistance. The Office of Emergency Management is responsible by statute to create a comprehensive emergency management program that includes policies, plans, and procedures that address the preparation, prevention, mitigation, response, and recovery from emergencies and disasters. Statute notes that the office shall prepare, maintain, and keep the program current in order to meet the needs of the state; a specific requirement for the frequency of updates is not indicated.

CDPHE was part of the design of the State Emergency Operations Plan (SEOP) and would participate as an executive branch state agency whenever the SEOP is activated. CDPHE's Office of Emergency Preparedness and Response coordinates planning contributions to the State Emergency Operations Plan, both through ongoing collaboration with the Division of Homeland Security and Emergency Management, and by maintaining the Federal Emergency Management Agency's (FEMA) Emergency Support Function 8 (Public Health and Medical Services Annex) to the State Emergency Operations Plan. Title V leadership in Colorado are not named in the Incident Management Structure in the State Emergency Operations Plan.

Although the SEOP for Colorado does not explicitly address the needs of the entire MCH population, there are components that relate to some cohorts with the MCH population. For example, the Colorado Division of Homeland Security and Emergency Management includes an Access and Functional Needs plan and resources, including a coordinator and program staff. The Access and Functional Needs plan coordinator is a partner and resource to promote and strengthen inclusive, whole community planning in Colorado, including people with disabilities, rural communities, non-English speaking communities and other people who may have additional needs related to emergency preparedness and response. CDPHE's Office of Emergency Preparedness and Response staff are key collaborators in this workgroup and also convene a Community Inclusion workgroup.

Office of Emergency Preparedness and Response's Community Inclusion Workgroup
This workgroup aims to support inclusive emergency preparedness and response through fostering relationships between community leaders and traditional emergency partners. It is a network that connects routinely to share relevant resources and updates and promote problem-solving that improves the state's ability to care for all Coloradans' health and well-being during disasters, and especially those with access and functional needs. Participants in the workgroup include a CYSHCN team member to represent the needs of children and youth with special healthcare needs and their families in the emergency preparedness and response planning process, state and local emergency and community-based organizations from around the state including local public health, local emergency managers, University of Colorado's Center for Inclusive Design and Engineering, the Colorado Commission for the Deaf, Hard of Hearing, and Deaf-Blind, county-based equity and emergency committees, the State Unit on Aging, Colorado Respite Coalition, the Colorado Department of Human Services, the Colorado Department of Local Affairs, and the Access and Functional Needs Program from the Colorado Division of Homeland Security and Emergency Management.

In July 2022, CDPHE's Office of Emergency Preparedness and Response trained MCH-funded care coordinators consisting of 11 local local public health departments, two state agencies, a parent organization and five CYSHCN staff members on How to Prepare for Everything. The author, Aaron Titus, provided MCH staff with all the worksheets from the book, which MCH translated into Arabic, Somali and Spanish in order to expand access to more communities. These materials are now also shared with individuals who have completed the training and were shared with the author as well as the Office of Emergency Preparedness and Response. MCH-funded care coordinators are in a unique position to help families with children with medical complexity "prepare for everything" by incorporating key strategies in the development of shared plans of care for their clients and families. To promote sustainability, this train-the-trainer model was also offered to local public health agency staff tasked with working with the community and/or local emergency planning. The CYSHCN team is also working on a plan to include the training in future orientation sessions for new MCH-funded care coordinators.

The Office of Emergency Preparedness and Response oversees the Community Inclusion in Colorado maps (CICOmaps). The CICOmaps were created by the Colorado Department of Public Health and Environment and University of Colorado Assistive Technology Partners to enhance current emergency preparedness and response planning and resources by making location-based community information easy-to-access. The maps include community demographics and functional

characteristics at the census-tract (sub-county) level. They include the locations, service areas, and phone numbers of community providers and health care facilities. In May 2023, the opportunity to leverage GIS mapping services to eliminate duplicate efforts and drive community to the CICOmaps by adding CYSHCN data to the database. The CYSHCN Section has also agreed to widely distribute an upcoming opportunity to share a free generator program for those who depend upon electricity to run their medical equipment, as well as a "go bag" program.

EMS for Children State Partnership

State Emergency Medical and Trauma Services Advisory Council (SEMTAC) is a Governor-appointed council consisting of 25 members and seven non-voting (ex-officio) members representing the interests of citizens and emergency medical service providers. The council advises the Department in developing, implementing and improving emergency medical and trauma services statewide. As of April 2023, a CYSHCN team member is a voting member of the Pediatric Care Committee (PCC), a SEMTAC committee. The purpose of the committee is to inform and advise the emergency medical and trauma services community on matters related to emergency medical services (EMS) for children within Colorado pursuant to applicable statutes and regulations. The committee will also provide guidance and support initiatives for the EMS for Children Colorado (EMSC) State Partnership grant program, a HRSA/MCHB grant which requires Title V representation. EMSC is charged with integrating, expanding, and improving pediatric emergency care by promoting the value and importance of integrating pediatric emergency care into the state emergency medical system.

Expert Emergency Epidemic Response Committee

The Governor's Expert Emergency Epidemic Response Committee under the authority of the Colorado Disaster Emergency Act (C.R.S. 24-33.5-701) includes the Executive Director, the Chief Medical Officer, the Chief Public Information Officer, the Emergency Response Coordinator, the State Epidemiologist for the Department of Public health and Environment; the Attorney General or the Attorney General's designee; the President of the State Board of Health or the President's designee; the President of the State Medical Society or the President's designee; the President of the Colorado Health and Hospital Association or the President's designee; the State Veterinarian of the Department of Agriculture; the Director of the Division of Homeland Security and Emergency Management; and the Executive Director of the Department of Local Affairs or the Executive Director's designee. In addition to the state members of the committee, the Governor appoints to the committee an individual from each of the following categories: a licensed physician who specializes in infectious diseases; a licensed physician who specializes in emergency medicine; a medical examiner; a specialist in post-traumatic stress management; a director of a county, district, or municipal public health agency; a hospital infection control practitioner; a wildlife disease specialist with the division of wildlife; and a pharmacist member of the State Board of Pharmacy. The Executive Director of the Department of Public Health and Environment serves as the chair of the committee.

Continuity of Operations Plan

Lastly, all executive state agencies, including CDPHE, are required to have a Continuity of Operations Plan to ensure that mission essential functions continue to be performed during a wide range of emergencies, including localized weather-related events (tornadoes, floods, blizzards, etc), long-term power outages, law enforcement activities, acts of terrorism, etc. CDPHE's Continuity of Operations Plan was updated in June 2023. This Continuity Plan works in conjunction with CDPHE's Internal All-Hazards Emergency Response Plan and provides a framework to minimize potential impact and allow for rapid recovery following a disruption. This plan outlines the management framework and establishes the operational procedures needed to sustain essential functions and services for a period of 30 days or until normal operations can be resumed. It applies to the full spectrum of threats and emergencies that may affect the Department. This Continuity of Operations Plan also establishes policy and guidance to ensure the execution of the essential functions for the Department in the event that an emergency at the agency or in its service area threatens or incapacitates operations, and/or requires the relocation of selected personnel and functions.

All new and current employees are trained on the contents of the Continuity of Operations Plan and their responsibilities as CDPHE employees. Services deemed as critical services in the CDPHE Continuity of Operations Plan that directly support the MCH population include vital statistics records, newborn screening and WIC services. The plan includes detailed procedures for each of these programs to continue operations during any type of emergency.

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

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

During the past two legislative sessions, Colorado experienced two significant changes to the state agency partner infrastructure, a new Department of Early Childhood and the creation of a Behavioral Health Authority.

The Colorado Department of Early Childhood was codified in law when Governor Polis signed HB22-1295. This bill establishes the functions of the Department of Early Childhood, a new executive level agency in Colorado, and moves early childhood, child health, and family support programs from other state agencies to the Department. While the MCH program remains within CDPHE, the explicit inclusion of child health in the mission of the new Department creates an opportunity for ongoing and enhanced partnership across programs serving young children and their families. To support this alignment, the MCH Director serves as the CDPHE representative on Colorado's Early Childhood Leadership Commission. To inform the development of the new Department, the Commission was responsible for the development and implementation of a transition plan.

In April 2021 Governor Polis signed HB 21-1097 into law, marking a major step forward in the efforts to strengthen the mental health system in Colorado. The bill created the Behavioral Health Administration, which is a cabinet member-led agency, housed within the Department of Human Services, designed to be the single entity responsible for driving coordination and collaboration across state agencies to address behavioral health needs.
In 2023, the BHA released their strategic plan for the next three years and outlined their priorities and desired outcomes in a roadmap.

The legislation also explicitly recognizes that children and youth have needs that differ from adults. Children and youth are often involved with multiple systems, and it is essential to support the entire family's wellness. Because of this, the Behavioral Health Authority will include a child-specific structure to ensure that the children, youth, and families receive the support they need. In 2022, the CYSHCN Director participated in a care coordination policy group that resulted in a report called *Bridging the Gaps: Care Coordination Recommendations*. The report was created to guide the Behavioral Health Service Organizations (BHASOs) that will launch in July 2025. The Behavioral Health Authority has produced a fact sheet outlining the role of the BHASOs and how they will interact with other components of the behavioral health system. To ensure that the MCH program has input into these contracts, the CYSHCN Director and School-Age Systems Specialist attend the monthly Behavior Health Authority's town hall meetings. In addition, the CYSHCN Director is co-facilitating an internal workgroup made up of key program representatives to strategize and align policy strategy recommendations from CDPHE.

MCH has had multiple existing collaborations to support the maternal population in partnership with the Behavioral Health Administration. State staff have worked together to promote messages from both the pregnancy-related depression campaign and the Tough as a Mother campaign, helping to highlight and destigmatize the intersection of maternal mental health and maternal substance use/misuse. This partnership has led to leveraging of resources, including the co-leading of toxicology best practice guidelines to be used in birthing facilities to support more consistent and equitable practices, the creation of story telling videos for the pregnancy-related depression campaign by leveraging the Tough as a Mother storytelling software, and development of a new curriculum for perinatal mental health and allied professionals focused on the intersection of maternal mental health and substance use, helping to address one of the leading causes of maternal mortality and morbidity. Staff from the Behavioral Health Administration also participate in the recently convened Maternal Health Task Force to inform future innovations.

Other Partnerships
The Colorado Perinatal Care Quality Collaborative (the Quality Collaborative) is the state's designated perinatal quality collaborative and the entity responsible for implementing Alliance for Innovation in Maternal Health (AIM) patient safety bundles in Colorado. CDPHE and the Quality Collaborative have worked together to improve maternal health for many years, and have a strong working relationship. The Quality Collaborative centers its work around addressing sources of care disparities by partnering with providers and patients to implement patient safety and quality improvement projects to reduce variations in care. Through funding provided by the ERASE Maternal Mortality grant from the CDC, CDPHE has a contract with the Quality Collaborative to support implementation of the AIM Care for Pregnant and Postpartum People with Substance Use Disorder patient safety bundle, in alignment with Maternal Mortality Review Committee recommendations to improve systems to support people impacted by perinatal substance use. Additional funding was secured this year through the Maternal Health Innovation and Data Capacity Program through HRSA, which will allow for the implementation of additional patient safety bundles and fund systems level changes to support the ability of staff at birthing hospitals to gather timely and accurate data. In addition, Quality Collaborative provides backbone support for the Maternal Mental Health

Collaborative and CDPHE staff have served in key roles on the leadership team for the collaborative for many years.

Over the past three years, Colorado's early hearing detection and intervention system has experienced significant changes. During the summer of 2021, a coalition of newborn hearing stakeholders raised concerns to CDPHE about the gaps in the state's current system. Based on these concerns, the MCH program contracted with a facilitator to convene public and private partners throughout the summer and fall of 2022 to identify existing gaps, opportunities to fill the gaps and additional resources that may be needed to strengthen the state's early childhood detection and hearing intervention system. Focus groups include audiologists, primary care providers, early interventionists, midwives, ENT specialists, hospital providers and screeners, Colorado Hearing (CO-Hear) Coordinators. In addition to providers, staff from the Colorado Department of Human Services (Early Intervention Colorado and Colorado Commission for the Deaf, Hard of Hearing, and Deafblind, which administers Colorado's Early Hearing Detection and Invention grant from HRSA) are participating, in addition to staff from CDPHE (MCH/CYSHCN and the Center for Health and Environmental Data, which houses the newborn hearing screening data system). Recommendations that will guide future actions were developed in the fall of 2022. Several work groups have been formed to implement the proposed recommendations. The MCH and CYSHCN Directors serve on an interagency workgroup to redefine the relationships of the Department of Human Services, Department of Early Childhood and CDPHE through the development of an MOU. Once finalized,this MOU will strengthen cross-agency collaboration and improve coordination of work through the clarification of roles, data collection and sharing, and a collective space for policy change that supports a comprehensive and coordinated early hearing detection and intervention system.

The establishment of the Colorado Office of eHealth Innovation (OeHI) and the eHealth Commission in 2015 were necessary to meaningfully organize public-private partnerships to advance the health of Coloradans. The MCH Director helped update a white paper, *Advancing a Coordinated Ecosystem for a Social Health Information Exchange (S-HIE) in Colorado*, that has been endorsed by the eHealth Commission and guides the state's efforts to support the infrastructure for an interoperable social-health information exchange. OeHI is providing leadership for the development of the statewide infrastructure through a *Social Health Information Exchange Invitation to Negotiate*. The application closed in the spring of 2023 and OeHI is currently in negotiations with a technology vendor(s) to execute a contract by fall of 2023. Once the contract is executed, OeHI will be launching a data governance workgroup and will include MCH-funded staff to ensure interoperability and connection to MCH projects, such as the developmental screening and e-referral pilot.

For a description of MCH partnerships with the Colorado Department of Health Care Policy and Financing, the state's designated Medicaid agency, refer to ***section III.E.2.b.v.b. Title V MCH – Title XIX Medicaid Inter-Agency Agreement.***

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

The MCH program collaborates with the state's Medicaid program, known as Health First Colorado, and is specifically included in the interagency agreement (IAA) between CDPHE and the the Department of Health Care Policy and Financing. The IAA is renewed annually and states that the Department of Health Care Policy and Financing, as the state's designated Medicaid administration agency, and CDPHE, as the state's designated public health programs and survey and certification agency, agree to work collaboratively on the Medicaid-funded health programs, services, health information systems, health facilities survey and certification, and any other provider certifications, licensing, or agency operations required. Through this IAA, the MCH program receives Medicaid data, such as outreach and enrollment data for the MCH population, as well as claims data specific to developmental screening and screening for pregnancy related depression. The claims data is matched with data from the Pregnancy Risk Assessment Monitoring System, in the Maternal Mortality Review Committee, and used as part of the Maternal Health Outcomes Data Initiative is a collaboration between the two Departments to maximize the effective use of claims data and birth certificate data from both state agencies to measure and track maternal health outcomes.

As part of the IAA, two members of the CYSHCN team, the CYSHCN Director and the Early Childhood Systems Specialist participate on the EPSDT Advisory Committee, which is facilitated by the Department of Health Care Policy and Financing to solicit input into the implementation of the EPSDT program. In 2023, the group has focused on discussing how to improve well-child visits and EPSDT screening for young children who are enrolled in Medicaid and do not regularly seek care or who have not utilized primary care since enrollment. The recommendations that were generated from this discussion were shared with the Medicaid's subgroup for Performance Management and Member Engagement.

Staff from the CYSHCN team continue to participate as voting members on the Performance Measurement and Member Engagement subcommittee and the Provider and Community Experience subcommittee of Medicaid's Program Improvement Advisory Committee. Subcommittee membership has provided a space for the CYSHCN team to influence policy decisions that impact systems of care for CYSHCN. This influence was particularly important when determining the pediatric performance measures for the contracts with Medicaid's Regional Accountability Entities, which impacts care coordination pathways for referral to and between the Regional Accountability Entities. In addition, the CYSHCN team influenced the development of recommendations for the Colorado Medicaid data dashboard to identify disparities among children enrolled in Medicaid, and promoted the policy recommendations outlined in the CYSHCN policy agenda. More recently, the CYSHCN team contributed to the development of recommendations for the care coordination of children with complex needs enrolled in Medicaid. With access to the state's pandemic relief funds, the Medicaid program was able to integrate the recommendations to expand their care coordination definition and increase the use of care managers through emergency rules. Medicaid's Program Improvement Advisory Committee intends to fold these recommendations into the Regional Accountability Entities' contracts in 2023 to ensure Medicaid members have access to a medical home, care coordination and specialty care, including behavioral health services.

Currently the subcommittee conversations are focused on providing input into future changes to Medicaid's Accountable Care Collaborative, referred to as ACC Phase III. Medicaid has shared their goals for the next phase of the program and they have contracted with the Colorado Health Institute to implement their stakeholder engagement plan. Through this contract, Colorado Health Institute teams are meeting with subcommittees and conducting listening sessions to get broader stakeholder input. To ensure consistent and strategic CDPHE input into the process, the CYSHCN Director is co-facilitating a division-wide workgroup that shares information on the ACC Phase III priority areas and to ensure CDPHE leadership has talking points and/or recommendations to take to cross-agency director-level meetings. In addition, members of the CYSHCN team have developed a set of talking points with key data highlights and potential policy recommendations to provide input that will impact the CYSHCN population.

Medicaid and CHP+ have returned to pre-pandemic eligibility renewal processes. Planning for the COVID-19 Continuous Coverage "unwind" started in April 2022 and intensified when the federal guidance was released in January 2023. Notifications to enrollees began in March 2023 for renewals due May 2023. Medicaid will take 12 months (14 months including the initial noticing period) to complete renewals for each of the approximately 1.7 million people currently enrolled. Renewal timing was selected in consultation with county partners and was based on several factors. This timing aligns with when new federal poverty levels will be active in the system, which ensures members are renewed with the new levels in place, thereby reducing county and member rework. Second, this timing is also consistent with the coordinated and collaborative plan already developed with a vast array of stakeholders. Third, it provides the time needed for operational or system adjustments, while still limiting state budget impacts. Last, this takes into account county workers' increased workload implementing changes to the SNAP program beginning in February 2023, given the new federal law. The CYSHCN team supported this process by convening a statewide care coordinator meeting to share a partner toolkit for resources.and by holding discussions with Parent to Parent of Colorado to ensure that families were aware of the timeline, renewal notices and how to respond.

In addition to pediatric focused collaboration with Medicaid, MCH partners with Medicaid on several maternity initiatives. The Accountable Care Collaborative includes the following programs - Maternity Condition Management, Nurse-Family Partnership, Prenatal Plus, and Special Connections. Metrics for these programs are measured and tracked on the Prenatal Care Key Performance Indicators to illustrate areas of opportunity and performance by Regional Accountable Entity, provider, and community. In 2023, the state's Medicaid agency released a report titled the Health First Colorado Maternity Report, completed in partnership with CDPHE/MCH-funded staff. The Hospital Quality Incentive Program operates as a subcommittee of the Colorado Healthcare Affordability and Sustainability Enterprise Board and is comprised of staff from hospitals, the Colorado Hospital Association and Colorado Medicaid. The subcommittee recommends performance measures that form the basis of the incentive payment, recommends how payments should be made, communicates with hospitals and gathers and analyzes data required for the performance measures. The Board's most recent report can be accessed here. MCH staff have been meeting regularly with the team that oversees the Hospital Quality Incentive Program to discuss how the recommendations from CDPHE's Maternal Health Task Force might inform future iterations of the Hospital Quality Incentive Program and other incentive programs administered by the Department of Health Care Policy and Financing.

Lastly, on November 1, 2020, Colorado Medicaid enacted a Maternity Bundle rule, an alternative payment method for perinatal services. The current set of participating providers represent about 25% of all Medicaid births in the state. Year two results from the project will be provided to the participating providers this summer. The Department of Health Care Policy and Financing expects to add more providers this year. The same rule required Colorado Medicaid to create a Maternity Advisory Council composed mainly of black, indigenous and people of color with lived experience in Medicaid maternity care (10 CCR 2505-10 8. 733.2.A.4). The Maternity Advisory Committee, which is now coordinated by the Maternal Health Policy team at the Department of Health Care Policy and Financing, reviews program data, provides input on member quality and experience metrics, and gives recommendations to help improve member experiences and maternity outcomes. Group members provide guidance on the strategic direction of programs, which will guide the Department and providers to improve member experience in maternity care. Members involved in the process also review updates to quality metrics and provide feedback. Advisory Committee members have supported MCH efforts by providing input on the perinatal toxicology guidance, as well as messaging for future iterations of the pregnancy-related depression campaign.

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

State Action Plan Introduction

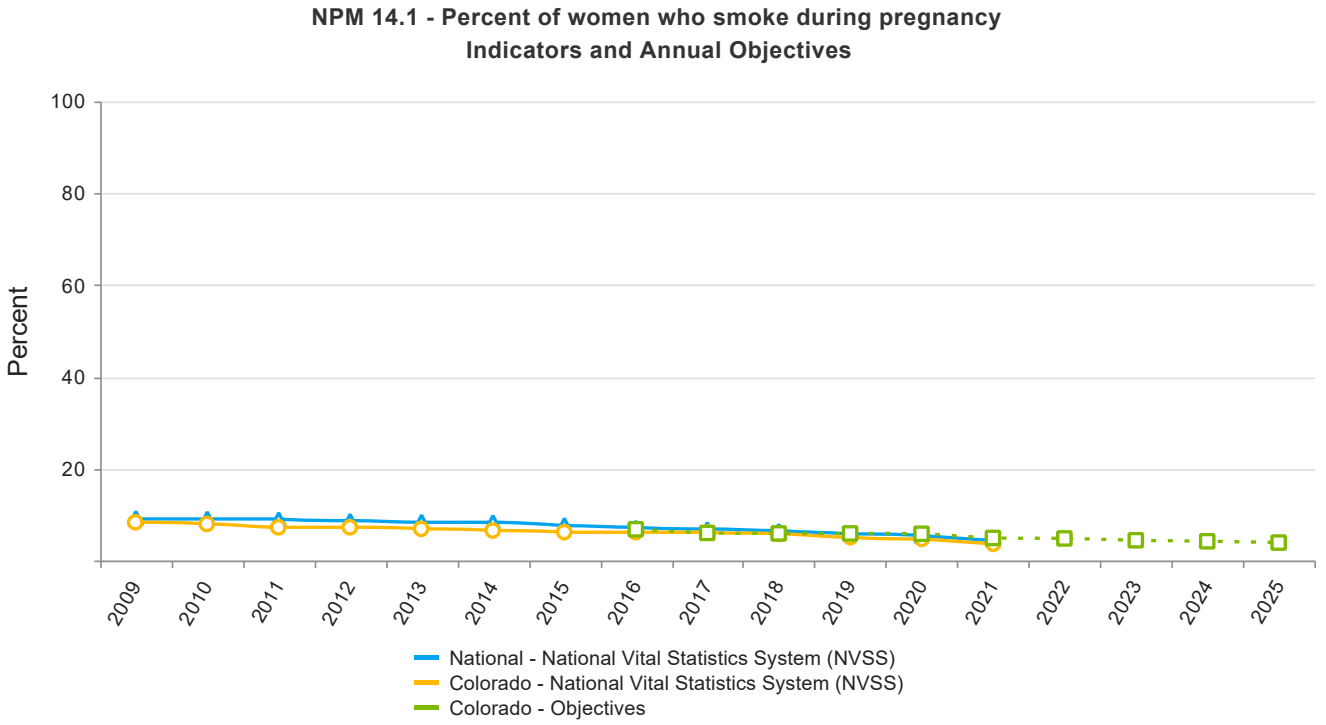
As of September 2023, Colorado's MCH program is completing the third year of state implementation of the 2021-2025 MCH priorities and the second year of local implementation with local public health agencies that receive more than $50,000 annually. As of July 2023, local public health agencies that receive less than $50,000 annually completed their first year of implementation and will enter year two. This phased transition is the result of local contract timelines. Here is a matrix of all agencies' award amounts and selected priorities for fiscal year 2024. and an MCH funding map, effective July 2022.. A statewide interactive map of MCH priorities (see third tab) allows community members to search by county or by priority area to see which MCH priorities are selected in their community and across the state.

The narrative sections for the state action plan summarize priority implementation efforts across each MCH population. Each narrative includes data on progress towards the NPM/ESM and/or SPM and annual objective; a brief description of the prioritized need; MCH funding and other resources being leveraged to address the prioritized need; an overview of the strategies being implemented to impact the prioritized need, as well as the existing evidence for selected strategies. This table outlines Colorado's state and national performance measures for the 2021-2025 MCH block grant cycle, and with which priority they are associated.

Priority	Federal Reported Measures (NPM, ESM, SPM)
Increase Social Emotional Well-being	NPM 14: A) Percent of women who smoke during pregnancy ESM 14.1: Percent of pregnant people insured by Medicaid who smoked during the last three months of pregnancy SPM 4: Percent of women of reproductive age (18-44 years) who report good mental health
Promote Positive Child and Youth Development	NPM 4: A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months ESM 4.1: Percent of births insured by Medicaid at Baby-Friendly hospitals
Improve Access to Supports	NPM 6: Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year ESM 6.1: Percent of children referred to early intervention who do not complete an evaluation NPM 11: Percent of children with and without special health care needs, ages 0 through 17, who have a medical home ESM 11.1: Percent of children with special health care needs ages 0-17 years who receive family-centered care
Increase Prosocial Connection	NPM 9: Percent of adolescents, ages 12 through 17, who are bullied or who bully others ESM 9.1: Percent of youth who identify as transgender who have a trusted adult to go to for help with a serious problem ESM 9.2: Percent of youth of color who have a trusted adult to go to for help with a serious problem
Increase Economic Mobility	SPM 5: Percent of children in poverty according to the supplemental poverty measure.
Reduce Racial Inequities	SPM 3: Number of points for racial equity related policy, practices and systems changes implemented a the program, division and department level
Create Safe and Connected Built Environments	SPM 1: Percent of children ages 0-17 who live in a supportive neighborhood

Women/Maternal Health

National Performance Measures



Federally Available Data					
Data Source: National Vital Statistics System (NVSS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	6	6	5.9	5	4.9
Annual Indicator	6.1	5.9	5.1	4.7	3.7
Numerator	3,940	3,683	3,183	2,909	2,325
Denominator	64,193	62,614	62,644	61,384	62,846
Data Source	NVSS	NVSS	NVSS	NVSS	NVSS
Data Source Year	2017	2018	2019	2020	2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	4.5	4.3	4.0

Evidence-Based or –Informed Strategy Measures

ESM 14.1.1 - Percent of pregnant people insured by Medicaid who smoke during the last three months of pregnancy

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			12.8	11.1
Annual Indicator	14.4	13.4	10	8.3
Numerator				
Denominator				
Data Source	Pregnancy Risk Assessment Monitoring System	Pregnancy Risk Assessment Monitoring System	Pregnancy Risk Assessment Monitoring System	Pregnancy Risk Assessment Monitoring System
Data Source Year	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	9.4	7.7	6.0

State Performance Measures

SPM 4 - Percent of women of reproductive age (18-44 years) who report good mental health

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			45	72
Annual Indicator	44.9	44.1	40.4	69
Numerator				
Denominator				
Data Source	Behavioral Risk Factor Surveillance System	Behavioral Risk Factor Surveillance System	Behavioral Risk Factor Surveillance System	Behavioral Risk Factor Surveillance System
Data Source Year	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	73.0	75.0	77.0

State Action Plan Table

State Action Plan Table (Colorado) - Women/Maternal Health - Entry 1	
Priority Need	
Increase social emotional well-being	
NPM	
NPM 14.1 - Percent of women who smoke during pregnancy	
Objectives	
By September 30, 2024, increase enrollment in the Baby and Me Tobacco Free and QuitLine smoking cessation programs for pregnant and postpartum people by at least 5%.	
Strategies	
Ensure comprehensive screening, referral, and connection to intervention for mental health and substance use among the MCH population for parent, caregiver and child.	
ESMs	Status
ESM 14.1.1 - Percent of pregnant people insured by Medicaid who smoke during the last three months of pregnancy	Active

NOMs

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

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

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

NOM 5 - Percent of preterm births (<37 weeks)

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

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

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

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

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

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

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

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

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

Priority Need

Increase social emotional well-being

SPM

SPM 4 - Percent of women of reproductive age (18-44 years) who report good mental health

Objectives

By September 30, 2024, increase the number of people reached with behavioral health messages in community, clinical and educational settings by 15%.

Strategies

Support universal prevention, early intervention, and treatment of behavioral health among MCH populations.

Priority: Social Emotional Wellbeing
Performance Measures and Annual Objectives

NPM 14a**:** Percent of women who smoke during pregnancy was 3.7%. The annual objective for reporting year 2022 was 4.9%. The annual objective was met. The annual objective for reporting year 2023 is 4.5%.

ESM 14.1: Percent of pregnant people insured by Medicaid who smoke during the last three months of pregnancy was 8.3%. The annual objective for reporting year 2022 was 11.1%. The annual objective was met. The annual objective for reporting year 2023 is 9.4%.

SPM 4: Percent of women of reproductive age (18-44 years) who report good mental health was 69.0%. The annual objective for reporting year 2022 was 72.0%. The annual objective was not met. The annual objective for reporting year 2023 is 73.0%.

The data source for the NPM is the National Vital Statistics System that is administered annually. The data source for the ESM is the Pregnancy Risk Assessment Monitoring System that is administered annually. The data source for the SPM is the Behavioral Risk Factor Surveillance System that is administered annually. As mentioned above, the annual objective for the SPM was not met. Contributing factors may include the negative effects that the pandemic has had on mental health, along with the rising cost of living and economic stressors.

Resource Allocation to Advance this Priority

For this reporting period, MCH Block Grant dollars funded 1.0 FTE of the Maternal and Infant Wellness team at CDPHE across multiple positions; MCH Block Grant dollars were also braided with state General Funds to support 1.0 FTE on the CYSHCN team at CDPHE for the implementation of strategies in the state action plan and for contracts with local public health agencies to implement local action plans. To advance and expand impact, MCH aligned and leveraged funding from the CDC grant that supported the Colorado Perinatal Care Quality Collaborative, state General Funds to reduce maternal mortality, the ERASE Maternal Mortality grant through the CDC, and HRSA funding through the State Maternal Health Innovation and Data Capacity grant. In addition, MCH Block Grant dollars continued to fund a portion of a Tobacco program staff position (0.25 FTE) to serve as a liaison between the Tobacco and MCH programs. Amendment 35 tobacco state tax revenue and a CDC grant continued to provide annual funding for additional tobacco program staff and comprehensive Tobacco program efforts, including MCH-related tobacco activities. Leveraging combined funds enabled the Tobacco program to extend the reach of strategic efforts that reduce the burden of perinatal tobacco use and exposure, increase positive birth outcomes and improve the health of families throughout the lifespan. Funded strategies and key outcomes are summarized below and are reflected in the state action plan for this priority. For a more detailed description, refer to the state action plan.

Strategy Implementation

The social emotional well-being state action plan was designed with the understanding that unmet behavioral health needs negatively impact the health of the individual and their family. The plan includes three broad strategies that allow state and local partners to implement a variety of activities that are meaningful to individual communities and will support social emotional well-being across the lifespan: 1) increase screening, referral, and connection to intervention for mental health and substance use treatment; 2) implement public awareness and school policy efforts focused on reducing the stigma associated with behavioral health and increase social connectedness for school age youth (see the ***Adolescent Health*** section for updates on this strategy); and 3) use data to better understand the root causes of inequities related to social and emotional well-being.

Strategy One: Increase screening, referral and connection to intervention for mental health and substance use treatment.

This first strategy in the social emotional state action plan aims to help systems achieve universal behavioral health screenings for the MCH population in a manner that is trauma-informed, non-stigmatizing, and done with cultural humility. MCH staff from the Maternal and Infant Wellness team partnered with the Colorado Perinatal Care Quality Collaborative to work with Colorado birthing hospitals on a series of quality improvement initiatives to increase screening for behavioral issues in the perinatal population. During this reporting period, 19 hospital labor and delivery units participated in a learning collaborative that provided support in implementing the Alliance for Innovation on Maternal Health's patient safety bundle for Obstetric Care for People with Substance Use Disorders. Hospitals received customized technical assistance to implement screening, identify local resources, support provider education, assist with data collection, and use customized reports to track outcomes and progress towards ensuring universal screening and care for patients identified with behavioral health concerns. This included participation in Screening Brief Intervention Referral to Treatment (SBIRT) trainings and assistance in selecting validated screening tools, revising workflows/protocols, updating electronic medical records, and developing resources and community connections to strengthen patient referrals. As of September 2022, 64 percent of the Colorado

hospitals in the learning collaborative reached sustainability in screening practices for substance use disorder, screening at least 90 percent of patients admitted to the labor and delivery unit. In the same period, 82 percent reached sustainability for screening for depression and anxiety.

A key component of this strategy is building the capacity of a perinatal mental health workforce that is well equipped to support patients who are facing challenges with perinatal substance use. MCH staff partnered with the state's Behavioral Health Administration, the Colorado Chapter of Postpartum Support International, and the University of Denver Graduate School of Professional Psychology, to develop and host an in-person training entitled *Connecting the Dots: Understanding the Intersection of Maternal Mental Health and Substance Use During Pregnancy and Early Parenthood.* Ninety perinatal professionals representing a wide variety of roles (therapists, nurses, doulas, case managers, etc.) registered for the training, with a waitlist of over 40 people. The training covered:

- understanding maternal perinatal substance use;
- social justice, systemic racism, and substance use disorders;
- the intersection between substance misuse, attachment histories, and our regulatory system; and
- a history of perinatal substance use and treatment.

In pre- and post-training surveys, participants indicated:

- an increase in knowledge and comfort across all domains (average of at least a full one point increase);
- 96% of respondents said they would recommend the training to a colleague;
- 85% of respondents said the program substantially enhanced their professional experience; and
- 96% of respondents found the content extremely useful.

Program staff are working on future iterations of the training, including a virtual option for greater statewide reach, online modules, and working with Postpartum Support International Central on the possibility of incorporating this content into their training materials.

MCH resources also supported the launch of a Colorado Chapter of the Perinatal Mental Health Alliance for Professionals of Color ("Health Alliance"). The Health Alliance serves to build infrastructure for mental health professionals of color to collaborate and strengthen support and referral networks. The Health Alliance is the result of a year-long series of targeted stakeholder interviews that focused on community-based solutions to address birth equity in Colorado and to increase the community's collective capacity to care for and support pregnant and parenting people. The Health Alliance is a national model that is embedded within the Colorado Chapter of Postpartum Support International. Collaboration with Postpartum Support International will allow Colorado's Health Alliance to connect with other communities across the nation, while also keeping a local voice and perspective. During this first phase of convening, the Health Alliance will develop a strategic vision and related goals to guide future efforts. Ultimately, the goal is to support a more diverse perinatal mental health workforce that will allow more people of color to receive culturally congruent care.

The MCH program at Tri-County Health Department and the Public Health Institute at Denver Health created a no cost training and action planning sessions to promote perinatal mental health and build workforce capacity. The two-hour sessions are designed to help service providers, organizations, and communities understand and embrace their role in supporting perinatal mental health. Participants learned about the Perinatal Continuum of Care, a framework that highlights opportunities across sectors to promote and address perinatal mental health and develop action plans that incorporate effective strategies that are applicable across sectors.

MCH staff also participated in the leadership team of the Colorado Maternal Mental Health Collaborative and Framework. The Collaborative represents a partnership of individuals and organizations committed to accelerating progress toward improved mental health and wellness of all pregnant and postpartum people in Colorado. This year the Collaborative had multiple policy impacts, with participating partners informing and monitoring bills that advance the four primary goals of Colorado's Maternal Mental Health Framework: Supportive Community; Maximized Prevention; Universal Screening and Appropriate Referral; and Comprehensive, Inclusive, and Responsive Continuum of Care.

An analysis of labor and delivery practices highlighted that the use of toxicology testing for substance use in pregnancy and during the labor and delivery period varied across hospitals and among individual providers. This analysis indicated that families of color were being tested at higher rates than white families, without adherence to consistent guidelines. To address this issue, MCH staff co-chaired a Policy Analysis Workgroup in partnership with Illuminate Colorado, a non-profit organization whose mission is to strengthen families and prevent child maltreatment. The workgroup created an evidence-based, equitable framework that labor and delivery hospitals can use to shape policy and practice for when and how to use toxicology tests to guide the care of birthing parents and newborns, understand lactation considerations, and determine how and when to engage child welfare. The members of the workgroup ranged from people with lived experience, lactation consultants, advocates, toxicologists, and providers, leading to many diverse perspectives and challenging conversations about the most equitable ways to support families and the most appropriate uses of toxicology testing. The guide was

finalized in the spring of 2023 and was shared with the Colorado Perinatal Care Quality Collaborative.

Tobacco use continues to negatively impact pregnancy outcomes and disproportionately impacts families with lower incomes, people of color, LGBTQ+ populations, and persons with a mental health diagnosis. There are a variety of reasons for these disparities, including these populations being historically targeted by the tobacco industry, as well as the chronic exposure to stress caused by racism as a determinant of health. In November 2020, Colorado voters approved a new tobacco tax that went into effect in January 2021, resulting in an increase of $1.10 per pack of cigarettes. Tobacco price increases are known to decrease smoking among pregnant people. The decrease in smoking reflected in the NPM and ESM, may be partly due to the tax increase. The QuitLine continued to offer a suite of evidence-based phone and digital tobacco cessation and treatment services for pregnant people, including a tailored pregnancy and postpartum protocol. During the reporting period, 263 pregnant people enrolled in the pregnancy protocol program.

The Baby and Me Tobacco Free™ Program continued to serve pregnant people and their partners across Colorado by providing perinatal smoking cessation services. During the reporting period, the program enrolled 391 pregnant people and their partners. Enrollees participated in either the in-person or telehealth modality. Baby and Me focused on increasing enrollment of Black pregnant people and their partners by actively engaging with organizations and providers that serve pregnant people of color. It also ensured that both in-person and telehealth modalities were available for potential enrollees in areas with significant BIPOC populations. The State Tobacco Education, Prevention, and Cessation Grants Program (STEPP) collaborated with the Colorado Black Health Collaborative to increase awareness of Baby and Me Tobacco Free™ and the QuitLine pregnancy protocol program in order to increase reach, especially to Black pregnant people and their partners. The Baby and Me Tobacco Free™ Program Coordinator and STEPP Project Officer were invited to join the Colorado Black Health Collaborative's Real Talk Facebook Live to talk about the program.

Comprehensive tobacco treatment benefits, including individual and group telephone counseling and FDA-approved medications, were available to all Colorado Medicaid members with no cost-sharing or prior authorization requirements. Tobacco treatment services offered through the QuitLine, Baby and Me Tobacco Free™, and Medicaid were available to any pregnant person or partner seeking help for any form of nicotine use or dependence, including e-cigarette use. Of the 391 total enrollments to the program, approximately 80 percent were Medicaid members.

Screening and connection to early intervention for mental health and behavioral concerns should begin early in the lifespan, and in the past year, MCH staff strengthened partnerships with programs that support pediatric behavioral health through both practice and evidence-based interventions. HealthySteps®, a program of ZERO TO THREE®, is an evidence-based and team-based pediatric primary care program that promotes nurturing parenting for babies and toddlers to support healthy development. In Colorado, Assuring Better Child Health and Development (ABCD) is the state intermediary for the implementation of the HealthySteps® program serving a wide range of communities throughout the state. HealthySteps® sites serve a high number of families with at least one of six risk factors that indicate a greater need for family support to promote healthy child development and integrated behavioral health. In the last year, HealthySteps® added almost 7,000 new children and onboarded six new sites, expanding the program's reach to 33,130 children ages 0-3 across the state via 29 sites. Technical assistance for sites was provided by ABCD to optimize program implementation. Professional development included monthly community of practice calls, a professional development series, and consultation on shared decision-making and motivational interviewing. As the state intermediary, ABCD supported the development of a "billing playbook" with a training webinar to maximize sites' Medicaid billing,which can help with overall site sustainability. The MCH Early Childhood Systems Specialist joined the Regional HealthySteps® Advisory Council, along with members from the state's Medicaid agency, and representatives from Medicaid's Regional Accountable Entities, to support the sustainability and growth of the program.

Strategy Three: Increase state investment in addressing inequities and population disparities related to social emotional well-being through data collection and dissemination and by incorporating people with lived experience into decision making processes.
With support from the MCH program, in 2021 CDPHE's Center for Health and Environmental Data published a report based on Health eMoms data entitled Postpartum Behavioral Health in Colorado. This report was shared widely, and stakeholders have been using it to drive funding decisions and local programming. MCH staff partnered with community stakeholders to inform legislation in 2022 that resulted in the allocation of ongoing state General Funds to provide sustainable funding for this unique source of data.

Colorado's Maternal Mortality Review Committee is charged with reviewing all the cases of maternal death in the perinatal period in Colorado to determine the factors surrounding the death and to make recommendations to help prevent future deaths. While the reviews represent the most tragic and worst case scenarios, recommendations have far reaching implications that would decrease maternal morbidity and improve maternal health and well-being. In alignment with the MCH strategic anchors of community inclusion and racial equity, the Review Committee diversified its membership to include

more people who have been affected by the drivers of maternal mortality. In 2021, 19 new members were onboarded, including ten members who identify as being from a marginalized community and six members with lived experience related to maternal health. In 2022, an additional two community members joined the committee. To support recruitment, MCH staff worked with the state Medicaid agency to share the opportunity in a patient-facing Medicaid newsletter. The application was also shared through various social media channels, such as parent support groups and other community-facing organizations. In an effort to address barriers to participation on the committee, participants were offered compensation for their time and expertise. The community members have been essential in naming the ways in which racism and discrimination are embedded within the healthcare system and affect a person's health outcomes.

The Maternal Mortality Prevention Program disaggregated data from 2016-2020, focusing on the disparities in maternal mortality across race and ethnicity. For the first time, by aggregating multiple years of data, Colorado data mirrored the national data that shows Black pregnant and postpartum people are three times more likely to die during the perinatal timeframe from causes directly related to pregnancy. A legislative report discussing these disparities will be released later this summer.

MCH contributed to funding a regional oversample of the National Survey of Children's Health that includes questions about social emotional well being. See ***Section III.E.2.b.iii. MCH Data Capacity*** for more about the oversample.

Priority: Social Emotional Wellbeing

Performance Measures and Annual Objectives

NPM 14a: Percent of women who smoke during pregnancy. The NPM 14a annual objective for reporting year 2024 is 4.3%.

ESM 14.1: Percent of pregnant people insured by Medicaid who smoke during the last three months of pregnancy. The ESM 14.1 annual objective for reporting year 2024 is 7.7%.

SPM 4: Percent of women of reproductive age (18-44 years) who report good mental health. The SPM 4 annual objective for reporting year 2024 is 75.0%.

Resource Allocation to Advance this Priority

For the upcoming reporting period, MCH Block Grant dollars will continue to support 1.0 FTE of the Maternal and Infant Wellness team at CDPHE across multiple positions; with continued braiding of state General Funds to support 1.0 FTE on the CYSHCN team for the implementation of the strategies outlined in the state action plan; and contracts with local public health agencies to implement social emotional wellness local action plans. To advance and expand impact, MCH will align with and leverage funding from the CDC grant that supports the Colorado Perinatal Care Quality Collaborative, state General Funds to reduce maternal mortality, ERASE Maternal Mortality grant through the CDC, and HRSA State Maternal Health Innovation and Data Capacity grant. In addition, MCH Block Grant dollars will continue to fund a portion of a Tobacco position (0.25 FTE). Amendment 35 tobacco state tax revenue and a CDC grant will continue to provide annual funding for additional Tobacco staff and MCH focused tobacco activities. Leveraging braided funds enables CDPHE's Tobacco program to extend the reach of strategic efforts that reduce the burden of perinatal tobacco use and exposure, increase positive birth outcomes and improve the health of families throughout the lifespan. The strategies (1 and 3) planned for the upcoming year for this priority are summarized below. Details about plans for strategy 2 can be found in the ***Adolescent Health Application for the Coming Year*** section. For a more detailed description, refer to the state action plan.

Strategy Implementation

Strategy One: Increase screening, referral and connection to intervention for mental health and substance use treatment.

For the upcoming reporting period, the Colorado Perinatal Care Quality Collaborative will continue to coordinate the hospital learning collaborative. The focus will be on increasing the number of individuals who are connected to treatment and support after a positive screen for behavioral health concerns, and expanding the number of facilities participating in the learning collaborative. Funding from the HRSA State Maternal Health Innovation and Data Capacity grant will be leveraged to build each facility's capacity for meaningful and accurate data collection.

The toxicology best practice guidance work will be implemented in the coming year, with a focus on partnering with the quality collaborative to support the implementation of this guidance both with hospitals participating in their learning collaborative and with hospitals across the State.

The QuitLine will continue to offer a suite of evidence-based phone and digital tobacco cessation services for pregnant people, including a tailored pregnancy/postpartum protocol.
The Tobacco program will promote the Quitline with pregnant people via Quitline Facebook posts, Tobacco Free Colorado Facebook posts, Quitline Twitter posts and Tobacco Free Colorado Twitter posts. As of July 2023, the Tobacco program started contracting with the University of Colorado Denver's Cancer Center to oversee the implementation of the Baby and Me Tobacco Free Program™ statewide. The team at the University has provided data and evaluation services for the program for several years. The Tobacco program will focus on strengthening local health provider participation and improved enrollment amongst communities of color and will continue to actively partner with organizations and providers that serve pregnant people of color. It will also ensure that both in person and telehealth modalities are available for potential enrollees in areas with significant BIPOC populations. CDPHE will continue discussions with the state's Medicaid program to explore avenues to expand the accessibility and sustainability of Baby and Me Tobacco Free™ through an interagency partnership.

Strategy Three: Increase state investment in addressing inequities and population disparities related to social emotional well-being through data collection and dissemination and by incorporating people with lived experience into decision making processes.

In the upcoming year, the MCH program will continue to leverage funds to support the Maternal Mortality Review Committee, charged with reviewing all the cases of maternal death in the perinatal period in Colorado to determine the factors surrounding the death and to make recommendations to help prevent future deaths.

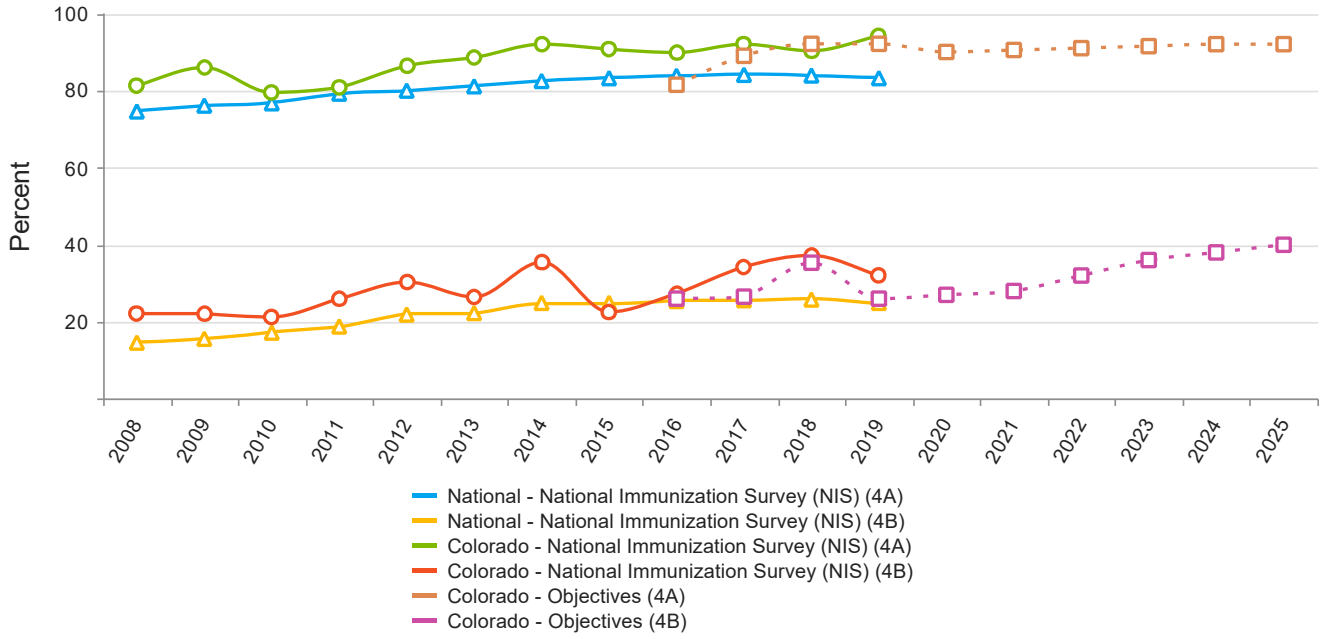
A new iteration of the developmental screening and referral data dashboard was released this year. The revised format includes one comprehensive annual dashboard release in April and four quarterly releases to better analyze screening and referral data trends from Early Intervention Colorado, Colorado HealthySteps® sites, and Colorado's state Medicaid program. A public-facing version of this internal data dashboard is in progress and in the upcoming year will be shared with key local, state and community partners for the purpose of identifying gaps and outlining critical next steps towards building improved social emotional screening and referral outcomes. Program staff will continue to collaborate with interagency partners to further crosswalk available data sources and disaggregated data to better understand the root causes of inequities related to social-emotional well-being, screening, referral, and access to behavioral health supports and early intervention services in the birth to three population.

The MCH program will also be analyzing the three years of data obtained through the state's oversample of the National Survey of Children's Health to illuminate disparities related to social emotional well being for the pediatric population.

Perinatal/Infant Health

National Performance Measures

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



NPM 4A - Percent of infants who are ever breastfed

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	92.1	92.1	90	90.5	91
Annual Indicator	90.9	89.7	92.2	90.1	94.0
Numerator	58,722	57,030	51,548	57,471	50,538
Denominator	64,623	63,579	55,918	63,762	53,772
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2015	2016	2017	2018	2019

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	91.5	92.0	92.0

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

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	35.3	26	27	28	32
Annual Indicator	22.4	27.3	34.1	37.3	32.1
Numerator	14,311	17,330	18,695	22,829	16,627
Denominator	63,830	63,405	54,859	61,261	51,807
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2015	2016	2017	2018	2019

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	36.0	38.0	40.0

Evidence-Based or –Informed Strategy Measures

ESM 4.1 - Percent of births insured by Medicaid at Baby-Friendly hospitals

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			38.7	36
Annual Indicator	38.2	37.9	35.5	36
Numerator	8,993	8,418	7,969	7,953
Denominator	23,546	22,212	22,447	22,118
Data Source	Birth Certificate	Birth Certificate	Birth Certificate	Birth Certificate
Data Source Year	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	37.0	37.5	38.0

State Action Plan Table

State Action Plan Table (Colorado) - Perinatal/Infant Health - Entry 1	
Priority Need	
Promote positive child and youth development	
NPM	
NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months	
Objectives	
By September 30, 2024, the percent of births at Baby-Friendly designated hospitals is maintained at approximately 37%.	
Strategies	
Build nutrition security through increased access to breastfeeding supportive environments in communities facing the greatest racial/ethnic disparities.	
ESMs	**Status**
ESM 4.1 - Percent of births insured by Medicaid at Baby-Friendly hospitals	Active
NOMs	
NOM 9.1 - Infant mortality rate per 1,000 live births	
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	

Priority: Positive Child & Youth Development

Performance Measures and Annual Objectives

NPM 4a: Percent of infants who are ever breastfed was 94.0%. The annual objective for reporting year 2022 was 91.0%. The annual objective was met. The annual objective for reporting year 2023 is 91.5%.

NPM 4b: Percent of infants breastfed exclusively through 6 months was 32.1%. The annual objective for reporting year 2022 was 32.0%. The annual objective was met. The annual objective for reporting year 2023 is 36.0%.

ESM 4.1: Percent of births insured by Medicaid at Baby-Friendly certified hospitals was 36.0%.
The annual objective for reporting year 2022 was 36.0%. The annual objective was met. The annual objective for reporting year 2023 is 37.0%.

The data for NPMs 4a and 4b comes from CDC's National Immunization Survey that is updated annually. The data for the ESM comes from Colorado Vital Statistics and is updated annually.

Resource Allocation to Advance this Priority

For this reporting period, MCH Block Grant dollars funded staff time (0.4 FTE) to implement breastfeeding strategies in this priority's action plan. MCH leveraged additional funding from the CDC's State Physical Activity and Nutrition grant to pay for staff time (0.35 FTE) and technical assistance and hospital recognition. Additionally, CDPHE was able to secure special breastfeeding supplemental funding through the SPAN grant for equity and physician training activities. Other breastfeeding FTE and associated strategy work was funded through the USDA Special Supplemental Nutrition Program for Women, Infants and Children program (0.2 FTE) and the state-funded Cancer, Cardiovascular and Pulmonary Disease grant program (0.05 FTE). In addition to breastfeeding support and promotion, MCH Block Grant dollars funded three positions totalling 1.05 FTE of staff time to build nutrition security through increased access to nutrient-rich locally grown food. The strategies and associated outcomes for this priority are summarized below. For a more detailed description, refer to the state action plan.

Strategy Implementation

Research shows that community-based breastfeeding initiatives to develop supportive policies and environments increase breastfeeding support, increase access to care, and influence positive social connections and mental health.[1],[2] The NPMs and ESM were selected because research shows that as the number of evidence-based Baby-Friendly Hospital Initiative's *Ten Steps to Successful Breastfeeding* practices increase in a hospital, breastfeeding rates increase as well. This is especially true for families with Medicaid health insurance or no insurance and families participating in the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), where significant increases in breastfeeding initiation and long term success is shown when Baby-Friendly policies were in place at a hospital. Additionally, Baby-Friendly certification in Colorado shows a specific health equity impact, with all races/ethnicities initiating breastfeeding at or above 90 percent at discharge at hospitals that are Baby-Friendly certified, compared with significantly lower breastfeeding initiation rates for Black/African American, American Indian and mixed race families at hospitals not Baby-Friendly designated or participating in the Colorado Baby-Friendly Hospital Collaborative.

The positive child and youth development priority includes a focus on building nutrition security through increased access to breastfeeding supportive environments in communities facing the greatest racial/ethnic disparities. Within this priority, strategies focus on development of breastfeeding supportive policies and environments in hospitals, medical offices, workplaces, child care programs, community resource centers, and county jails. Hospitals and medical offices serving a high proportion of patients insured by Medicaid, workplaces with hourly and lower-income workers, community resource centers serving families of color, and publicly-funded county jail systems are of specific focus to remove known barriers to breastfeeding and improve health equity practices and breastfeeding support.

Breastfeeding staff emphasize implementation of evidence-based breastfeeding supportive maternity care practices in Colorado as data shows hospital practices impact both initiation and breastfeeding exclusivity and duration rates beyond the hospital setting. For instance, the Colorado Pregnancy Risk Assessment Monitoring System (PRAMS) survey results show the importance of hospital support on breastfeeding duration. Parents who report receiving at least five of the *Ten Steps* during their hospital stay not only initiate breastfeeding at higher rates but also have more than two months longer breastfeeding duration compared to parents who do not report receiving at least five of the *Ten Steps* in the hospital.

Implementing the evidence-based *Ten Steps* improves breastfeeding prevalence and increases breastfeeding support throughout local communities with a health equity, population health impact. The Colorado Baby-Friendly Hospital Collaborative has seen success assisting hospitals to achieve Baby-Friendly designation since its creation in 2013, when only three hospitals in Colorado were designated, to 14 designated hospitals in 2022, serving more than 36 percent of births

in the state each year. Additionally, by the end of the 2023 calendar year, it is anticipated the number of Baby-Friendly designated hospitals will rise to 16 in Colorado. Based on the previous successes of the Collaborative, ESM 4.1 is designed to create a focus on recruiting hospitals with the highest percent of births insured by Medicaid to join the Collaborative and support facilities to become Baby-Friendly certified. Families with lower incomes often experience greater inequities in receiving breastfeeding support. Focusing on hospitals serving larger proportions of Medicaid-paid births will support more families to breastfeed and continue breastfeeding longer.

The Colorado Baby-Friendly Hospital Collaborative is one of the most successful state initiatives to address hospital support of breastfeeding. During this reporting year the Collaborative expanded to include 28 birth facilities, which is more than half of all birthing facilities in the state. In September 2022, 28 individuals from 22 member facilities participated in the Collaborative's Annual Networking Workshop - a virtual one-day technical assistant event for hospitals to achieve and maintain Baby-Friendly designation. To further enhance this work and continuity-of-care strategies, through the SPAN grant's breastfeeding supplemental funding, a free, online, interactive, asynchronous breastfeeding training for physicians and health care providers was developed with assistance from community training experts and in alignment with Baby-Friendly USA training requirements. The online training will be available for years to come and will provide continuing education credits as incentive for health care providers to take the eight-part training series. Additionally, the Breastfeeding Specialist participated in national discussions on the White House's newly proposed Birthing Friendly recognition program for hospitals to ensure Baby-Friendly and breastfeeding support is included in the new proposed national program.

To expand implementation of statewide policies and practices that promote, support, and protect breastfeeding, the Breastfeeding Specialist assisted Colorado's Medicaid program, the Colorado Governor's Office, and the Office of Saving People Money on Health Care regarding the infant formula crisis and 2022 legislation (HB22-1289) to expand breastfeeding coverage in Colorado Medicaid. Due to the national infant formula crisis in 2022, CDPHE assisted in the execution of an Emergency Declaration and Executive Order by the Governor's Office to provide emergency funds for free donor human milk to anyone in need. This included budget, contracting, and communication assistance between state agencies, Mothers' Milk Bank (Colorado's regulated donor human milk bank), WIC, and the public. CDPHE's Breastfeeding Specialist collaborated with community advocacy groups and the state's Medicaid program in crafting the legislative language to improve lactation support benefits in Colorado Medicaid. Since HB22-1289 passed in May 2022, CDPHE has assisted in policy creation and implementation to include providing breast pumps as well as advanced lactation care for Medicaid members, while no longer requiring WIC enrollment. These policy changes will remove barriers and provide equitable access to breastfeeding support for families with low incomes.

Beyond the hospital setting, employers, child care and health care providers play critical roles in supporting breastfeeding duration and exclusivity. Breastfeeding staff worked with community partners, including local public health agencies and the Colorado Breastfeeding Coalition, to develop, pilot, and implement three statewide lactation-friendly recognition programs for workplaces, child care providers, and medical offices. All of these lactation-friendly programs include resources such as toolkits and online trainings, as well as statewide recognition from the Coalition. Additionally, all available resources have been transcreated into Spanish. Since the start of these recognition programs, which began in local communities in 2016, over 600 worksites (serving over 100,000 employees), over 180 child care programs/providers (including both licensed and unlicensed programs and family, friend and neighbor providers), and 16 medical offices have been supported and achieved lactation-friendly recognition. While incubated with MCH support, these programs have become sustainable beyond MCH funding through other incentives. For example, breastfeeding friendly practices are now embedded in the Office of Early Childhood's Quality Rating and Improvement System, as a way for early care and education programs to receive child health points in the Colorado Shines quality rating system.g

Additional community-based work included partnerships with the Colorado Breastfeeding Coalition, Colorado WIC, and Advancing Breastfeeding in Colorado (ABC; one of the state funded Cancer, Cardiovascular and Pulmonary Disease grantees) to provide advanced lactation training, public resources, and mini-grant funding. In August 2022, CDPHE assisted community partners and the Coalition in hosting the annual Breastival - a free family festival to connect the community to breastfeeding resources and services. In September 2022, CDPHE assisted partners in hosting the biennial Colorado Lactation Conference, in which over 150 individuals from the region attended the one-day virtual conference to enhance breastfeeding knowledge and support. In April 2023, breastfeeding staff trained 109 WIC staff and 36 non-WIC community members and public health staff in advanced breastfeeding training at the free WIC Lactation Specialist virtual training. The training is also in the process of being developed into asynchronous online trainings for WIC staff and the general public. Additionally, during the reporting year, approximately $36,000 in mini-grants (funded by ABC and the Colorado Breastfeeding Coalition) were awarded to community organizations and individuals to fund advanced lactation training and implement

community-driven strategies to increase rural access to care.

In partnership with The Center for African American Health, a community needs assessment of Black breastfeeding report was performed in 2021, resulting in the widely disseminated *Colorado Black Breastfeeding Report*. This community work led to a new partnership with a Black woman owned small business, Mama Bird Doula Services. Mama Bird is a community nonprofit serving Black families and families of color in the Denver metro area through prenatal, birth, and postpartum doula services. With this partnership and SPAN grant supplemental breastfeeding funding, CDPHE was able to provide advanced lactation training scholarships to 37 individuals of color (doulas and other community members), create community-led lactation classes, support groups and one-on-one lactation care for families of color. Through these efforts and the additional available leveraged funding, Colorado went from having three International Board Certified Lactation Consultants who identify as a person of color, to ten, thus increasing diversity in the lactation field in Colorado.

After soliciting input from over 300 community members, the Perinatal Behavioral Health Specialist and Breastfeeding Specialist created content for a new *Cannabis, You and Your Baby* handout for families. Community input dramatically improved the final version and helped to alter CDPHE's language (e.g., using "cannabis" rather than "marijuana") and adoption of a harm-reduction approach to educational materials for the public. Additionally, this project led to the development of new clinical guidance documents for health care providers on cannabis use during pregnancy and lactation that includes comprehensive literature review summaries, toxicology and screening information, and policy recommendations. Dissemination of the newly created materials will continue through the next reporting year.

[1] Johnston M, et.al. *Pediatrics*. 2012. https://pubmed.ncbi.nlm.nih.gov/22371471/

[2] Office of the Surgeon General. 2011. https://www.ncbi.nlm.nih.gov/books/NBK52682/

Priority: Positive Child & Youth Development
Performance Measures and Annual Objectives

NPM 4a: Percent of infants who are ever breastfed. The NPM 4a annual objective for reporting year 2024 is 92.0%.

NPM 4b: Percent of infants breastfed exclusively through 6 months. The NPM 4b annual objective for reporting year 2024 is 38.0%.

ESM 4.1: Percent of births insured by Medicaid at Baby-Friendly certified hospitals. The ESM 4.1 annual objective for reporting year 2024 is 37.5%.

Resource Allocation to Advance this Priority

For the upcoming reporting period, MCH funding will continue to support staff time to implement breastfeeding strategies in the Positive Child and Youth Development priority action plan. MCH will continue to leverage funding from the CDC State Physical Activity and Nutrition (SPAN) grant to pay for staff time and technical assistance and hospital recognition. Additional breastfeeding FTE (and associated strategy work) will be funded through the USDA Special Supplemental Nutrition Program for Women, Infants and Children (WIC). In addition to breastfeeding support and promotion, MCH Block Grant dollars will continue to fund staff time to build nutrition security through increased access to nutrient-rich locally grown food. The strategies planned for the upcoming year for this priority are summarized below. For a more detailed description, refer to the state action plan.

Strategy Implementation

Staff will continue to convene the Advisory Committee of the Colorado Baby-Friendly Hospital Collaborative to plan for technical assistance and hospital recruitment strategies, as well as, to review the Collaborative's annual needs survey results. The Collaborative will continue to recruit hospitals, especially those with the highest percentages of births paid by Medicaid, to join the Collaborative and provide technical assistance to Collaborative members to implement Baby-Friendly hospital guidelines and increase breastfeeding support for families with lower incomes. One in three (36.0 percent) births in Colorado insured by Medicaid occurred at Baby-Friendly certified hospitals in 2022. Colorado aims to reach 38.0 percent by 2025.

To expand implementation of policies and practices that promote, support and protect breastfeeding, breastfeeding staff will engage at least two state agencies and/or hospital systems to identify at least one policy to implement that promotes, supports and protects breastfeeding. Staff will explore with one hospital system potential barriers to implement system-wide breastfeeding supportive policies and practices, including Baby-Friendly certification, and report on the discussion to inform future activities.

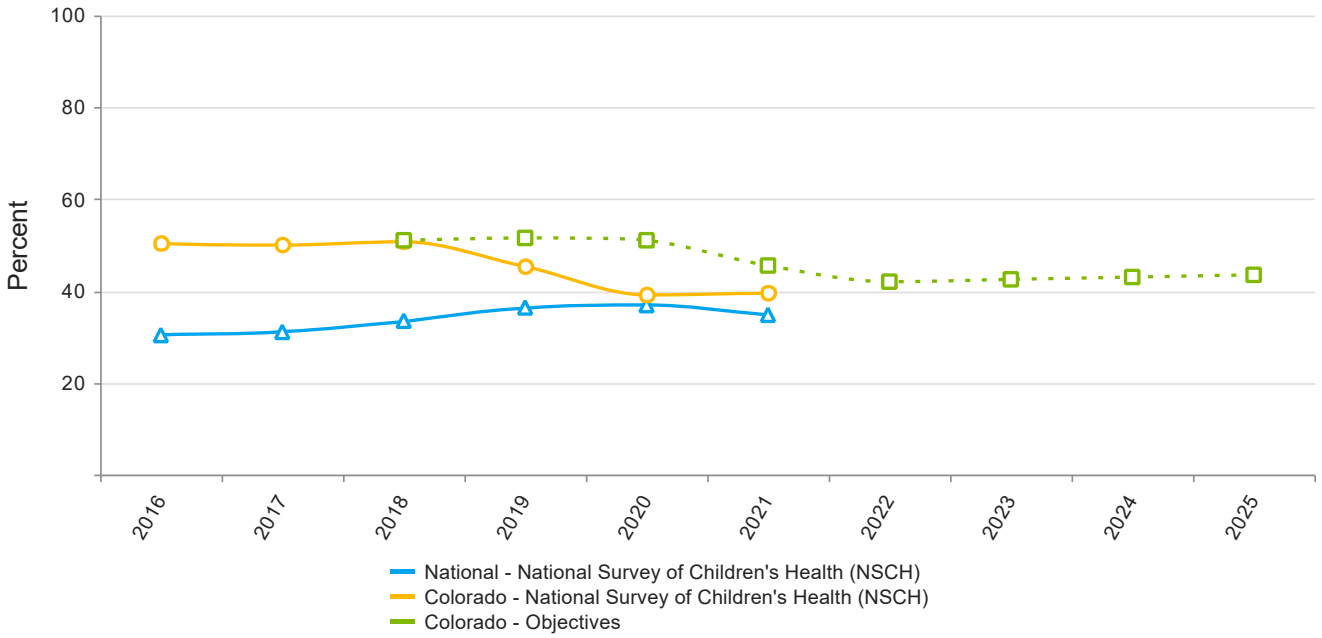
Breastfeeding staff will continue to provide technical assistance in community settings (e.g., medical offices, schools, worksites, home visitor programs, jails, early care and education, etc.) to support the continuation of breastfeeding. Staff will identify or develop at least two state trainings and/or resources to build capacity of staff in community settings to become breastfeeding-supportive environments. Staff will continue to support the Center for African American Health, Mama Bird Doula Services, the Black Breastfeeding Coalition of Colorado and Families Forward Resource Center to advance breastfeeding activities focused on improving breastfeeding support in Black/African American families. Additionally, staff will: partner with the Colorado Breastfeeding Coalition to explore creation of statewide resources and Lactation Friendly recognition programs; support breastfeeding policies in school systems to include students and employees; and convene partners to develop online asynchronous lactation trainings for health care providers and community health workers.

Child Health

National Performance Measures

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Indicators and Annual Objectives



Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	51	51.5	51	45.5	42
Annual Indicator	49.9	50.5	45.2	39.0	39.6
Numerator	73,016	89,845	76,174	53,733	55,492
Denominator	146,238	177,856	168,605	137,773	140,204
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	42.5	43.0	43.5

Evidence-Based or –Informed Strategy Measures

ESM 6.1 - Percent of children referred to early intervention who do not complete an evaluation

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			40	35
Annual Indicator	40.7	40	32.3	22.2
Numerator	14,999	5,598	4,857	3,808
Denominator	36,885	14,007	15,019	17,150
Data Source	Early Intervention Colorado	Early Intervention Colorado	Early Intervention Colorado	Early Intervention Colorado
Data Source Year	2018-2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	22.0	21.0	20.0

State Action Plan Table

State Action Plan Table (Colorado) - Child Health - Entry 1	
Priority Need	
Improve access to supports	
NPM	
NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year	
Objectives	
By September 30, 2024, provide consultation and active implementation support for at least three projects where state or local MCH-related digital health modernization efforts are identified, including a focus on referrals.	
Strategies	
Advance MCH priorities through the integration of technology strategies.	
ESMs	**Status**
ESM 6.1 - Percent of children referred to early intervention who do not complete an evaluation	Active
NOMs	
NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)	
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	

Priority: Access to Supports

Performance Measures and Annual Objectives

NPM 6: Percent of children, ages 9-35 months, who received a developmental screening using a parent-completed screening tool in the past year was 39.6%. The annual objective for reporting year 2022 was 42.0%. The annual objective was not met. The data for this measure has a wide 95% confidence interval (14.8 percentage points) as a result of the small sample size (340 children, ages 9-35 months). The annual objective for reporting year 2023 is 42.5%.

ESM 6.1: Percent of children referred to early intervention who do not complete an evaluation was 22.2%. The annual objective for reporting year 2022 was 35.0%. The annual objective was met. The annual objective for reporting year 2023 is 22.0%.

The data source for the ESM is Early Intervention Colorado and is compiled quarterly and annually.

As noted above, the annual objective for NPM 6 was not met. Developmental screening rates are closely tied to well child visits and the decline in well child care during the pandemic has been well documented. While the overall rate of developmental screening is trending in the wrong direction, the rate of children who receive an evaluation once referred is trending in a positive direction, as measured by the ESM.

Resource Allocation to Advance this Priority

For this reporting period, MCH Block Grant dollars were braided with state General Funds to support approximately 3.0 FTE on the CYSHCN team and .35 FTE on the Health Informatics and Telehealth and Digital Inclusion teams at CDPHE; implementation of strategies in the state action plan; and contracts with local public health agencies to implement local action plans that support the CYSHCN population. The CYSHCN team leveraged additional MCHB grant funds (the Pediatric Mental Health Care Access Grant) to continue and/or expand several existing partnerships and to support state and local implementation efforts. The funded strategies and associated outcomes are summarized below. For a more detailed description, refer to the full state action plan.

Strategy Implementation

The access to supports priority includes, but extends beyond, access to health care services. This is based on the understanding that the health of individuals and families is primarily influenced by non-medical factors such as food, housing, social connectedness and safety, often referred to as social and structural determinants of health (CDPHE Office of Health Equity, 2018). Policy and systems improvements are needed to support whole-person care and make it easier for women, children, youth and families living in Colorado to access the comprehensive services and supports they need. This includes strengthening partnerships, communication, coordination and collaboration across and between organizations and systems that provide support for women, children, youth, and their families.

Most systems are made up of some combination of people (i.e., both those seeking and those providing services and supports), process(es) used by those people (i.e., getting or giving a referral) and technology (i.e., interoperable data systems, a website, or an app on a smartphone). Using this lens, the state action plan for the access to supports priority focuses on the following strategies: 1) increase equitable access to and use of specialty care, with a focus on behavioral health; 2) enhance provider and system capacity to bridge healthcare and other partners; and 3) use data to identify, illuminate, and address access, utilization, and outcome inequities. The first and third strategies are included in the Access to Supports narrative in the CYSHCN domain. The second strategy for this priority is reflected below.

Strategy Two: Enhance provider and system capacity to bridge healthcare and other partners to connect people to supports they need and want.

Efforts related to this strategy have focused on supporting the coordination of care across community-based organizations and systems and advancing Colorado's vision towards a statewide social health information exchange (S-HIE) infrastructure. The intention was to inform recommendations for other communities or enable the state to better understand common workflows and technologies that should be reflected in an integrated statewide S-HIE system. MCH staff have been actively engaged in workgroups to advance interoperability of data systems that are coordinated, in partnership with the Colorado Office of eHealth Innovation. This work includes efforts from the collaborative Metro Denver Partnership for Health (MDPH), where the Colorado Health Institute has led the compilation of statewide guidance documents and agreements including the following that are in the process of finalization:

- Social Health Information Exchange Accountability Plan: This plan is a living document that is designed to evolve as Colorado's interoperable S-HIE ecosystem is being built and includes a Progress Tracker that will be updated throughout implementation.
- Community-Clinical Linkage Implementation Plan: This plan is solely focused on the MDPH S-HIE initiative, and it

documents specific commitments among participating partners to advance interoperable S-HIE through shared responsibilities and equity-drive practices. This plan focuses on interoperability among partners, and not on the internal implementation of specific programs or activities within any single partner organization.

The Colorado Office of eHealth Innovation (OeHI) staffs the state's eHealth Commission and the Commission's associated workgroups. CDPHE's Center for Health and Environmental Data Division Director served as the state's public health representative on the eHealth Commission from its inception through February 2023, when this role shifted to the Branch Director of CDPHE's Health Information Systems Branch, who is funded in part by MCH. The Commission was created to provide advice and guidance on advancing health information technology in Colorado. Information from these workgroups informed revisions to the state's Health Information Technology Roadmap. In November 2021, a refreshed Health IT Roadmap for the state was unanimously approved by Colorado's Lieutenant Governor Dianne Primavera and Colorado's eHealth Commission. It charts a path for harnessing and expanding the digital tools and services that support the health of all Coloradans.

OeHI has coordinated four work groups and several projects that are in progress to reach the Roadmap goals. The work groups are 1) Advancing Health Information Exchange and Rural Connectivity, 2) Care Coordination, 3) Consent Management, and 4) Health Information Governance. MCH-funded staff have been active mainly in the Rural Connectivity and Care Coordination workgroups during this reporting period to ensure alignment of MCH investments with the design of a statewide S-HIE infrastructure and to connect state and local partners to this work and resources.

Ongoing highlights include:

- Opportunities to receive funding to further S-HIE work in Colorado, including Social Determinants of Health Service Providers Request for Information (solicitation Social Health Information Exchange Invitation to Negotiate), and Dollars to Digitize Grant Opportunity through funding from the American Rescue Plan Act.
- Telehealth and Digital Inclusion Projects
    - As a follow up to the 2021 Colorado Telehealth Provider survey, the 2022 Colorado Telehealth Provider Survey Report illustrates how the telehealth landscape has changed in a year. Key findings include: 1) patient broadband access and digital literacy remain a challenge; 2) provider training is needed; and 3) sentiments and utilization of telehealth remain positive.
    - Non-Governmental Funding for Health IT in Colorado was released in December 2022 as the result of a research project funded by the Office of eHealth Innovation that conducted a landscape analysis of private and nonprofit funding opportunities to support health IT, specifically telehealth, electronic health records, and cybersecurity in order to understand gaps in funding and potential partnership opportunities. Linked is a compilation of this research.

The second strategy in the access to supports state action plan is to enhance provider and system capacity to bridge healthcare and other partners to connect people to supports they need and want. The Early Childhood Screening and Referral Policy Council, which is co-facilitated by Assuring Better Child and Health and Development (ABCD) and a CYSHCN team member, is a collaboration to help accomplish this strategy. The policy council is comprised of representatives from the Department of Education, Department of Early Childhood, Parent to Parent of Colorado and other organizations that are involved in early childhood systems improvement. The Early Childhood Screening and Referral Policy Council exists to advance policies that remove barriers to children accessing needed developmental services, from screening to evaluation to connection to Early Intervention Colorado and other needed services. Three primary goals guide the council's work: 1) increase awareness about the importance of early developmental milestones and monitoring with all caregivers; 2) foster meaningful conversations and shared decision-making with families as partners; and 3) reduce disparities in screening, referral, and service access.

While Colorado remains in the top tier amongst states for developmental screening rates, the policy council illuminated significant barriers in the process for families after screening. In 2022, approximately 22 of Early Intervention Colorado referrals were not completed. Half of these referrals were closed because program intake was unable to contact the family, and half were closed because the parent/caregiver chose not to proceed. Based on this data, the policy council has focused on increased community/family engagement, which includes working alongside parents to learn more about their understanding of early identification, referral for additional developmental evaluations, and supporting families in shared decision-making with early childhood and healthcare professionals. Activities have included piloting strategies with pediatricians to improve shared decision-making, using tools to improve communication, build trust, and increase the number of successful referrals to additional supports and services.

In 2022, the Early Intervention Colorado program centralized their intake process, marking a systemic shift in the way referrals are received and how families are contacted. This shift towards a more consistent statewide intake process, has created an opportunity to more closely analyze and address the reasons why children referred to the program do not receive an evaluation. MCH's Early Childhood Systems Specialist also connected Early Intervention Colorado's intake

manager with pediatricians at Children's Hospital Colorado to discuss feedback they've received from parents and identify how providers can support families' understanding of the process, the purpose of the evaluation and potential benefits to early intervention services.

The policy council also developed a recommendation to develop more integrated data system linkages to increase the quality of the data being shared and to support more timely and meaningful communication between the family, health care provider and Early Intervention Colorado from the time of referral throughout the evaluation process. As a result, MCH is funding a pilot to facilitate electronic referrals through the patient's electronic health record through a health information exchange directly into Early Intervention Colorado's newly centralized data system. The implementation plan for the e-referral pilot was developed in partnership with staff from Denver County's early intervention program, the Office of Early Childhood, MCH/CYSHCN, ABCD and one of Colorado's two health information exchanges. Salud Family Health Centers (which has seven clinics across the state) was selected to be the first health system to participate in the pilot and the system went live in July 2022. Initial data from the pilot shows an increase in overall referrals from the pilot practice to Early Intervention Colorado over the previous year. Project goals have been expanded to include comprehensive evaluation strategies to determine the impact of the pilot in increasing provider satisfaction, workflow enhancement, and a decrease in errors of closed referrals due to missing or incorrect contact information. Progress notes have improved communication about referral status and has provided real time updates related to early intervention services provided.

Additional work to expand e-referral and data system interoperability emerged through a gap analysis of Colorado's Early Hearing Screening and Detection System that was funded by MCH in 2022. Through that facilitated process, over 100 stakeholders representing different parts of Colorado's newborn hearing screening system helped develop a map to depict specific steps in Colorado's current system, as well as to illuminate the gaps and challenges that exist. Colorado's newborn hearing screening system is supported by three state agencies: the Colorado Department of Human Services, the Colorado Department of Early Childhood and CDPHE. During the summer of 2023, representatives from these three agencies began developing an intergovernmental agreement to clarify the roles and responsibilities of each agency in addressing the issues identified through the gaps analysis.

Priority: Positive Child & Youth Development

Resource Allocation to Advance this Priority

For this reporting period, MCH Block Grant dollars funded staff time (0.4 FTE) to implement breastfeeding strategies in this priority's action plan. MCH leveraged additional funding from the CDC's State Physical Activity and Nutrition grant to pay for staff time (0.35 FTE) and technical assistance and hospital recognition. Additionally, CDPHE was able to secure special breastfeeding supplemental funding through the SPAN grant for equity and physician training activities. Other breastfeeding FTE and associated strategy work was funded through the USDA Special Supplemental Nutrition Program for Women, Infants and Children program (0.2 FTE) and the state-funded Cancer, Cardiovascular and Pulmonary Disease grant program (0.05 FTE). In addition to breastfeeding support and promotion, MCH Block Grant dollars funded three positions totalling 1.05 FTE of staff time to build nutrition security through increased access to nutrient-rich locally grown food. The strategies and associated outcomes for this priority are summarized below. For a more detailed description, refer to the state action plan.

Strategy Implementation

In addition to the breastfeeding strategies outlined in the perinatal/infant health domain, additional strategies to promote positive child and youth development include increasing access to locally grown foods. Research demonstrates that purchasing local foods not only supports the community and local economy, but provides child care centers and homes with fresh, nutritious, and seasonally produced foods. Farm to Child empowers children and their families to make informed food choices while strengthening the local economy and contributing to vibrant communities. Farm to Child research is beginning to show positive results for children (Chan, et al. 2022; Elrakaiby, et al. 2021; Izumi, et al. 2015; Izumi, et al. 2016) and their families. Meals in centers that focus on serving local food have been found to be more nutritious than non-local meal service, especially in fruits and vegetables.

During this reporting period, CDPHE continued to co-lead the Farm to Child Collaborative. In coordination with stakeholders, the Farm to Colorado Specialist finalized the Farm to Child Roadmap (English; Spanish). The Farm to Child Collaborative voted to prioritize three strategic initiatives for work group formation: racial, economic and linguistic justice; capacity building and systems coordination; and increasing purchasing power of early care and education (ECE) providers. Work groups finalized action plans for each of the three areas of focus and continue to gather community input on funding needs and expanding partnerships. Community-based leadership is a key aspect of each work group and members have begun to take ownership of individual tasks within the action plans.

Early care and education sites are an important access point of nutritious food for children and their families. Incorporating local foods in meals can increase nutritional value, quality, and meal participation, helping to increase nutrition access while

strengthening our regional food system. The Farm to Child Collaborative Purchasing Power and Capacity Building workgroups collaborated with the Colorado Food Systems Advisory Council Institutional Procurement workgroup to align statewide baseline data collection. These data will enhance the understanding of current procurement practices at early care and education sites, potential value chain coordination and market channel gaps, areas for intervention, and considerations for resource and training development. In the spring of 2023, CDPHE re-released the Farm to Child statewide survey, administered every five years, and aligned all local procurement questions with the Advisory Council's data collection survey. The survey included language specific to Family Friend and Neighbor providers, and was translated to Spanish. Data will be presented to the Colorado Department of Education and the Colorado Department of Agriculture to help inform the allocation of USDA Local Procurement funding, totaling $60 million over four years. Survey data shows: expanded reach across the state, with 52 of 64 counties represented in responses; a 45 percent increase in response rate; and an increase in local procurement, from 37 percent participating in some local procurement in 2018, to 58 percent procuring local food (10 percent planning to start in 2023).

A partner sharing toolkit was developed in English and Spanish by the Farm to Child Collaborative Capacity Building workgroup and released in October 2022 during Farm to Child Month to support dissemination of the Farm to Child Roadmap audience specific guides. The guides were completed and translated into Spanish with the provider guide also translated into Arabic. A social media campaign was implemented in English and Spanish with 33 promotional resource images created (66 total images) tailored for the three groups (ECE, Farmer/Producer, and Organizations). A total of 10,681 individuals saw the social media images, and 389 individuals clicked the link to view the resources.

The Farm to Child Collaborative hosted two 90-minute planning sessions to develop drivers, secondary drivers, and activities for the third and final year of the Association of State Public Health Nutritionists' (ASPHN) Farm to Early Care and Education Implementation Grant. With 32 members in attendance,the session saw greater group interaction, voting, and community inclusion. The grant application was submitted by CDPHE and approved by the Association of State Public Health Nutritionists for sustained funding through June 2023 to support local mini-grants and the Collaborative.

Farm to ECE Implementation Grant year one mini-grants were completed and increased access to locally grown produce for 570 children in early learning settings. The mini-grant application for year two was released in English and Spanish. The mini-grants were awarded to five grantees in Arapahoe, Fort Morgan, La Plata, Montrose and Weld Counties with a focus on gardening, local food purchasing, and nutrition education with participation of 946 children and approximately 576 families. The five mini-grants increased access to local foods at 25 FFN care sites, 12 licensed child care centers, 21 family child care homes, and four community-based food sites (e.g., summer meals, food banks), for a total of 65 sites. The decision was made to offer continuation funding to the same five grantees for year three to examine implementation through five videos (each 4 minutes long), visualizing the success of each program. Year three funding was extended to include garden grants for licensed and unlicensed providers, and the application was available in English and Spanish. The grant opportunity solicited a total of 48 applications and awarded 12 providers representing seven counties, including the one provider who submitted a Spanish application.

The Farm to Child Collaborative hired a bilingual technical assistance provider at 12.5 hours per month for the third year of funding for the Farm to ECE Implementation Grant. This individual will work to contact Spanish-speaking members and prior participants no longer attending meetings to better understand barriers to participation. Additional external stakeholders will be engaged to increase participation of the Spanish-speaking food system, early learning settings, and support organizations. To capture their voices and needs for the Farm to Child Roadmap, Spanish-speaking contractors hosted a listening session with Spanish-speaking Family Friend and Neighbor child care providers, provided translated meeting notes as follow-up and sought feedback on resource development. Funding was leveraged to include translation of resources into Spanish, including all twelve Harvest of the Month documents (Spanish, Arabic), Eating, Growing, Learning: A Colorado Farm to Child Guide, and the Farm to Child Roadmap Guide (Spanish; Arabic) for child care providers. Simultaneous translation is also provided at monthly coalition meetings to expand language access.

Additional collaboration with stakeholders resulted in a Proclamation by the Colorado Governor's Office for the Colorado Crunch Off, a local produce promotion event where schools, early care and education/family child care homes, and community members were encouraged to “crunch” into local produce. The Farm to Colorado Specialist assisted in the development of promotional materials for this event including a video in English and Spanish and partner sharing fliers.

CDPHE staff also partnered with the CYSHCN team to support access to nutritious food for children and their families. Staff hosted Gardening with *Children of All Abilities* trainings in English and Spanish in August 2022. There were 19 English-speaking participants and 11 Spanish-speaking participants. Participants agreed/strongly agreed that the training met expectations and objectives. An additional webinar focused on *Feeding and Nutrition for Children with Special Health Care Needs* webinar was held in May 2023.

Priority: Access to Supports

Performance Measures and Annual Objectives

NPM 6: Percent of children, ages 9-35 months, who received a developmental screening using a parent-completed screening tool in the past year was 39.6%. The NPM 6 annual objective for reporting year 2024 is 43.0%.

ESM 6.1: Percent of children referred to early intervention who do not complete an evaluation was 22.2% The ESM 6.1 annual objective for reporting year 2024 is 21.0%.

Resource Allocation to Advance this Priority

For the upcoming reporting period, MCH Block Grant dollars will be braided with state General Funds to support approximately 3.0 FTE on the CYSHCN team and .35 FTE on the Health Informatics and Telehealth and Digital Inclusion teams at CDPHE; implementation of strategies in the state action plan; and contracts with local public health agencies to implement local action plans that support the CYSHCN population. The CYSHCN team will continue to leverage additional MCHB grant funds (the Pediatric Mental Health Care Access Grant) to continue and/or expand several existing partnerships and to support state and local implementation efforts. The first and third strategies are included in the Access to Supports narrative in the CYSHCN domain. The second strategy for this priority is reflected below. For a more detailed description, refer to the full state action plan.

Strategy Implementation

Strategy Two: Increase the capacity to bridge healthcare and other community partners using technology to receive and respond to referrals, as well as to expand access to services through the developmental screening e-referral project.

In the upcoming year, the developmental screening and e-referral project will scale up with a much larger health system, Children's Hospital Colorado, than the first pilot practice. This will increase this project's reach and impact, as current referral rates to Early Intervention Colorado are currently more than four times the referrals from the first health system piloted. Ongoing evaluation measures and lessons learned from phase one of the project will help improve the identification of barriers and implement solutions to ensure effective, standardized developmental screening and referral systems and improve coordination of follow up services for children and families.

Additional work to expand e-referral and data system interoperability emerged through a gap analysis of Colorado's Early Hearing Screening and Detection System that was funded by MCH in 2022. One of the recommendations that emerged from the gaps analysis was to explore interoperability options for the newborn hearing data system that is managed by the Center for Health and Environmental Data within CDPHE. In response to that recommendation, a workgroup coordinated by CYSHCN staff will be assessing the value and viability of interoperability between CDPHE's newborn hearing screening data system and Early Intervention Colorado's statewide intake system to strengthen communication and cross-systems follow up when a child has not passed a newborn hearing screen.

Three local public health agencies (Adams/El Paso/Douglas) will no longer be providing care coordination in the upcoming year and will be participating in a community of practice support and learn from one another as they begin implementing new strategies to improve systems for CYSHCN in their communities. Weld County will be using the CYSHCN Decision Tool to determine whether they will continue to provide care coordination and/or explore other strategies to support CYSHCN.

Priority: Positive Child & Youth Development

Strategy Implementation

In the upcoming reporting year, the positive child and youth development priority will continue to include a focus on building nutrition security through increased access to nutrient-rich locally grown food in communities facing the greatest racial/ethnic disparities. MCH Block Grant dollars will continue to support implementation of the 2022-2025 *Farm to Child Roadmap*. The Colorado Farm to Child Collaborative, local public health agencies, and stakeholders, priority staff and coalition partners will implement the strategic initiatives outlined in the Roadmap that ensures racial/ethnic equity and aligns with the strategies in the action plan for the positive child and youth development priority.

The Farm to Colorado Specialist will continue to lead the Colorado Farm to Child Collaborative. Staff will continue to review the *Farm to ECE Roadmap* with the strategic plan and farm-to literature reviews to compile information for sharing with partners and stakeholders. Nutrition security staff will participate on the Colorado Food Systems Advisory Council to represent CDPHE programs and communicate Council information and resources to CDPHE programs.

Nutrition security staff will identify and increase Colorado-specific technical assistance resources to support institutions and programs in initiating a farm-to program. This includes convening state and local partners to identify nutrition education resources to support farm to institution and program and the WIC Farmers' Market Nutrition Program to ensure shared messaging and modifying *Colorado's Farm to ECE* training into modules to enable use with different audiences.

The focus during this application year will be to increase the number of early learning facilities and children/youth programs that procure local foods and/or implement gardens in a minimum of four communities. In an effort to reach this goal, priority staff will identify and apply for funding to support additional staffing and project resources to support Farm to ECE and Farm to child/youth programs.

In partnership with the Colorado Farm to Child Collaborative and other community partners, including local public health agencies, priority staff will provide support to at least four communities facing racial and ethnic disparities to identify, study and develop resources to support early learning settings in growing gardens and purchasing local food. Nutrition security staff will also work to build the capacity of staff and partners through offering at least one web based training on nutrition security and farm-to strategies.

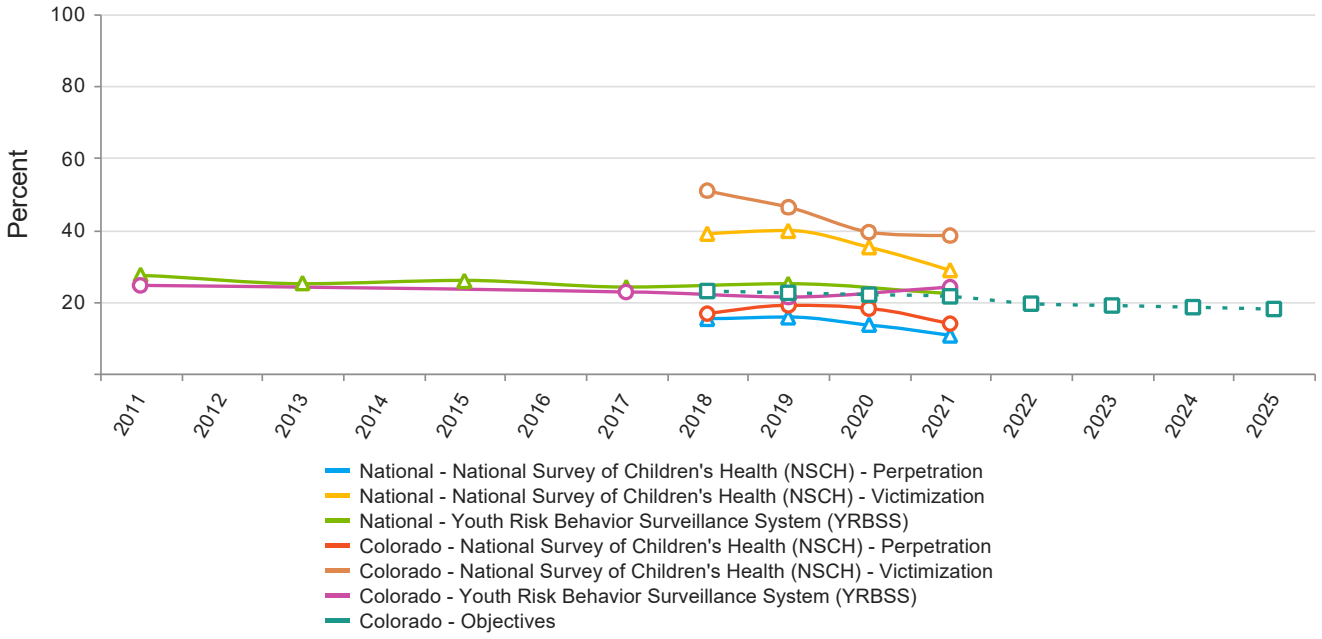
In addition to the nutrition security strategies included in the state action plan, MCH will continue to strengthen cross-sector systems of support to enhance positive child and youth development through leadership of the Early Childhood Screening and Referral Policy Council. This collaborative group, co-facilitated by Assuring Better Child and Health and Development (ABCD) and a CYSHCN team member, is comprised of representatives from the Department of Education, Department of Human Services' Office of Early Childhood, Parent to Parent of Colorado and other organizations that are involved in early childhood systems improvement.

The Council will continue to focus on advancing policies that remove barriers to children accessing needed developmental services, from screening to evaluation to connection to Early Intervention Colorado and other needed services. The most significant piece of early childhood legislation was the passage of House Bill 22-1304 that created a new state Department of Early Childhood as of July 2022. Given the passage of this state legislation, the Council will continue to monitor the impact of the changes on the state's early childhood system and provide any needed partnership to enhance access to services and supports for young children. See the narrative for the Access to Supports priority for more information on the Department of Early Childhood.

Adolescent Health

National Performance Measures

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



Federally Available Data					
Data Source: Youth Risk Behavior Surveillance System (YRBSS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	23	22.5	22	21.5	19.5
Annual Indicator	22.8	22.8	21.2	21.2	23.9
Numerator	53,094	53,094	50,864	50,864	57,049
Denominator	232,406	232,406	239,788	239,788	238,257
Data Source	YRBSS	YRBSS	YRBSS	YRBSS	YRBSS
Data Source Year	2017	2017	2019	2019	2021

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - Perpetration					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective		22.5	22	21.5	19.5
Annual Indicator		16.6	19.1	18.3	13.9
Numerator		69,342	80,754	79,073	59,520
Denominator		416,926	423,583	430,963	429,083
Data Source		NSCHP	NSCHP	NSCHP	NSCHP
Data Source Year		2018	2018_2019	2019_2020	2020_2021

Previous NPM-9 NSCH data for survey years 2016 and 2017 that was pre-populated under the 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable to 2018 survey data given major wording and response option changes.

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - Victimization					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective		22.5	22	21.5	19.5
Annual Indicator		50.7	46.1	39.2	38.2
Numerator		212,730	195,148	168,451	164,060
Denominator		419,974	423,321	429,650	429,371
Data Source		NSCHV	NSCHV	NSCHV	NSCHV
Data Source Year		2018	2018_2019	2019_2020	2020_2021

Previous NPM-9 NSCH data for survey years 2016 and 2017 that was pre-populated under the 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable to 2018 survey data given major wording and response option changes.

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	23	22.5	22	21.5	19.5
Annual Indicator	24.1	22.7	22.7	16.4	16.4
Numerator					
Denominator					
Data Source	Healthy Kids Colorado Survey	Healthy Kids Colorado Survey	Healthy Kids Colorado Survey	Healthy Kids Colorado Survey	Healthy Kids Colorado Survey
Data Source Year	2017	2019	2019	2021	2021
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	19.0	18.5	18.0

Evidence-Based or –Informed Strategy Measures

ESM 9.1 - Percent of youth who identify as transgender who have a trusted adult to go to for help with a serious problem

Measure Status:				Active
State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			45.8	57.5
Annual Indicator	45.3	57.9	57.4	57.4
Numerator				
Denominator				
Data Source	Healthy Kids Colorado Survey	Healthy Kids Colorado Survey	Healthy Kids Colorado Survey	Healthy Kids Colorado Survey
Data Source Year	2017	2019	2021	2021
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	58.0	58.5	59.0

ESM 9.2 - Percent of youth of color who have a trusted adult to go to for help with a serious problem

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			69.9	70.4
Annual Indicator	69.4	68.3	68.4	68.4
Numerator				
Denominator				
Data Source	Healthy Kids Colorado Survey	Healthy Kids Colorado Survey	Healthy Kids Colorado Survey	Healthy Kids Colorado Survey
Data Source Year	2017	2019	2021	2021
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	70.9	71.4	71.9

State Action Plan Table

State Action Plan Table (Colorado) - Adolescent Health - Entry 1	
Priority Need	
Increase prosocial connection	
NPM	
NPM 9 - Percent of adolescents, ages 12 through 17, who are bullied or who bully others	
Objectives	
By September 30, 2025, technical assistance provided to LPHAs, schools and community based organizations will result in at least eight policy or practice changes that create supportive environments for youth.	
Strategies	
Coordinate and collaborate with community partners to create supportive environments for youth facing the greatest racial disparities.	
ESMs	**Status**
ESM 9.1 - Percent of youth who identify as transgender who have a trusted adult to go to for help with a serious problem	Active
ESM 9.2 - Percent of youth of color who have a trusted adult to go to for help with a serious problem	Active
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	

Priority: Prosocial Connection
Performance Measures and Annual Objectives
NPM 9: Percent of adolescents who are bullied on school property or electronically was 16.4%.
The annual objective for reporting year 2022 was 19.5%. The annual objective was met. The annual objective for reporting year 2023 is 19.0%.

ESM 9.1: Percent of youth who identify as transgender who have a trusted adult to go to for help with a serious problem was 57.4%. The annual objective for reporting year 2022 was 57.5%. The annual objective was not met. The annual objective for reporting year 2023 is 58.0%.

ESM 9.2: Percent of youth of color who have a trusted adult to go to for help with a serious problem was 68.4%. The annual objective for reporting year 2022 was 70.4%. The annual objective was not met. The annual objective for reporting year 2023 is 70.9%.

The data source for the NPM is the National Survey of Children's Health that is administered annually. The data source for the ESMs comes from the Healthy Kids Colorado Survey that is administered in Colorado every two years. Analysis of relevant survey data reveals inequities based on race, sexual orientation, and gender identity. The prosocial connection action plan prioritizes equity and is focused on improving school and community environments for youth of color and transgender youth.

As noted above, the annual objectives for ESM 9.1 and ESM 9.2 were not met. Community connection, school connectedness, participation in extracurricular activities, and connection to trusted adults are all protective factors for experiencing bullying. During this reporting period, the pandemic continued to impact schools and youth-serving organizations, disrupting opportunities for young people to connect in community and school settings, participate in extracurricular activities, and build relationships with trusted adults, all of which may be contributing factors towards why the ESMs were not met.

Resource Allocation to Advance this Priority
During this reporting period, MCH Block Grant dollars funded approximately 2.0 FTE to implement the state prosocial connections action plan. MCH staff time was leveraged with additional state funding including: $400,000 of state General Funds to support gender sexuality alliances, staff mental health training and school and district policy development with Colorado schools and districts; state General Funds for maternal mortality prevention community-based strategies to promote social connectedness; and state funds from tobacco and marijuana programs for a public awareness campaign for youth. The action plan strategies and associated outcomes for this priority are summarized below. For a more detailed description, refer to the full state action plan.

Priority Implementation
During this reporting period, three strategies were the focus of the prosocial connection priority: 1) utilize a community-centered process to identify barriers to community connectedness; 2) increase connectedness and social capital for caregivers and parents; and 3) increase connectedness among youth, including building trusted relationships with adults, within schools and youth-serving organizations.

During this reporting period, prosocial priority staff supported an intern to develop a literature review and policy analysis on prosocial connection efforts for marginalized youth. This project included key informant interviews and an intentional focus on LGBTQ+and youth of color. The recommendations included in the report are: 1) support safe, inclusive policies at state, local, school, medical offices, and workplaces to promote prosocial behavior and healthy relationships in all aspects of life; 2) provide grant funding for organizations working with LGBTQ+ youth and youth of color; 3) include demographically representative adults for youth-led programs, including mentorship, parenting education, and physical activity programs; and 4) support trauma-informed practices with community partners tackling suicide prevention and creating positive prosocial connection. The literature review, in addition to input from the Community Advisory Board and the Youth Partnership for Health, also served as a driver to pilot a community-based mini-grant project. Staff leading the prosocial connection, built environment and social emotional well-being priorities partnered on the pilot, which is described in more detail in the narrative for the built environment priority.

Prosocial connection priority staff provided technical assistance and contract oversight to 23 Colorado schools and school district grantees, with funding through Senate Bill 18-272. This legislation was passed in 2018 to support suicide prevention and crisis response in schools and school districts. The program supports schools and districts to implement comprehensive suicide prevention efforts, including staff training, policy development and equity, and LGBTQ+ school climate strategies. Policies such as affirming gender identity and sexual orientation and anti-bullying policies advance both bullying and suicide prevention. Research indicates that LGBTQ+ students in school districts with sexual orientation and

gender identity protections in their anti-harassment and anti-bullying policies reported greater school safety and less peer victimization based on their sexual orientation and gender expression, when compared to students without such protections. Additionally, implementing school climate efforts like Gender Sexuality Alliances (GSAs) and diversity clubs can help to create a safe school environment for all students. Research has also shown that GSAs have positive effects on student health, wellness, and academic performance; as well as protect students from harassment based on sexual orientation and gender identity.

In addition to implementing state strategies, prosocial connection priority staff provided consultation to three local public health agencies, representing eight counties. Support included technical assistance in the development of action plans and budgets, collective problem solving, and connection to community resources and aligned initiatives. Jefferson County Public Health Department contracted with a youth-serving community-based organization, Apprentice of Peace Youth Organization, to identify opportunities to create positive environments for youth in the community. Boulder County Public Health collaborated with community partners to host restorative practices events for the community and the local school district, which led to the hiring of a restorative justice coordinator. Boulder County also hosted their first youth summit, Mental Health Matters. This event was planned by youth for youth and created a space for connection activities that was welcoming and inclusive for the diverse participants from throughout the county.

Through the prosocial connection priority, the MCH program has continued to promote positive youth development. Positive Youth Development is a strengths-based approach to supporting adolescents by helping youth acquire the knowledge and skills they need to become healthy and productive adults. The positive youth development training system guides individuals and organizations in how they implement services, opportunities, and support to engage youth in reaching their full potential. During this reporting period, seven Positive Youth Development 101 trainings were held, with over 100 attendees and three virtual train-the-trainer sessions with about 44 participants. In an effort to more closely align with Colorado's State Youth Development Plan, led by the Colorado Department of Human Services, Colorado's positive youth development statewide training system is transitioning from being housed within the MCH program in CDPHE to the Colorado Department of Human Services. MCH will provide funding for the next three years to help support the transition.

Through the prosocial connection priority, the MCH program contributes funding to Forward Together, a public health awareness campaign developed through a collaboration between CDPHE and the Colorado Department of Human Services. The campaign engages youth ages 12-17 and adults to strengthen authentic and supportive youth-adult and youth-peer relationships. To date, the campaign has garnered over 237 million impressions (130 million adults and 107 million youth) and 35 million adult and youth engagements with website visits, video views, likes, shares and saves. As of the last evaluation, the campaign achieved the following awareness levels: 59 percent of youth are aware of the campaign and 42 percent of adults are aware of the campaign. Additionally, there were successful efforts to incorporate youth voice and diverse lived experience in the development and ongoing management of the campaign. There were over 200 youth-made content items published on the web or social media with over 30 youth contributors statewide. Through on-staff youth advisors, the YConnect youth advisory panel for the campaign, the youth creators group and on-the-ground and virtual outreach, youth throughout Colorado regularly contributed insights, stories, artwork and creative design. There were also over 50 adult-made content items from a diverse group of Colorado parents, grandparents, youth experts, and mentors. Prosocial priority staff served as subject matter experts and supported youth engagement efforts for the campaign.

To support community connectedness among parents, caregivers and families and to reduce maternal mortality, the Community Solutions to Prevent Maternal Mortality Request for Applications was developed and released by the Maternal Mortality Prevention Program in fall of 2021. It was designed to be a community-responsive grant to prevent and reduce deaths among pregnant and postpartum people. The opportunity leveraged MCH and CDC funding to support grassroots, community-centered, and BIPOC-led organizations, and prioritized projects that aligned with top causes of maternal mortality as well as MCH priorities, including prosocial connection. Glowmundo and Elephant Circle were the two community-based organizations selected to receive funds starting in the spring of 2022.

Glowmundo is focused on increasing access to safe, supportive, culturally responsive, trauma-informed services to pregnant and postpartum young people to improve behavioral health outcomes through two different peer support programs: Lead Your Way and Circle of Parents®. Glowmundo initially experienced challenges implementing the programming in the way they had originally planned. After some delays, the project was able to launch in February 2023, and has had good initial participation in a new location, which is a federally-designated Title 1 early childhood development center. The majority of participants in Circle of Parents® are recent immigrants from Spanish speaking countries, under the age of 23, and are here without partners as their partners are currently detained or they aren't sure where they are. The program has enrolled 22 participants in the program as of April 2023. A few testimonials from participants stated, *"I have learned to ask for help and not feel ashamed. In my country it is not acceptable."* and *"It was so important for me to understand how my emotions affect my baby and learn ways to calm my anxiety and sadness."* The Lead Your Way program is focused on developing social emotional skills necessary to thrive including: self-esteem, self-awareness, resiliency, and empowering teen parents to make positive choices for themselves and their child. The program is being implemented at New Legacy Charter School in Aurora and has enrolled 17 participants.

Elephant Circle's project is focused on increasing the capacity of the doula workforce to provide person-centered services to pregnant and postpartum individuals with a focus on those who are non English speaking, first-time parents, low income and/or incarcerated. During the first year of funding for the project that ended September 2022, the program trained 17 doulas using the *Doula is a Verb* training across three locations: students at New Legacy Charter School, participants in the Alma peer support program, and pregnant and postpartum people in the Denver Women's Correctional Facility. Of the 16 participants who provided race/ethnicity data, 13 (or 81%) identified as Black, African American, Hispanic, Filipino, American Indian/Alaska Native, Asian, or multi-racial; three identified as white. The project has continued to expand in the current funding year. The two trained doulas working for Alma are facilitating weekly perinatal support groups, in addition to providing doula services to the Alma community. The availability of an additional doula, who also has expertise in perinatal substance use and recovery, has made it possible for the program to facilitate the peer-led Circle of Parents® curriculum with people at the Denver Women's Correctional Facility. The program will also train doulas at the hospital to more effectively work with the women from the correctional facility during delivery. An additional doula training at New Legacy Charter school occurred in the spring of 2023.

Priority: Social Emotional Wellbeing
Strategy Two: Support universal prevention, early intervention, and treatment of behavioral health among MCH populations, through public awareness campaigns that destigmatize behavioral health, as well as through increasing social connectedness and emotional well-being among school-aged youth through policies that promote positive social norms, opportunities and authentic relationships.

As one component of this strategy, MCH funding continued to support the pregnancy-related depression and anxiety campaign. Paid media in English and Spanish reached audiences across the state, sharing messages of support, de-stigmatizing behavioral health, and directing affected individuals and families to support and resources. The pregnancy-related depression and anxiety campaign launched with refreshed content in the spring of 2022. The campaign website was updated with new images and messages and a social media toolkit was also created. Given the need to incorporate video content to stay current with social media trends, the Real Stories about Pregnancy, Parenting, and Mental Health video campaign was launched this year, featuring testimonials from people with lived experience with depression and anxiety. People were able to record their stories from an app on their phone. Videos were integrated into campaign materials and ads and launched in October 2022 on Facebook, Instagram, and TikTok. Local partners, such as Larimer County Public Health, continue to share campaign materials with community members, including at community gatherings and library story hours.

Based on the School Climate Report, the state tobacco program prioritized technical assistance to school administrators to provide information and resources to implement alternatives to suspension and expulsion for tobacco and other substance use violations. The program uses intersectional approaches to address racism and confront challenges faced by LGBTQ+ youth and youth on Individual Education Plans by changing school policies. Tobacco staff collaborated with school partners to create, update, and disseminate a school handout of prevention strategies for school administrators to continue implementing non-punitive and equitable approaches to addressing school violations. Tobacco staff will continue working with school partners to provide guidance and technical assistance to schools, partners, and grantees, including updated evidenced-based strategies and resources to address tobacco/vape use.

See the ***Women Maternal Health*** section for the rest of the ***Social Emotional Wellbeing Annual Report***.

Adolescent Health - Application Year

Priority: Prosocial Connection
Performance Measures and Annual Objectives
NPM 9: Percent of adolescents who are bullied on school property or electronically. The annual objective for reporting year 2024 is 18.5%.

ESM 9.1: Percent of youth who identify as transgender who have a trusted adult to go to for help with a serious problem. The annual objective for reporting year 2024 is 58.5%.

ESM 9.2: Percent of youth of color who have a trusted adult to go to for help with a serious problem. The annual objective for reporting year 2024 is 71.4%.

Resource Allocation to Advance this Priority
MCH Block Grant dollars will continue to fund approximately 2.0 FTE to implement the state prosocial connection action plan. In addition, MCH staff time will be leveraged with additional state funding including: $400,000 of state General Funds to support gender sexuality alliances, staff mental health training and school and district policy development with Colorado schools and districts; state General Funds for maternal mortality prevention community-based strategies to promote social connectedness; and state funds from tobacco and marijuana programs for a public public awareness youth campaign. The strategies planned for the upcoming year for this priority are summarized below. For a more detailed description, refer to the state action plan.

Strategy Implementation
For the upcoming reporting period, strategies within the prosocial connection action plan will continue to build upon the previous action plan efforts. The strategies will remain the same, including: 1) working with communities to address structural and systemic barriers to community connectedness; 2) building connectedness and social capital for parents, caregivers and families; and 3) creating supportive environments for youth facing the greatest racial disparities.

Staff from the prosocial connections, built environment priority and social emotional priorities plan to host a larger funding opportunity in the fall of 2023, leveraging lessons learned from the community-based mini-grant pilot project, and braiding MCH funds with additional built environment resources.

In the upcoming reporting period, the prosocial connections priority will benefit from continued efforts to identify and implement community connectedness strategies for parents, caregivers, and families. During the previous reporting period there was turnover among staff leading these activities in the action plan. The prosocial connection priority implementation team will continue to recruit staff who have the expertise with parents, caregivers and families and have capacity to support connectedness for parents, caregivers and families.

Prosocial connections staff will continue to prioritize activities to create supportive environments for young people. The prosocial connection priority will collaborate on updates to the positive youth development training material and alignment of youth development efforts with the Colorado Department of Human Services. Priority staff will continue to provide consultation and expertise to inform the strategic direction of the Forward Together campaign. Additionally, technical assistance and contract monitoring will be provided to school and district grantees implementing efforts outlined in Senate Bill 18-272. This includes four district grantees prioritizing building positive school environments for LGBTQ+ young people, developing suicide prevention and crisis policies, and providing mental health training for staff and students. It is also anticipated that an additional ten grantees will receive one-year awards to support mental health training for staff and students.

During the upcoming reporting period, prosocial connections priority staff will continue to support local public health agencies. It is anticipated that three agencies will continue to implement a local action plan for the prosocial connection priority. Additionally, state prosocial connections staff will provide consultation on the development of local action plans and budgets, assist with problem solving, and provide connection to community resources and aligned initiatives.

Priority: Social Emotional Wellbeing
Strategy Two: Support universal prevention, early intervention, and treatment of behavioral health among MCH populations, through public awareness campaigns that destigmatize behavioral health, as well as through increasing social connectedness and emotional well-being among school-aged youth through policies that promote positive social norms, opportunities and authentic relationships.

In the coming year there is a continued commitment to improved statewide and community-specific awareness of HealthySteps® with the ultimate goal of increasing access to support and early intervention for young children and families in addition to improved developmental and social emotional well-being and screening. MCH will continue work with Assuring Better Child Health and Development (ABCD) to expand sites across the state with the goal of reaching 25 percent of Colorado's children by 2024. Plans are underway for additional sites in El Paso, Mesa, and Alamosa counties with the goal to establish new sites across a mix of geographies, including 12 new sites in urban counties, 11 new sites in rural counties, and four new sites in frontier counties. Future plans include exploring opportunities to connect HealthySteps® with local public health agencies to increase community engagement. MCH staff will continue to sit on the Regional HealthySteps Advisory Council, supporting sustainability and ongoing growth and sustainability of the program. Active outreach for funding to support onboarding costs for new sites, increased messaging, and outreach are critical goals for this upcoming year.

In the upcoming year, Tobacco staff will work with Rocky Mountain Center for Health, the program's technical assistance provider, and other partners, to prioritize outreach to schools in Health Statistic Regions reporting youth health disparities by race and sexual orientation, and rural communities. Schools will be supported in implementing and enrolling students in the Second Chance program as an alternative to suspension in school policy work and disseminating prevention resources to address youth substance use, mental health issues, and other risk factors. The Tobacco program will continue to collaborate with other internal and external school partners to share ongoing updated survey results of students' feedback on school engagement to include perceptions of belonging and equity in the enforcement of school discipline policies. One specific effort will be to work with Tobacco grantees and Rocky Mountain Center for Health to provide guidance and support to school administrators on using prevention strategies to meet the needs of both students and administrators. For example, schools should understand why installing vape detectors in school bathrooms is not a recommended strategy and will further be a barrier to students feeling safe and fostering positive relationships in the school environment.

Data on suspensions for Colorado students with disabilities is currently not available. Starting in 2024, the Tobacco program will work with Rocky Mountain Center for Health to add a question to the Second Chance intake information to determine if students who are referred to an alternative-to-suspensions-or-expulsion program have special needs. The data from this question will provide baseline information to better address the needs of this population.

In the upcoming year, MCH funds will support the next iteration of the pregnancy-related depression and anxiety prevention campaign, including sharing updated video content, which has been shown to be successful in engaging digital users. Recognizing that maternal substance use has a high rate of co-occurrence with maternal mental health concerns, but remains a highly stigmatized issue, new campaign materials will address the intersection of perinatal substance use and mental health. MCH staff will continue to look at ways to maximize future campaign efforts and reach wider audiences.

In the coming year, MCH staff will continue to focus on strengthening cross-systems partnerships to support the social emotional wellness of MCH populations. The CAPTA (Child Abuse Prevention Treatment Act) and Beyond State Interagency Workgroup is an ongoing collaboration comprised of four state agencies: Colorado Department of Public Health and Environment, Colorado Department of Education, Colorado Department of Early Childhood, and Colorado Department of Human Services, in partnership with members from multiple local programs and family leaders. The purpose of this group is to explore barriers, potential solutions, and to develop deliverables for improving developmental screening, referrals, and system-wide improvements to ensure that children, birth through five, involved in Colorado's Child Welfare System have their needs identified and are connected to relevant family-driven services and supports. Charter goals and objectives include a comprehensive mapping of both the current state (3-5 age example) and potential future state (3-5 age example) of the referral processes for children birth to five years of age. The workgroup staff also partnered with Pueblo, Jefferson, Fremont and El Paso counties, to understand what those counties are currently doing in their communities with overall success in the face of limited resources. Lessons learned from those communities, along with the mapping project, will help inform the recommendations and approaches for pilot projects,within the next year, through collaboration with the Colorado Department of Early Childhood and the renewed Preschool Development Grant which will allocate some funding for process improvements that include capacity building of regional and local community systems for screening.

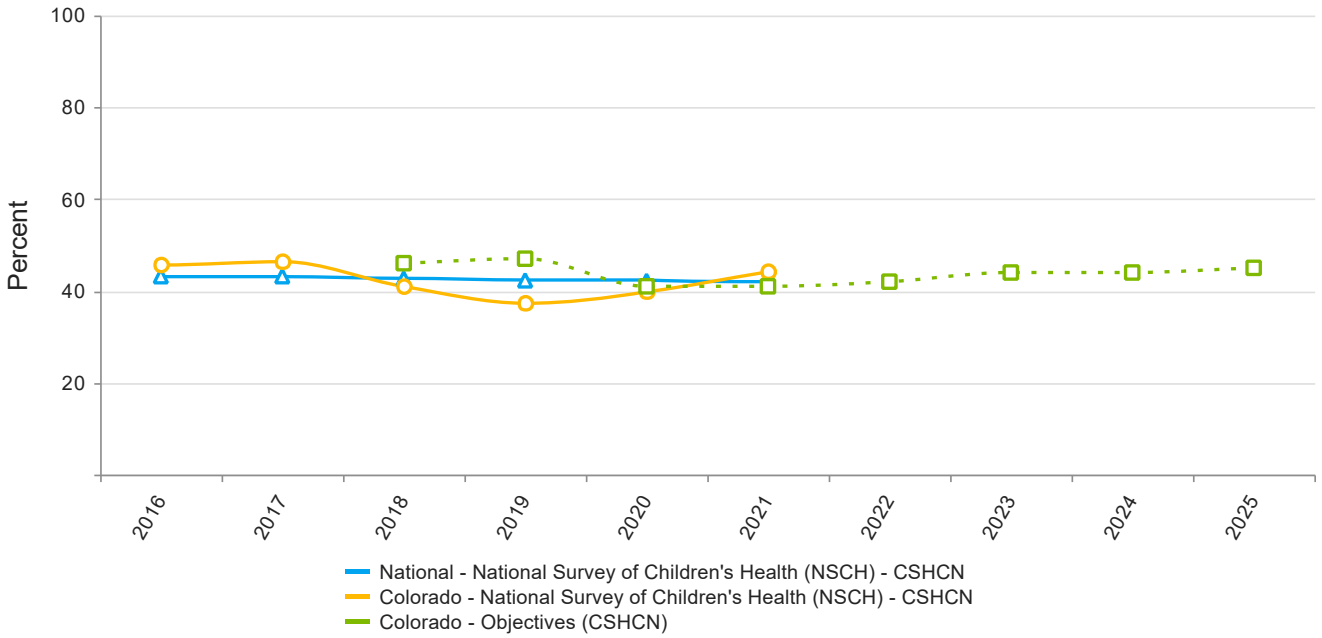
See the ***Women Maternal Health*** section for the rest of the ***Social Emotional Wellbeing Application for the Coming Year***.

Children with Special Health Care Needs

National Performance Measures

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

Indicators and Annual Objectives



NPM 11 - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	46	47	41	41	42
Annual Indicator	46.2	40.9	37.2	39.7	44.0
Numerator	104,246	97,057	87,287	89,834	110,170
Denominator	225,707	237,019	234,693	226,196	250,234
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	44.0	44.0	45.0

Evidence-Based or –Informed Strategy Measures

ESM 11.1 - Percent of children with special health care needs ages 0-17 years who receive family-centered care

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			87	84
Annual Indicator	86.9	84.2	82.9	85.4
Numerator				
Denominator				
Data Source	National Survey of Childrens Health	National Survey of Childrens Health	National Survey of Childrens Health	National Survey of Childrens Health
Data Source Year	2017-2018	2018-2019	2019-2020	2020-2021
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	86.0	87.0	88.0

State Action Plan Table

State Action Plan Table (Colorado) - Children with Special Health Care Needs - Entry 1	
Priority Need	
Improve access to supports	
NPM	
NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home	
Objectives	
By September 30, 2024, advance at least three recommendations through the ACC 3.0 stakeholder engagement process that ensure a more comprehensive, integrated system of care for all children including CYSHCN.	
Strategies	
Increase equitable access to and use of specialty care, with a focus on behavioral health.	
ESMs	**Status**
ESM 11.1 - Percent of children with special health care needs ages 0-17 years who receive family-centered care	Active
NOMs	
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	
NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year	

Priority: Access to Supports
Performance Measures and Annual Objectives
NPM 11: Percent of children with special health care needs, ages 0-17, who have a medical home was 44.0%. The annual objective for reporting year 2022 was 42.0%. The annual objective was met. The annual objective for reporting year 2023 is 44.0%.

ESM 11.1: Percent of children with special health care needs ages 0-17 years who receive family-centered care was 85.4%. The annual objective for reporting year 2022 was 84.0%. The annual objective was met. The annual objective for reporting year 2023 is 86.0%.

The data source for both the NPM and ESM is the National Survey of Children's Health that is administered annually.

Resource Allocation to Advance this Priority
For this reporting period, MCH Block Grant dollars were braided with state General Funds to support approximately 3.0 FTE on the CYSHCN team and .35 FTE on the Health Informatics and Telehealth and Digital Inclusion teams at CDPHE; implementation of strategies in the state action plan; and contracts with local public health agencies to implement local action plans that support the CYSHCN population. The CYSHCN team leveraged additional MCHB grant funds (the Pediatric Mental Health Care Access Grant) to continue and/or expand several existing partnerships and to support state and local implementation efforts. In partnership with the Pediatric Mental Health Institute, MCH also leveraged the $4.6 million in pandemic relief funds associated with the SB22-147 that was passed during the 2022 Legislative Session to expand the program funded through the Pediatric Mental Health Care Access Grant to more rural areas of the state and extend implementation efforts through 2024. The funded strategies and associated outcomes are summarized below. For a more detailed description, refer to the full state action plan.

Strategy Implementation
The access to supports priority includes, but extends beyond, access to health care services. This is based on the understanding that the health of individuals and families is primarily influenced by non-medical factors such as food, housing, social connectedness and safety, often referred to as social and structural determinants of health (CDPHE Office of Health Equity, 2018). Policy and systems improvements are needed to support whole-person care and make it easier for women, children, youth and families living in Colorado to access the comprehensive services and supports they need. This includes strengthening partnerships, communication, coordination and collaboration across and between organizations and systems that provide support for women, children, youth, and their families.

Most systems are made up of some combination of people (i.e., both those seeking and those providing services and supports), process(es) used by those people (i.e., getting or giving a referral) and technology (i.e., interoperable data systems, a website, or an app on a smartphone). Using this lens, the state action plan for the access to supports priority focuses on the following strategies: 1) increase equitable access to and use of specialty care, with a focus on behavioral health; 2) enhance provider and system capacity to bridge healthcare and other partners (see the ***Child Health Annual Report*** for more details on this strategy); and 3) use data to identify, illuminate, and address access, utilization, and outcome inequities.

Strategy One: Increase equitable access to and use of specialty care, with a focus on behavioral health.
MCH continues to serve as an implementation partner with the Pediatric Mental Health Institute and the Department of Psychiatry at the University of Colorado for the Colorado Pediatric Psychiatry Consultation and Access Program (CoPPCAP). The goals of the program are to increase timely detection, assessment, treatment and referral of children and youth with behavioral health disorders in pediatric primary care settings, with a focus on rural and underserved areas. The program offers pediatric primary care providers a phone or email consultation with a child psychiatrist within 45 minutes of a request. Providers can also receive one face-to-face consultation, either in person or through telehealth, to support diagnosis or treatment. Enrolled practices can also receive continuing education opportunities tailored to their community, free screening tools, and educational materials. Since CoPPCAP was launched in September 2019, the project has enrolled 76 pediatric and family practices and 739 practitioners, representing 577,716 covered lives, and provided 2,173 consultations. Specialist consultation topics with primary care providers has included: medication initiation, medication change and/or ongoing medication management; general medical education; therapy referrals; care coordination support; assisting with a diagnosis or interpretation of screening results; requests for community resource assistance; and patient support specific to anxiety, depression, attention deficit hyperactivity disorder, and autism spectrum disorder.

The CoPPCAP Advisory Committee guides program implementation and expansion and includes the Colorado Chapter of the American Academy of Pediatricians, the Colorado Child Health Access Program, Children's Hospital Colorado, the state's Medicaid program, Parent to Parent of Colorado and many other organizations working statewide to improve access to behavioral health services. During this reporting period, the Advisory Committee had two significant policy impacts.

CoPPCAP promotes the consistent use of screening tools by primary care providers to identify behavioral health needs in children as early as possible. Through consultation with pediatric providers, the Advisory Committee learned that the Pediatric Symptom Checklist tool, used to identify behavioral health conditions in school age children, was not reimbursable by Medicaid. Representatives from the Advisory Committee met with the Medicaid program to highlight the importance of this tool being added to the list of reimbursable screening tools and, as a result, Medicaid approved the tool for reimbursement in November 2021. A second policy impact was made in October 2021, when the CYSHCN team, in partnership with the CoPPCAP Advisory Committee, developed a recommendation for funds made available through the American Rescue Plan Act to be allocated to enhance and expand the program. Based on that recommendation, legislation was passed during the 2022 session that provided $4.6 million to CoPPCAP over two years.

Strategy Three: Use data to identify, illuminate, and address access, utilization, and outcome inequities.
This strategy reflects the intentionality of using data to identify future objectives and activities that explicitly reduce racial inequities between different population groups. The data from the National Survey of Children's Health (NSCH) indicates that there are disparities among children of different races/ethnicities across the United States related to access to care and a medical home. Based on Colorado data from the 2020-2021 NSCH, about half (47.9%) of all children living in Colorado do not have a medical home (56.0% of children with special health care needs and 45.9% of children without special health care needs). Disparities in access to a medical home are apparent by race/ethnicity and household income among children. In Colorado, only 42.8% of children who are Hispanic have a medical home compared to 57.3% of white non-Hispanic children. 42.5% of children with a household income between 0 and 199% Federal Poverty Level (FPL) have a medical home, compared to 61.7% of children at 400% FPL or greater (NSCH, 2020-2021). These data may not be reliable for other races and ethnicities due to wide confidence intervals. More information about Colorado's oversample of the NSCH to address this issue is described in the MCH Data Capacity section.

In addition to the strategies being implemented through the state action plan, eight of the 15 largest local public health agencies selected the access to supports priority. Nine of the 15 agencies have expanded their CYSHCN work into other priority areas, such as economic mobility and built environments. Twelve of the 15 agencies continue implementing MCH-funded care coordination. Four partner agencies (Boulder, Denver, Eagle and Jefferson) are leveraging other local and state resources to offer the Family Connects Colorado program to all families within their community. These agencies are building upon their MCH-funded CYSHCN care coordination expertise and infrastructure. For example, Boulder's Family Connects program is intentionally integrated with their agency's MCH-funded care coordination program. Integration with Family Connects is intended to increase NICU referrals to the care coordination program and to improve the system of referrals to other Boulder County support programs. Family Connects leveraged over 300 resources from the existing care coordination community resource guide for their database.

The CYSHCN decision tool was created, in partnership with families and local public health agencies, to guide data-driven and community-informed decision making when selecting strategies to support children and youth with special needs, either in addition to or in place of care coordination for CYSHCN. During this reporting period, five local public health agencies completed the tool and two additional agencies are currently exploring its use. After completing this tool, two local public health agencies (El Paso and Jefferson) decided to discontinue MCH-funded care coordination services for CYSHCN. These agencies identified other options for clients through community based organizations and/or other care coordination programs/providers, such as the Medicaid program's Regional Accountability Entity. These agencies will continue to provide information and referral services for families with CYSHCN, as per core Colorado public health service requirements. El Paso and Jefferson Counties are now engaging their community to identify their new CYSHCN strategies.

Two Counties (Denver and Mesa) decided the best path forward was to continue providing care coordination for CYSHCN. They also identified changes like reduced staffing for the program and/or rescoping their services to focus on a specific subpopulation or those with higher acuity of needs, such as children and youth with a dual diagnosis (specifically autism and a mental/behavioral health diagnosis).

Tri-County Health Department also completed the tool prior to the dissolution of the agency in December 2022. As part of the transition to three separate agencies for Douglas, Adams and Arapahoe counties, Tri-County shared their findings and recommendations with staff from each agency to inform their future strategies to support the CYSHCN population. Weld County will move from exploration to implementation of the decision tool and is currently exploring contractors to provide support with their community engagement and data efforts.

Children with Special Health Care Needs - Application Year

Priority: Access to Supports
Performance Measures and Annual Objectives
NPM 11: Percent of children with special health care needs, ages 0-17, who have a medical home was 44.0%. The NPM 11 annual objective for reporting year 2024 is 44.0%.

ESM 11.1: Percent of children with special health care needs ages 0-17 years who receive family-centered care was 85.4%. The ESM 11.1 annual objective for reporting year 2024 is 87.0%.

Resource Allocation to Advance this Priority
For the upcoming reporting period, MCH Block Grant dollars will be braided with state General Funds to support approximately 3.0 FTE on the CYSHCN team and .35 FTE on the Health Informatics and Telehealth and Digital Inclusion teams at CDPHE; implementation of strategies in the state action plan; and contracts with local public health agencies to implement local action plans that support the CYSHCN population and a contract with Assuring Better Child Health and Development (ABCD). The CYSHCN team will continue to leverage additional MCHB grant funds (the Pediatric Mental Health Care Access Grant) to continue and/or expand several existing partnerships and to support state and local implementation efforts. In partnership with the Pediatric Mental Health Institute, MCH will also be leveraging the $4.6 million in pandemic relief funds associated with the SB22-147 that was passed during the 2022 Legislative Session to expand the program funded through the Pediatric Mental Health Care Access Grant to more rural areas of the state and extend implementation efforts through 2024. The strategies (One and Three, for details about Strategy Two see the ***Child Health Application for the Coming Year***) planned for the upcoming year for this priority are summarized below. For a more detailed description, refer to the full state action plan.

Strategy Implementation
Strategy One: Increase equitable access to and use of specialty care, with a focus on behavioral health In the upcoming year.
CoPPCAP is currently in year five of HRSA's Pediatric Mental Health Access grant that funds the Colorado Pediatric Psychiatry Consultation and Access Program (CoPPCAP). CDPHE submitted the application for the competitive continuation award in June 2023 and, if awarded, will continue to fund and serve as an implementation partner with the Pediatric Mental Health Institute and the Department of Psychiatry at the University of Colorado for the CoPPCAP. In 2022, the program received $4.6 million in state allocated American Rescue Plan Act funds to expand their efforts. However, due to staff turnover and complex guidance for receiving and administering the funds, CoPPCAP has been significantly delayed expending those funds.

CoPPCAP has expansion plans which include the development of regional hubs where one child and adolescent psychiatrist is assigned to support the enrolled practices within a designated area. Through this new infrastructure, the program has the goal of fostering regional knowledge and expertise and deepening the relationships built between CoPPCAP child and adolescent psychiatrists and primary care practice teams in that region. In addition, CoPPCAP's Tribal Liaison, together with the MCH program's School Age Systems Specialist, is developing a plan to strengthen relationships with the Southern Ute and the Ute Mountain Ute tribal councils to customize the CoPPCAP approach and expand to those areas identified by the tribal leaders.

The CYSHCN team's School Age Systems Specialist will continue to serve as a liaison between the CoPPCAP enrollment efforts of CDPHE's school based health center program. The school based health center program to align behavioral health efforts across the two programs, as more as 30,000 children and youth in Colorado receive primary physical and behavioral health care through school based health centers. To date, CoPPCAP has enrolled four school based health centers and recognizes the value of enrolling more to create a more cohesive system of behavioral health support to the workforce in primary care settings. Through this approach, CoPPCAP will provide technical guidance in the form of care guides, recommended screening tools and learning sessions to ensure the screening of children for behavioral health conditions at the earliest points in their development. CoPPCAP also plans to align efforts with the new Behavioral Health Administration Service Organizations infrastructure, along with the current behavioral health statewide crisis system.

The CYSHCN Director and the Pediatric Care Coordination Systems Consultant each continue to hold a voting member position on one of the subcommittees of the Medicaid Program Improvement Advisory Committee. The subcommittees play a critical role in informing the Medicaid contracts for the Regional Accountability Entities. Through these workgroups, CYSHCN staff are uniquely positioned to provide input into the Medicaid program's contracts, which are scheduled to begin with new contracts in July 2025 (see timeline for the stakeholder engagement process leading up to the new contracts). The CYSHCN Director will continue to serve as a voting member on the Performance Management Member Engagement subcommittee. This group will continue to focus on developing recommendations for how the performance of Medicaid's Regional Accountability Entities will be evaluated in their next contract cycle.

The Pediatric Care Coordination Systems Consultant is participating in the Provider and Community Experience subcommittee, which is focused on developing recommendations for improving care coordination delivered through Medicaid, as well as improving access to specialty care. Medicaid program priorities are identified and explained in this fact sheet, however, the CYSHCN team has focused their input on four of the priority areas: 1) the development of care coordination standards for groups with unique needs children with complex needs; 2) improving outcomes for children and youth with unique needs, including CYSHCN and youth in foster care; 3) strengthening referrals from Medicaid to other community partners outside the Medicaid service system; 4) and behavioral health transformation, which includes the integration of the Medicaid's Regional Accountability Entities with the new Behavioral Health Administrative Service Organizations.

In order to effectively provide input into these statewide conversations, the CYSHCN team developed a meeting inventory of all the spaces the staff occupy and identified relevant data, talking points, and policy recommendations so that all team members can provide consistent and timely input when the opportunity arises. In addition to this coordination effort, the CYSHCN Director is co-covening a group of leaders across the Prevention Services Division to coordinate communication with Medicaid and the new Behavioral Health Administration and inform recommendations for stakeholder engagement efforts and program implementation.

The Early Childhood Screening and Referral Policy Council will continue to focus in the upcoming year on advancing policies that improve access to necessary developmental services and supports ongoing advocacy for universal screening as part of the newly defined quality standards for the launch of Universal Preschool in the fall of 2023. New work in the upcoming year will include the development of best practice guidance for transitions across systems and programs, a transition road map, and pilot training for community partners for the coordinated transition of children (3-5 years of age) who require additional developmental services.

Strategy Three: Use data to identify, illuminate, and address access, utilization, and outcome inequities.
One activity in the action plan for this priority is to intentionally explore ways to make data related to equitable access and use of supports simpler and more digestible. Examples include: 1) compiling information on data available related to equitable access to supports in a single space; 2) exploring value for Colorado in partnering with the Casey Family Programs to create interactive community opportunity maps that would present information from various sources in a single place to facilitate local planning; and 3) creating a Developmental Screening and Referral Data Dashboard. See the ***Social Emotional Well-Being Plan for the Application Year*** for more information.

Cross-Cutting/Systems Building

State Performance Measures

SPM 1 - Percent of children ages 0-17 years who live in a supportive neighborhood

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			57.8	54.5
Annual Indicator	57.2	53.8	54.1	57.2
Numerator				
Denominator				
Data Source	National Survey of Childrens Health	National Survey of Childrens Health	National Survey of Childrens Health	National Survey of Childrens Health
Data Source Year	2017-2018	2018-2019	2019-2020	2020-2021
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	55.0	55.5	56.0

SPM 2 - Percent of households that spend more than 30% of household income on housing costs

Measure Status:	Inactive - Replaced			
State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			31	31
Annual Indicator	31.7	31.4	31.4	32.6
Numerator				
Denominator				
Data Source	American Community Survey	American Community Survey	American Community Survey	American Community Survey
Data Source Year	2018	2019	2019	2021
Provisional or Final ?	Final	Final	Final	Final

SPM 3 - Number of points for racial equity related policy, practices and systems changes implemented at the program, division and department level

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			3	6
Annual Indicator	0	0	3	9
Numerator				
Denominator				
Data Source	Racial Equity Specialist	Racial Equity Specialist	Racial Equity Specialist	Racial Equity Specialist
Data Source Year	2019	2020	2021	2021
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	9.0	12.0	15.0

SPM 5 - Percent of children in poverty according to the supplemental poverty measure

Measure Status:	Active

State Provided Data	
	2022
Annual Objective	
Annual Indicator	8.1
Numerator	
Denominator	
Data Source	Current Population Survey
Data Source Year	2019-2021
Provisional or Final ?	Final

Annual Objectives		
	2024	2025
Annual Objective	7.9	7.7

State Action Plan Table

State Action Plan Table (Colorado) - Cross-Cutting/Systems Building - Entry 1
Priority Need
Reduce racial inequities
SPM
SPM 3 - Number of points for racial equity related policy, practices and systems changes implemented at the program, division and department level
Objectives
By September 30, 2024, implement at least two racial equity best practices or policies per year into MCH program infrastructure.
Strategies
Build program infrastructure and capacity for racial equity efforts.

State Action Plan Table (Colorado) - Cross-Cutting/Systems Building - Entry 2

Priority Need

Create safe and connected built environments

SPM

SPM 1 - Percent of children ages 0-17 years who live in a supportive neighborhood

Objectives

By September 30, 2025, provide influence on a minimum of six new or enhanced built environment policies or initiatives for state implementation to increase safe and connected communities that will have a positive impact on equity and connectedness.

Strategies

Build cross-sector partnerships to increase capacity for implementing place-based policy strategies to increase equity, community safety, activity-friendly routes.

State Action Plan Table (Colorado) - Cross-Cutting/Systems Building - Entry 3

Priority Need

Increase economic mobility

SPM

SPM 5 - Percent of children in poverty according to the supplemental poverty measure

Objectives

By September 30, 2024, Increase traffic on the Get Ahead Colorado/Hacia Adelante website by at least 10% through outreach partnerships.

Strategies

Identify and implement policy/systems changes that support increased tax credit claims.

Priority: Racial Inequities

Performance Measure and Annual Objectives

SPM 3: Number of points for racial equity related policy, practices and systems changes implemented at the program, division and department level was 9. The annual objective for reporting year 2022 was 6. The annual objective was met. The annual objective for reporting year 2023 is 9.

This data for the SPM is tracked by the Racial Equity Specialist in the MCH Workforce Development Section and is calculated annually based on efforts across the MCH program. By tracking changes to policies and practices, the MCH program can document tangible examples of change that vary in scope and impact.

Resource Allocation to Advance this Priority

For this reporting period, MCH Block Grant dollars supported 1.0 FTE for the Racial Equity Specialist to develop and implement state action plan strategies and consult with internal and external partners to integrate racial equity approaches across programs and systems that serve the MCH population. There are three main strategies associated with this priority: 1) build program infrastructure and capacity for racial equity efforts; 2) develop and strengthen workforce competencies related to racial equity; and 3) coordinate and align racial equity efforts between the MCH program and the Workforce Development Section, Children, Youth and Families Branch, Prevention Services Division, Department, and the Office of Health Equity. The funded strategies and associated outcomes are summarized below. For a more detailed description, refer to the full state action plan.

Strategy Implementation

Strategy One: Build program infrastructure and capacity for racial equity efforts.

The Racial Equity Specialist formalized an implementation team to co-lead activities in this strategy. The priority implementation team includes the Community Inclusion Specialist, Change Specialist, and Workforce Development Section Manager. Core activities in the action plan related to the first strategy center on 1) implementing the stress-responsive, trauma-informed learning series; 2) using storytelling to deepen understanding of inequities; and 3) normalizing the use and application of equity tools.

Stress-responsive, Trauma-informed Environments

A trauma-informed system is one that builds awareness and knowledge of trauma to shape policies and practices aimed at reducing the re-traumatization of youth and families and the professionals who serve them. The Racial Equity Specialist and Workforce Development Section Manager conducted research on the implementation of trauma-informed systems in public health to explore how to advance trauma-informed practices in state and local MCH work. They identified both national and local entities that are engaging in trauma-informed systems efforts, including the San Francisco Department of Public Health, Trauma Transformed, Flourish Agenda, Denver Health, Metro Denver Partnership for Health, and Neurosequential Model. They engaged in a series of conversations to better understand how each entity approached advancing trauma-informed systems, inquired about the frameworks and principles guiding the work, and audited several training/workshop modules. This extensive exploration led to the conclusion that the existing trauma-informed curricula must be adapted to ensure relevancy for the public health workforce and multi-disciplinary partners.

The Racial Equity Specialist and Workforce Development Section Manager selected the Neurosequential Model as the curriculum that is most aligned with the MCH program and the public health workforce. This is a novel initiative to integrate brain-based, somatic, trauma-informed science and associated strategies into the Reduce Racial Inequities action plan and Workforce Development Section's programming and practices. The research also revealed that national entities, such as the Association of State and Territorial Health Officials, are beginning to use similar strategies to support workforce retention and resiliency and are also partnering with Dr. Bruce Perry, the founder of the Neurosequential Model.

During this performance period, the Racial Equity Specialist and Workforce Development Section Manager completed the 10-month cohort-based learning of the Neurosequential Model. The Racial Equity Specialist and Workforce Development Section Manager received consultation support from the Educational Access Group on adapting the Neurosequential Model training and resource content from educational systems to organizational settings. Support from the Educational Access Group included observation of workshops with growth-focused feedback and recommendations, the development of an evaluation plan to measure progress and practice changes within implementation teams, and monthly coaching sessions with the Racial Equity Specialist and the Workforce Development Section Manager. A primary challenge was being trained in the Neurosequential Model, while simultaneously modifying the content to ensure the materials and examples were relevant to the public health workforce. The Racial Equity Specialist and Workforce Development Section Manager have revised and refined the workshop series based on participant feedback.

The Racial Equity Specialist and Workforce Development Section Manager co-created a stress-responsive, trauma-informed learning series and began piloting it with CDPHE staff within the Children, Youth and Families Branch (the branch

that administers the MCH program), as well as with two local public health agencies (Pueblo and Broomfield). These local partners committed to a year-long effort that included participation in a foundational three hour workshop, followed by 8 to 10, 1.5 to 2-hour monthly workshops, completion of pre- and post-surveys to evaluate progress, and received coaching support to implement strategies at the individual (self-regulation), interpersonal (co-regulation), and organizational levels (collective regulation). During this reporting period, the Racial Equity Specialist and the Workforce Development Section Manager have facilitated 36 Stress-responsive, Trauma-informed workshops for a broad range of internal and external public health staff and their partners.

The Racial Equity Specialist and Workforce Development Section Manager met with the Change Specialist to discuss the intersection between change management, behavioral insights, and stress-responsive, trauma-informed learning series, and identify potential opportunities for collaboration in the upcoming fiscal year. The Racial Equity Specialist also introduced stress-responsive, trauma-informed concepts to the department-wide BIPOC Connection Employee Resource Group and integrated key elements of this approach into this setting. For example, it is now a standard practice to close the meeting with a brief regulation or somatic practice (e.g. mindfulness, body scan, etc.). In addition, the MCH program's stress-responsive, trauma-informed learning series has been endorsed by CDPHE's Organizational Development team within the Office of Human Resources.

Storytelling Project
To promote a race equity culture, the Racial Equity Specialist and Community Inclusion Specialist engaged the Community Advisory Board to lead a storytelling project. Co-creating a project with the community is not only a community inclusion best practice but is an opportunity to partake in a process that narrates stories that may illuminate the impact of inequities that resonate with the community.

The Racial Equity Specialist and Community Inclusion Specialist introduced the storytelling idea to Community Advisory Board members to assess interest, motivation, and capacity to engage and complete this project. Community Advisory Board members agreed they would like to be part of a project that is meaningful, highlights their expertise and experiences, and shares who they truly are. Community Advisory Board members also identified several concerns related to retraumatization and confidentiality. Through several discussions, they identified their must-haves: 1) utilize strategic story-telling; 2) embed a call-to-action; and, 3) compensate appropriately. Community Advisory Board ownership of the storytelling project is unique to the Reduce Racial Inequities priority and a new approach for illuminating inequitable experiences. It has been both a success and a challenge that has required the implementation team to closely partner with Community Advisory Board members to address concerns and ensure the project is action-oriented.

In designing the project, the Community Inclusion Specialist and Community Advisory Board members reflected and responded to the following: "What questions should we answer when telling our stories?" Community Advisory Board members identified their audience of interest and prioritized the following:

1. What challenges related to MCH did you experience when growing up?
2. How and where did policies that were designed to help actually fail you?
3. How did your own culture impact interactions with and perceptions of various systems?
4. What is the generational trauma confronting our communities? How could intergenerational healing be facilitated?

Community Advisory Board members selected a local community media servicer, Loclyz, to develop the videos. The video includes stories of community members, highlighting the importance of community voice in driving decision-making and elevating the intersectionality of identities. Community Advisory Board members reviewed and provided feedback to finalize the storytelling video. The Community Inclusion Specialist and Community Advisory Board members partnered with the Prevention Services Division's Communication Director to develop a dissemination plan. Community Advisory Board members identified the goal(s), audience(s), call to action, communication channels, and mechanisms for sharing the video broadly. CDPHE staff and external stakeholders will continue to partner with Community Advisory Board members to utilize the products of their storytelling videos to influence MCH-related policy.

Application of Equity Tools
The Racial Equity Specialist completed a certification process to become a Qualified Administrator of the Intercultural Development Inventory (IDI) and Intercultural Conflict Style (ICS). Both assessments are culturally-valid and frequently used in the larger Equity, Diversity, and Inclusion field. The assessments help to build individual and group intercultural competence and navigate conflict across cultures. The Racial Equity Specialist embedded the use of the assessments into the stress-responsive, trauma-informed learning series and normalized the use of racial equity tools such as these assessments, with local public health agencies and community-based partners. During this reporting period, the Racial Equity Specialist has administered 35 IDI assessments and individual debriefs. The Racial Equity Specialist also compiled group IDI results, when applicable, allowing teams to understand their groups' intercultural competence skills. Unlike other assessments, each IDI report is accompanied by an Intercultural Development Plan (IDP). IDPs are customized to each individual and support increasing intercultural competence skills through developmentally appropriate intercultural learning opportunities.

The Racial Equity Specialist developed questions to vet potential contractors for values and expertise alignment. MCH staff piloted these questions when seeking out contractors to facilitate the Maternal Mortality Review Committee Retreat, as well as to select the vendor to facilitate upcoming race-based affinity groups with the Children, Youth and Families Branch. Throughout this reporting period, the Racial Equity Specialist and the Workforce Development Section Manager have been researching best practices and building the readiness amongst staff in the Children, Youth and Families Branch for the affinity groups.

Strategy Two: Develop and strengthen workforce competencies related to racial equity.
Throughout this reporting period, the Racial Equity Specialist designed relevant racial equity workshops as needs emerged. The Racial Equity Specialist responded to 113 requests (39 consultations, 37 workshops, 2 coaching sessions, and 35 IDI debriefs). Requests for racial equity capacity-building originated from a variety of external and internal partners, such as the Rocky Mountain Society for Adolescent Health and Medicine, Colorado Department of Human Services, Colorado Judicial Branch, Rocky Mountain Public Health Training Center, state and local MCH staff, and CDPHE staff in the Office of Human Resources and the Culture, Strategy, Equity and Innovation team. These partners regularly interact with MCH populations, and their increased capacity to advance racial equity will have a positive impact on women of reproductive age, child, and youth, and children and youth with special healthcare needs.

Locally, prior to Tri-County Health Department's dissolution into three separate local public health agencies, the equity manager and reducing racial inequities priority lead at Tri-County requested ongoing consultation for the creation of an organizational equity framework and facilitation of race-based conversations. The local MCH staff bridged their MCH race equity work with Tri-County's larger organization-wide equity efforts and Tri-County's Health Equity Action Team and community supervisors implemented regulation strategies into their team meeting structure. Two of the three new health departments, Adams and Arapahoe, selected the reducing racial inequities priority and will continue to champion equity efforts locally in the upcoming fiscal year. In Spring 2023, the Departments of Public Health and Environment In Broomfield and Pueblo began a year-long effort to strengthen competencies related to racial equity and trauma-informed systems.

Strategy Three: Coordinate and align racial equity efforts between the MCH program and the Workforce Development Section, the Children, Youth and Families Branch, the Prevention Services Division, CDPHE, and the department's Office of Health Equity.
Workforce Development Section
The Racial Equity Specialist and Workforce Development Section Manager co-created an MCH Learning Framework that detailed the intersection between inter-related topics such as racial equity, community inclusion, and trauma-informed systems. This framework helped to connect the dots between workforce development, the Division's racial equity plan, community engagement efforts, as well as the Department's equity efforts. The Racial Equity Specialist and Workforce Development Section Manager have shared this framework with key leaders in the department and there seems to be overall support and validation for the approach.

Children, Youth and Families Branch
The Racial Equity Specialist is a member of the Branch Culture Planning team and during this reporting period, coordinated the administration of the Intercultural Development Inventory and led the planning efforts for race-based affinity groups that will launch in September 2023. The Children, Youth and Families Branch staff also host branchwide monthly anti-racism conversations.

Prevention Services Division
The Racial Equity Specialist was invited to participate on the Division's core team for the Division's strategic planning process. MCH staff and several others advocated for racial equity to be reflected in the strategic plan, both as an operational and programmatic priority. The Racial Equity Specialist and the Inclusion, Diversity, Equity and Accessibility Manager for the Division have monthly coordination meetings to discuss opportunities for bi-directional alignment. The Racial Equity Specialist was also selected to participate on the workgroup responsible for implementing the Division's strategic priority focused on Equitable Hiring and Retention Practices.

CDPHE
During this reporting period, members of the Workforce Development Section have collaborated across the Department to advance internal equity efforts. The Racial Equity Specialist, along with two other colleagues, presented the charter to formalize a BIPOC Connection Employee Resource Group to the Department's Senior Management Team. This type of Employee Resource Group is an intentional anti-racist method to create a space for listening and healing to address the impact of racism on individuals and communities of color that had never existed within CDPHE. The Racial Equity Specialist is one of two co-chairs that continues to coordinate this group. The Racial Equity Specialist works closely with the Department's Senior Inclusion, Diversity, Equity and Accessibility Specialist to coordinate Employee Resource Group activities (e.g. developing an action plan, planning for heritage month celebrations, elevating themes to the Department's

senior leadership, etc.)

In addition, the Racial Equity Specialist and the Workforce Development Section Manager were invited to co-lead a learning and development series focused on culture and equity for the Culture, Strategy, Equity and Innovation team within the Department's Executive Director's Office. The Racial Equity Specialist was also asked to participate in a focus group with other state Inclusion, Diversity, Equity and Accessibility professionals to share perspectives on the newly formed statewide Equity Office in the Department of Personnel and Administration and their recruitment process for an Executive Director.

Priority: Economic Mobility
Performance Measure and Annual Objective
SPM 2: Percent of households that spend more than 30% of household income on housing costs was 32.6%. The annual objective for reporting year 2022 was 31.0%. The annual objective was not met. The SPM for this priority has been changed for reporting year 2023 (see below).

The data for the SPM comes from the American Community Survey that is administered annually. As noted above, the annual objective for the state performance measure was not met. A contributing factor may include rising housing prices throughout Colorado and relatively less buying power due to inflation in 2022. It is also possible that the metric is too distal from the current economic mobility strategies; and that tax credit outreach, integrated referrals, and data products and data sharing do not have enough of a direct influence on the number of households spending more than 30% of their income on housing costs. Discussion with the Built Environment team has highlighted the difficulty of public health directly influencing housing costs, given the extent of local control of zoning and development. As a result, we have selected a new state performance measure: "Percent of children in poverty according to the supplemental poverty measure." This decision was made because decreasing child poverty is closely aligned with the strategies in the economic mobility action plan and its intended impact. While housing affordability remains an important driver of economic mobility, it is not the current focus of the economic mobility work plan. The supplemental poverty measure also aligns with the program's Earned Income Tax Credit and Poverty Measures dashboard. The supplemental poverty measure is based on cash resources and noncash benefits (tax credits, housing subsidies, utility and nutrition assistance) from the government (as opposed to the official poverty measure which is based on cash resources only). The supplemental poverty measure also takes into account necessary household expenses (work expenses, child care expenses, taxes, medical expenses) and regional variation in cost of living. The data for the new state performance measure is from the Current Population Survey and is reported annually.

Resource Allocation to Advance this Priority
For this reporting period, MCH Block Grant dollars funded 0.6 FTE Economic Mobility Program Manager to implement the strategies outlined in the state action plan, and also funded contracts with local public health agencies to implement economic mobility local action plans and strategies. To expand impact, MCH continues to leverage additional funding of $5.2 million to support tax credit outreach and communication efforts in 2022-24. Funding sources include private foundation funding from Gary Community Ventures, the U.S. Department of Labor, and federal pandemic recovery funds from the American Rescue Plan Act. This supplemental funding helped support 4.5 additional FTE to support contracting, grant coordination, evaluation and communication. The funded strategies and associated outcomes are summarized below. For a more detailed description, refer to the state action plan.

Strategy Implementation
The connection between economic status and health is well-established, and poverty can have serious effects on children's long-term health. 8.1 percent of children in Colorado lived in poverty according to the supplemental poverty measure in 2019-2021. A full-time minimum wage job ($12.56/hour in 2022) is not sufficient to cover basic needs in Colorado. The level at which Colorado families can be economically self-sufficient varies substantially by geographic location. For example, for one adult and one preschooler, $21.10 per hour is needed to make ends meet in Baca County, compared to $42.56 per hour in Eagle County, or from 243 percent of the federal poverty guidelines to 491 percent of the federal poverty guidelines for a family of two (The Self-Sufficiency Standard for Colorado 2022, Colorado Center on Law and Policy).

In this reporting period, the focus of the economic mobility state action plan shifted from assessment, establishing partnerships, and beginning strategy implementation to expansion of partnerships and influence, increasing community based tax outreach and free tax filing contracts, and refinement and expansion of the Get Ahead public awareness campaign and media plan. Coordination with state benefits enrollment efforts was strengthened, and several activities aimed at broadening economic mobility activities beyond tax credit outreach were added to the work plan. The state action plan was updated to move the family-friendly policy objective to monitoring status as implementation of statutory statewide paid family leave has launched. The remaining three strategies are: 1) identify and implement policy and system changes

that support increased tax credit claims; 2) engage community partners using a lifecourse perspective to strengthen and expand common eligibility and enrollment in services that support economic mobility; and 3) gather and share data, research and policies related to improved access to economic mobility and the benefits of improved economic mobility among Coloradans.

In 2022, the Economic Mobility State Implementation Team met monthly, co-led by the CDC Essentials for Childhood grant coordinator and the Economic Mobility Program Manager and included representation from local public health. The focus of the team was to develop clear and compelling messaging about the relationship between economic well-being and health outcomes to support increased partnership with other internal and external programs. These communication tools were completed in May 2023. In early 2023, the State Implementation Team workgroup was reconfigured to focus on the MCH state action plan for this priority and Prevention Services Division Strategic Plan deliverables that are aligned with MCH's economic mobility strategies.

As the cost of living continues to rise in Colorado, one clear action to immediately improve the economic status of Colorado families is to reduce barriers to claiming all the tax credits to which they are entitled. One in four eligible Coloradans does not claim the Earned Income Tax Credit (EITC), which can be up to $6,935. Expanded tax credits support economic mobility and are associated with reduced child and household poverty, increased food security, and fewer adverse childhood events.

The Get Ahead Colorado /Hacia Adelante Colorado media campaign launched January 31, 2022 and continues to provide partners and families with updated, vetted, Colorado-specific tax information, outreach materials, and media presence. The program kicked off the 2023 tax season with its second annual partner webinar with introductory remarks from Governor Jared Polis. With 232 in attendance, the webinar featured a preview of the website and campaign, tax referral training and an overview of the 2023 bilingual partner toolkit of outreach materials. The webinar included presentations from the IRS, Code For America and state agency and volunteer income tax assistance (VITA) partners.

Get Ahead Colorado campaign efforts resulted in a number of earned media opportunities and additional paid media appearances. For the 2022 tax season, this partnership generated 2.2 million digital impressions, 4.7 million radio impressions, 527,000 texts to eligible potential filers, and 41,446 site visits. In 2023, the campaign increased its reach, generating 4.9 million digital impressions, 11.5 million radio impressions, 884,000 text messages to eligible potential filers, and over 90,000 site visits, reflecting a 115% year-over-year increase in website traffic to the English and Spanish campaign websites. The program has been featured in numerous earned media radio, television, print and online appearances over the last two years. The campaign continues to respond to changes in the state and federal tax code. In 2022, the campaign rapidly developed a mini-campaign promoting the Colorado Cash Back Rebate of $750 for each Colorado taxpayer and late filing, and in 2023, in partnership with the Department of Early Childhood and the Department of Revenue, the campaign highlighted the new Colorado Early Childhood Educator Tax Credit, a fully refundable credit of up to $1,500 for credentialed child care workers.

In 2023, the program debuted a Get Ahead Colorado newsletter emailed to 1,361 recipients in the Get Ahead Colorado partner database highlighting tax filing, affordable internet, and banking services for the un- and under-banked. In 2022, through a contract with iNow, a non-profit focused on refugee services, 11 videos in 11 languages were created to promote tax filing and tax credit claims. New videos were created and posted for the 2023 tax season. In a new partnership with Rocky Mountain PBS, Get Ahead Colorado messaging was included in multiple PBS Kids newsletters reaching 8,595 recipients, as well as spots on KUVO Jazz and The Drop radio stations. The program continues to expand and refine texting outreach as a best practice. In a partnership with Bright By Text, the program sent multiple text messages to an audience of roughly 14,000-15,000 caregivers of children 0-18, receiving above average click through rates of up to 16 percent. Through the Get Ahead Colorado media plan, the program will continue to text hundreds of thousands of Coloradans who may be missing out on tax credits, with a focus on low-income parents and rural residents.

The program's tax credit project continues to create innovative, community inclusive partnerships and outreach strategies. Program staff have been invited to present on the project nationally by the Catalyst Center at Boston University, American Public Human Services Association and the Colorado State Board of Health. In 2022, program staff were invited to present at the Prosperity Summit in Atlanta, and to participate on two national panels: one hosted by Brookings and the Urban Institute and the other hosted by the Bipartisan Policy Council and carried by C-Span. The AmeriCorps partnership was highlighted in a White House fact sheet and at a White House tax outreach workshop for states. During the 2022 legislative session, Colorado state bill SB22-182 was passed to establish the MCH Economic Mobility Program in statute and allocate an additional $4 million in American Rescue Plan recovery funds through 2024 to support tax credit outreach. Program staff also successfully submitted abstracts to present on economic mobility strategies at CityMatch, Public Health in the Rockies, and the Association of Maternal and Child Health Programs' annual conference.

SB-182 is signed into law by Governor Jared Polis in 2022.

The racial equity strategic anchor is primarily represented in this work through language justice activities related to the Get Ahead Colorado /Hacia Adelante Colorado campaign and the program's tax outreach funding opportunity for community-based organizations. The 2023 website was published in English and Spanish, as was the partner toolkit for 2023. Community-based organizations that were funded to work on tax outreach could request any of the outreach materials from the partner toolkit in any languages needed for their communities of focus. CDPHE paid for the translations so that organizations did not have to use their budgets for these materials. All translated materials were added to the partner toolkit and also sent directly to the requesting organizations. Also, the tax outreach training for grantees was live interpreted into Spanish. Grantees were invited to select additional languages for interpretation ahead of the training, however no additional languages were identified.

The Economic Mobility Program contracted with ten organizations that coordinate and/or directly operate Volunteer Income Tax Assistance (VITA) sites across Colorado during the 2022 tax season, and continued these partnerships in 2023 with a third posted funding opportunity. These organizations operate 53 sites throughout the state, including at least 20 sites outside of the greater Denver metro area. In 2022, funding supported four sites to become IRS Certified Acceptance Agencies to facilitate more residents to obtain Individual Taxpayer Identification Numbers (ITIN) for those without a social security number. Four sites reported processing 62 ITIN registrations in 2022, and six sites supported 124 individuals in applying for ITIN numbers during the 2023 tax season, including helping applicants mail or bring their documents to the IRS. For the 2022-23 tax assistance site funding formula, the Economic Mobility Program added a bonus to incentivize new sites; as a result five new locations expanded Colorado's free tax filing capacity. Increasing free tax assistance site capacity will continue to be a priority for the program as it builds out strategy for 2023-24.

In collaboration with tax assistance sites throughout Colorado and the Governor's Office, the program organized "taxathon" free tax clinics in fall 2022, serving between 55 and 110 filers across three consecutive Saturdays. These events aimed to facilitate free tax filing for more https://drive.google.com/file/d/10-RJuU3i2-rOae9HChrO1ZtW7AyKJU_o/view?usp=sharingColoradans, enabling them to claim the Colorado Cash Back tax rebate announced in May 2022, before the October 17th IRS deadline. To further promote both taxathons and Get Ahead Colorado, Governor Polis recorded and shared videos in English and Spanish.

In late 2022, the program renewed its innovative economic mobility MOU with AmeriCorps and the Governor's Office. To celebrate year two of this successful partnership, state, national and community partners came together at a free tax assistance site in March 2023 to celebrate over $15 million in tax refunds claimed for Coloradans by MCH-sponsored AmeriCorps teams since November 2021. CDPHE Chief Medical Officer Dr. Eric France joined Lt. Gov. Dianne Primavera, Rep. Diana DeGette, and AmeriCorps National leadership to celebrate the groundbreaking partnership between the Economic Mobility Program and AmeriCorps.

In 2023, the program increased the number of AmeriCorps tax filing teams deployed to free tax assistance sites from two to three, adding Pueblo United Way as a new AmeriCorps host site. For the 2023 tax season, five tax assistance sites requested AmeriCorps teams, however AmeriCorps capacity was limited to three.

2-1-1 Colorado continues to be an important outreach partner through referrals from entities, benefits navigation call centers, and online resources. The Economic Mobility Program renewed its contract to train six 2-1-1 call centers around the state on tax referral and to provide content for the Colorado 211.org website. As part of the agreement, 2-1-1 reported monthly call center and website metrics and a final summary report. In 2022, 2-1-1 fielded 5,697 tax-related calls, made 5,013 referrals to VITA sites, and links on the 2-1-1 website yielded 913 website referrals to the Get Ahead Colorado website. In 2023, 2-1-1 fielded 6,262 tax-related calls, made 5,489 referrals to VITA sites, and links on the 2-1-1 website yielded 653 website referrals to the Get Ahead Colorado website thru May 31, 2023.

During this reporting period, Denver, Mesa, Tri-County, Otero-Crowley, Boulder, Larimer, and San Juan Basin local public health agencies implemented strategies to improve economic mobility in their communities. Using a variety of approaches, these agencies integrated tax outreach into benefits referral, disseminating Get Ahead Colorado campaign materials and connecting clients with free tax filing and tax credit information. For example, Denver Department of Public Health and Environment supported co-enrollment of SNAP, WIC, and tax credits, collaborated with the Denver Indian Family Resource Center to host tax filing events and address barriers specific to native communities, and partnered with Denver Housing Authority to distribute over 10,000 flyers. Mesa County Public Health established Grand Valley Connects, a centralized hub for health and social services, which received 609 referrals and connected 410 community members to supportive resources, including tax resources, between May 2022 and June 21, 2023. Smaller agencies wove tax outreach into existing benefits enrollment programs and services.

Before its dissolution in December 2022, Tri-County Health Department served as a backbone organization in the implementation of a five-week pilot project in the spring of 2022. In collaboration with the Early Childhood Partnership of Adams County and Tax Help Colorado, a new tax assistance site was co-located with a variety of other services and supports on the Commerce City Community Campus. Tri-County Health Department provided the Early Childhood Partnership with $2,800 to fund tax navigation services on site. Ultimately, 60 appointments were made, 50 were kept and more than 40 filed tax returns during the pilot period. This was the only free tax filing site in Commerce City, and by placing it within the Commerce City Community Campus building, individuals were able to access additional services within the resource hub while claiming tax credits, and vice versa. After debriefing the pilot, the group decided to partner again, hosting a co-located free tax assistance site in the spring of 2023. Adams and Arapahoe counties' newly formed public health departments also supported tax credit outreach in 2023, partnering with Find Help and 2-1-1 Colorado to support connection to services.

The Economic Mobility Program continues to convene and facilitate a state agency workgroup to support outreach and alignment across agencies in support of family financial well-being. Participating agencies include health policy, public health, human services, education, public safety, employment, and economic development. Two new agencies began participating in 2023: The Colorado Department of Early Childhood and the Office of Financial Empowerment in the Attorney General's office. Economic Mobility Program staff also serve on a variety of collaborative workgroups to ensure prioritization and representation of family financial well-being, including the Colorado Partnership for Thriving Families and the Essentials for Childhood Steering Committee. Economic Mobility Program staff have also been invited to join the Office of Financial Empowerment's Community Voices Committee to inform the Office's community engagement and community inclusion efforts.

During the reporting period, the program strengthened its partnership with the state library system. The Economic Mobility

Program staff presented to state libraries in December 2022 at the State Library Partner Forum to provide an overview of the tax landscape and options for low-burden outreach. The state libraries coordinator worked with the Economic Mobility Program to create a resource toolkit with materials to support libraries with tax outreach, and collaborated to deliver 265 posters and 26,500 bilingual Get Ahead Colorado flyers to Colorado libraries statewide.

In late 2022, the Economic Mobility Program partnered a second time with the Colorado Benefits Management System to mail out 450,000 flyers to recipients of public benefits. In 2023, state partners again placed banners on their website home pages and benefits enrollment pages, including the Departments of Labor and Employment and of Human Services, the Colorado Perinatal Care Quality Collaborative, and the Colorado PEAK unified benefits enrollment portal. The program partnered with a number of agencies on mailers to recipients likely to qualify for the Earned Income Tax Credit and the Child Tax Credit. The Hunger Free/GetAhead/LEAP Energy Assistance mailer went out with the LEAP program application to 113,000 previous LEAP participants, in the 3rd week of September 2022. In fall 2022, a mailer sent by the Department of Revenue engaged 35,308 Coloradans who filed taxes and appeared eligible for, but did not claim, tax credits, and was repeated in 2023 to 36,651 recipients. In January 2023, in partnership with the Department of Revenue, the program sent a Get Ahead flyer as a page in 11,914 application booklets mailed to potential Property Tax/Rent/Heat rebate filers, reflecting an ongoing strong collaboration with the Department of Revenue on both outreach and tax data sharing.

In 2022, the Economic Mobility Program worked with the Colorado PEAK unified benefits enrollment platform to pilot a banner promoting tax filing and linking to the Get Ahead Colorado website, dramatically increasing website metrics as a result. Using this data, the program then advocated for a banner benefits enrollment website during tax season 2023. This year, this banner was the top driver to the Get Ahead Colorado website. Building upon this success, the program requested to add a permanent tile to the “cash aid” page of available benefits programs. This tile was successfully added in April 2023 and represents a major outreach win and cross-agency partnership for the program. Work related to the “upstream” strategic anchor primarily falls within the above strategies of systems changes and cross-agency collaboration to increase reach.

The Economic Mobility Program developed communication resources to support community based organizations in integrating tax outreach into their operations, including guidance for expanding engagement, how to set up a VITA site, and changes to the tax code summary.

In 2022-23, the program launched small community tax outreach pilot projects with the Spring Institute, the Community Resource Center and the International Rescue Committee to support tailored, community-informed tax outreach to populations that may be missing out on tax credits. These pilots informed the creation of a request for applications that the program posted in late 2022 to distribute $1.1 million in leveraged funding to small community-based organizations to design innovative and culturally responsive approaches to tax outreach, prioritizing communities not typically reached by traditional outreach methods.

The community inclusion strategic anchor was explicitly reflected through a funding opportunity for community-based organizations. Funding that began in December 2022 and will continue through June 2024, was allocated to multiple small, community-based organizations, with the aim of reaching immigrant, refugee, newcomer communities, and low- to middle-income families and individuals. The funding opportunity was intentionally designed with less jargon/plain language and a simpler format to encourage participation from organizations that may not usually apply for funding through CDPHE. The application review process prioritized community inclusion by engaging and inviting four community members to join the review committee. This committee, which also included four state staff members, reviewed, scored, and discussed applications, ultimately deciding on funding recommendations. As well, the funding announcement itself and the scoring criteria reflected community input gathered at multiple community advisory board meetings in 2021 and 2022. Out of 20 applications, the review committee selected eight organizations for funding, representing geographically and demographically diverse Colorado communities.

In 2021-22, MCH funding supported the implementation of pilots providing referral information to other services that support economic mobility. The Economic Mobility Program worked with state and community partners to support referral to the Federal Communications Commission’s Affordable Connectivity Program and to Colorado BankOn services. Affordable Connectivity is a program that provides affordable internet to eligible individuals. Through the program’s Bright by Text partnership, close to 8,000 individuals received text messages about the program.

The Economic Mobility Program utilized MCH funding to support the creation of Colorado-specific data products. The Earned Income Tax Credit and Poverty Measures Dashboard and the Health eMoms Economic Mobility data brief was created and shared with key partners in 2022. The Economic Mobility Program created four communications pieces in 2023 designed for internal dissemination about the connection between economic mobility and long term health outcomes, with the goal of generating momentum within CDPHE to innovate work supporting economic mobility for the MCH population. These data products were used to support economic mobility efforts and to support the passage of Senate Bill 22-182 by sharing the data with the state legislature. The bill provides $1,720,060 to fund the Economic Mobility Program that is led by

MCH.

The economic mobility team continues to explore opportunities to build upon current tax outreach performance metrics towards measuring the scope and impact of these efforts. Tax outreach performance metrics are currently limited to campaign site visits and texting click throughs, and dollars claimed through the three AmeriCorps teams directly supported by the Economic Mobility Program. Eight additional VITA sites receive funding through the Economic Mobility Program to support enhanced free tax filing capacity, however, it is not currently possible to tease out the direct impact of the supplemental funding that these sites receive from the Economic Mobility Program from other funding sources. Other challenges that the economic mobility team face are adapting to the continually evolving state and federal tax code, the ongoing high demand for access to free tax filing statewide and the capacity of state staff to continue to expand outreach efforts and partnerships.

Priority: Built Environments
Performance Measure and Annual Objectives
SPM 1: Percent of children ages 0-17 years who live in a supportive neighborhood was 57.2%.
The annual objective for reporting year 2022 was 54.5%. The annual objective was met. The annual objective for reporting year 2023 is 55.0%.

This data for the SPM comes from the National Survey of Children's Health that is administered annually. This measure indicates availability of support via neighbors and places to seek and receive help. This measure indicates perception of safety and connection to community and may indicate availability of safe places to walk, bicycle, and wheelchair roll.

Resource Allocation to Advance this Priority
MCH Block Grant funds continue to be braided with CDC funding for physical activity, nutrition, comprehensive cancer prevention, violence and injury prevention, and state tobacco tax funds to develop and implement the state action plan for this priority. Leveraging these funds enables CDPHE's Health Promotion and Chronic Disease Prevention Branch to extend the reach of implementation efforts to the MCH population. For this reporting period, MCH Block Grant dollars funded approximately 0.6 FTE in the Healthy, Equitable, Livable Communities (HELC) Unit (also referred to as "built environment staff") for action planning, implementation, technical assistance, and community engagement support. The funded strategies and associated outcomes are summarized below. For a more detailed description, refer to the state action plan.

Strategy Implementation
Daily experiences such as feeling safe, taking a walk, visiting a park, having healthy food nearby, the ability to afford stable housing, and being part of social networks are critical to physical, mental, and social well-being. Thoughtful planning and design of a community's buildings, streets, sidewalks, transportation networks, parks, and homes can make it easier for children, youth, and families to engage, connect with others, and access resources in their communities. Safe and accessible built environments increase opportunities for physical activity by being able to walk, bike, or wheelchair roll to everyday destinations and decrease violence by creating safer environments for people to meet and connect.[1]

Staff within the Healthy, Equitable, Livable Communities Unit implemented state logic models and action plans for safe and connected built environments that reflect upstream collaborative work across CDPHE's Violence and Injury Prevention Mental Health Promotion Branch, the Health Promotion and Chronic Disease Prevention Branch, Environmental Health, and Maternal and Child Health program. Strategies to create safe and connected built environments include: 1) build cross-sector partnerships to increase capacity for implementing place-based policy strategies that promote equity, community safety, and activity-friendly routes; and 2) provide technical assistance for the implementation of equity driven, evidence-based, policy strategies to increase activity-friendly routes, community safety, and opportunities for social interaction.

Built environment staff foster partnerships with sectors such as parks, planning, public works, transportation, and schools to increase capacity for implementing place-based policy strategies and to increase equity, community safety, and activity-friendly routes. Built environment staff serve as members of the Cancer, Cardiovascular, and Pulmonary Disease Review Committee, Colorado Safe Routes to School Advisory Committee, Colorado Public Health and Parks and Recreation Collaborative, the Inter-Agency Conservation and Recreation Council, the Revitalizing Main Streets Advisory Committee, Colorado Cancer Coalition Board of Directors, Crime Prevention through Safer Streets Advisory Committee, as well as with advisory committees to support plans and programs for multiple municipal planning organizations, and the Bicycle Colorado Respect, Inclusion, Diversity, and Equity committee. Through these collaborations, CDPHE built environment approaches are aligned and integrated into partners' goals, strategies, policies, and funding opportunities.

CDPHE built environment staff collaborate with state and local partners to increase safe equitable access to parks and safe

opportunities for physical activity. Colorado was one of three states selected to participate in the Safe Routes to Parks Accelerator Program. CDPHE is partnering with the Colorado Department of Transportation and the Colorado Department of Natural Resources to implement an interagency action plan to increase access enhancements for parks and trails, such as transportation connections, street crossings, and expanded hours of operation. To address the inequitable distribution of accessible park resources for children and youth with special health care needs, built environment staff partnered with the Environmental Health Tracking Program, Great Outdoors Colorado, PlayCore, and parents to gather information and develop a statewide map of playgrounds in Colorado that have inclusive, accessible, and/or universal design features and amenities. In partnership with multiple MCH priorities, built environment staff hosted three virtual focus groups with parents of children and youth with special needs to better understand existing challenges and opportunities for accessible and inclusive playgrounds. Focus group data will inform future policy change and interventions to create more inclusive and accessible playgrounds and develop a best practice resource to share with partners. Built environment staff partnered with the Colorado Public Health and Parks and Recreation Collaborative to host a site visit at Panorama Park, a newly renovated park and universally accessible playground in Colorado Springs that was designed through extensive community input. All of these efforts align with the MCH program's community inclusion strategic anchor.

Colorado Springs city and community leaders enjoying the view during the Panorama Park site visit in August 2022.

Promoting shared-use/joint-use agreements, such as schools opening up playgrounds as parks after school and on weekends, is a best practice for increasing access to safe spaces for physical activity. The built environment priority action plan includes developing a map to identify locations of shared-use agreements. This activity is being re-evaluated due to limitations with data sharing agreements and perceived safety concerns, primarily related to gun violence, about making site-based shared-use agreements publicly available.

The built environment team at CDPHE partners with state, regional, and local partners to advance healthy built environment policies. Through partnerships across state agencies, the team identified that Colorado communities added at least 70 linear miles of active transportation network (e.g., bicycle lanes) that connect people to everyday destinations. Fifteen sites like parks and recreation centers that are connected to activity-friendly routes were created or enhanced, meaning people can walk, bike, wheel, or bus to those destinations. For the fourth year, the built environment team funded community quick-win projects to support local implementation of safe and connected built environments and physical activity promotion. After receiving 63 applications, the team leveraged funds across multiple programs to expand the budget to provide funding for 25 community-led projects.

Children and families enjoying a "pop up park" during the Mid Autumn Festival in Denver. Supplies for the park were funded by built environment quick-win funding.

Engaging youth in the built environment is a cross-priority strategy to advance safe and connected built environments, prosocial connections, and the community inclusion strategic anchor. The built environment and prosocial connections priority implementation teams developed shared activities in their action plans to support youth-led initiatives to improve the built environment. Priority coordinators co-created a pilot program that leverages funding across multiple programs to engage youth coalitions to identify and implement small-scale built environment changes. The pilot program was launched in April 2023 and projects implemented throughout the summer and fall of 2023. While the pilot program was informed by lessons learned from previous quick-win programs, the pilot establishes a new and separate process that will guide the creation of a larger-scale MCH funding opportunity in the upcoming fiscal year.

A large part of CDPHE's work to create safe and connected built environments involves providing education, technical assistance and subject matter resources to partners. Built environment staff partnered with 68 unique entities to provide 77 technical assistance touch points. For example, built environment staff developed a presentation on safe and connected built environments and met with local public health agencies to discuss strategies and partnerships for implementation. Built environment staff from CDPHE provided technical assistance to local initiatives in Routt County on built environment pedestrian safety measures; to partners in Archuleta County, La Plata County, Adams County, and Boulder County on model policy language for food access and nutrition security strategies; and to Weld County on affordable housing policy and community engagement strategies. To more broadly share resources, the built environment team redesigned CDPHE's Built Environment webpage to include information about the connection between built environment and health, best practices, success stories, and state and national resources and data.

As a result of the technical assistance and cross-sector partnerships, the built environment team supported partners at Colorado Department of Transportation to develop a policy that was passed by the Colorado Transportation Commission in December 2021. This first-of-its-kind climate change policy called the Greenhouse Gas (GHG) Pollution Reduction Planning Standard shifts resources away from polluting highway expansion projects and toward more environmentally and health-friendly projects like public transit, sidewalks, and bicycle lanes. In May 2022, the Colorado Transportation Commission approved Policy Directive 1610 (PD-1610) to establish an ongoing administrative process and guidelines for the greenhouse gas mitigation measures. In December 2022, Policy Directive 1610 was amended to establish an equity framework to assess transportation system impacts and prioritize transportation funding for historically under-resourced and under-represented communities, including MCH populations. CDPHE is exploring how to support the Colorado Department of Transportation in implementing the framework through a racial equity lens.

To support policy implementation, built environment staff participated in an interagency and stakeholder workgroup to explore options to incentivize smart land use decisions as a built environment approach to reducing greenhouse gas emissions. The group developed a report for the Governor and legislature that identifies Colorado's land use challenges, best practices and potential solutions, and recommendations for developing new tools to reach local and state goals through land use planning. The report was used to inform the drafting of Senate Bill 23-213 that was introduced in March 2023 to increase housing availability and affordability aligned with land use best practices. The land use legislation did not pass this session, but we anticipate providing subject matter expertise to inform legislative action related to housing affordability in the 2024 session.

Built environment staff provide ongoing technical assistance to the Revitalizing Main Streets program that helps create safe and connected built environments for MCH populations. Staff review applications to ensure public health and equity are included and help select local communities to fund to implement best practices for safe pedestrian and bicycle infrastructure. This program is one of the only sources of funding for communities to implement bicycle and pedestrian infrastructure and provides much needed resources and support to Colorado's small, rural communities. In 2022, approximately $2.7 million was distributed to 22 communities. Built environment staff regularly share information about Revitalizing Main Streets with local public health agencies and provide technical assistance to help communities with their application.

The built environment team collaborated with Colorado Safe Routes to School and the Safe Routes Partnership to develop and publish a resource to advance community inclusion and support authentic and equitable community engagement called, "*Working Together to Make Meaningful Change: A Toolkit for Engaging Communities Across Colorado*." The toolkit is used to implement cross-priority work and is integrated into the Safe Routes to School grants program. To disseminate the toolkit, the partners hosted a series of webinars to review the contents of the toolkit. Subsequently, the Safe Routes Partnership created a spin-off national toolkit called, *"Let's Get Together: A Guide for Engaging Communities and Creating Change."* The three partners co-designed a training series to help local communities implement engagement strategies from the toolkit, and two communities were trained in 2022.

Over this reporting period, one of the built environment priority coordinators was appointed to the Crime Prevention through Safer Streets Advisory Committee as part of Senate Bill 22-001, specifically to serve as a voice for heath and racial equity for the grants program. The Crime Prevention Through Safer Streets Act creates the Crime Prevention Through Safer Streets Grant Program in the Colorado Department of Public Safety. Local governmental agencies or local governments in partnership with a community-based nonprofit organization can apply for grants to make improvements to decrease crime and create safer streets ($10.3M).

[1] https://www.cdc.gov/physicalactivity/community-strategies/activity-friendly-routes-to-everyday-destinations.html

Cross-Cutting/Systems Building - Application Year

Priority: Racial Inequities

Performance Measure and Annual Objective

SPM 3: Number of points for racial equity related policy, practices and systems changes implemented at the program, division and department level. The annual objective for reporting year 2024 is 12.

Resource Allocation to Advance this Priority

For the upcoming reporting period, MCH Block Grant dollars will continue to support the implementation of the reducing racial inequities priority. The funding will support 1.0 FTE for the Racial Equity Specialist to develop and implement state action plan strategies and consult with internal and external partners to integrate racial equity approaches across programs and systems that serve the MCH population. The strategies planned for the upcoming year for this priority are summarized below. For a more detailed description, refer to the state action plan.

Strategy Implementation

In the upcoming year, the Racial Equity Specialist will partner with the reducing racial inequities implementation team to continue to navigate how to most effectively influence state policies and practices to advance a race equity culture. Efforts will focus on: 1) implementing the stress-responsive, trauma-informed learning series with additional local public health agencies and evaluating its impact; 2) normalizing the use and application of equity tools; 3) coordinating race equity efforts across the Branch, Division, and the Department; and, 4) continuing coaching, consultation, and training to state and local partners related to racial equity.

The Racial Equity Specialist and Workforce Development Section Manager will evaluate the effectiveness of the stress-responsive, trauma-informed approach. The learnings from this evaluation will inform critical changes for the next wave of implementation with additional local public health agencies.

The reducing Racial Equity Specialist will continue to provide consultation to local public health agencies and other community-based MCH partners as requested. Currently, this includes Adams and Arapahoe Departments of Public Health and Environment who have selected the reducing racial inequities priority. The Racial Equity Specialist will also work with the Departments of Public Health and Environment in Broomfield and Pueblo on a year-long effort to strengthen competencies related to racial equity and trauma-informed systems.

The Racial Equity Specialist will continue to support Branch, Division, and Department-wide race equity efforts. This includes implementation of race-based affinity groups in the Children, Youth and Families Branch, which will launch in September 2023 with a four-hour foundational workshop led by two external facilitators, followed by monthly 2-hour gatherings through June of 2024. The monthly gatherings will begin with the full group, then break into two groups (one with those who identify as BIPOC and one who identify as white). The Racial Equity Specialist and the Workforce Development Section Manager will meet regularly with the facilitators in order to address issues as they arise, as well as to identify opportunities to support internal infrastructure to continue key components of the affinity groups once the external contract ends in June 2024.

Additionally, the Racial Equity Specialist will continue to partner with the inclusion, diversity, equity and accessibility leads for the Division and Department, will implement activities in the Division's racial equity strategic plan, and co-chair the CDPHE BIPOC Connection Employee Resource Group.

Priority: Economic Mobility

Performance Measure and Annual Objective

SPM 5: Percent of children in poverty according to the supplemental poverty measure. The annual objective for reporting year 2024 is 7.9%.

Resource Allocation to Advance this Priority

During the upcoming reporting period, MCH Block Grant funds will continue to anchor the Economic Mobility Program's backbone operations, including the Economic Mobility Program Manager and partial FTE supporting community grant coordination, contract administration, evaluation and communications. The program will continue to rely on other funding sources including private foundation funds, American Rescue Plan Act dollars and AmeriCorps volunteers. Additionally, braided funding will support contracts with local public health agencies, Volunteer Income Tax Assistance (VITA) sites, and community-based organizations. Funding will continue to support ongoing outreach efforts through the Get Ahead Colorado public information campaign. The Economic Mobility Program will continue to promote tax credit outreach and referral, expand partnerships, and promote additional economic mobility supports beyond tax credits. Data and evaluation staff will

also continue to support the priority through maintaining the Earned Income Tax Credit and Poverty Measures Dashboard, compiling program data and updating the priority's evaluation plan. The strategies planned for the upcoming year for this priority are summarized below. For a more detailed description, refer to the state action plan.

Priority Implementation
In addition to the ongoing activities, the Economic Mobility Program will continue to expand partnerships with a focus on strengthening collaboration with other state agencies, such as the Department of Early Childhood, the Department of Human Services, and the Department of Revenue. Examples of partner programs include early childhood educator credentialing, the Colorado Child Care Assistance program, early childhood councils, Head Start, and family resource centers. By partnering with these programs, the Economic Mobility Program aims to provide additional support and resources to families with young children, as well as early childhood educators. The program will also expand volunteer recruitment to free tax assistance sites to increase free tax filing capacity. Through continued collaboration with local public health agencies, AmeriCorps, and state agency programs, the program will seek to add additional economic mobility support to outreach and referral efforts, these include financial literacy tools, affordable internet and banking information. Data and evaluation staff will continue to refine and share products to tell the story of inequality, economic mobility, and health in Colorado.

The Get Ahead Colorado media campaign will continue to increase its reach through various channels, including a new partnership with Rocky Mountain PBS and ongoing refinement of texting outreach methods. The program will leverage its analysis of campaign performance metrics to improve outreach and communications strategies to further enhance impact. Additionally, the program will expand its AmeriCorps footprint through the recruitment of more VISTA volunteers and AmeriCorps tax filing teams. These volunteers will be placed at CDPHE, the Governor's Office and tax assistance sites to enhance outreach and referral efforts and support free tax filing.

The program will draw from lessons learned and shared themes identified across the eight community-based organizations funded to implement tax outreach projects prioritizing hard-to-reach populations. This knowledge will be used to develop more effective strategies and approaches for future tax outreach efforts within and beyond CDPHE. Moreover, the program will embark on a fourth year of funding for free tax assistance sites, which will again build in bonus incentives to encourage increased free tax filing capacity using a funding formula. Through these efforts, the program aims to expand access to free tax filing services, particularly in underserved areas and for non-English speaking, immigrant, and refugee groups.

The program plans to continue developing a menu of strategies for both small and large local public health agencies. An additional focus for economic mobility beyond tax credit outreach, will be to identify policy and other structural barriers that are contributing to financial burden for families and working with other state agencies to address these barriers. One example is the Certified Nursing Aide (CNA) program. This program is the most straightforward way for parents of children or youth with special needs to become eligible to be paid to provide care – it is both a program for family caregivers and a career path for those who want to work in home health and nursing home settings. The CNA skills exam, part of the CNA certification, is currently only offered in English. This limits the number of people who can become CNAs, and the lack of other language options limits the economic mobility of non-English speaking families who may want to become CNAs. Working to make this exam offered in other languages is a policy change that can support economic mobility. In the coming year, we plan to connect with local public health agencies and community-based organizations to help identify other policies that create barriers to economic mobility.

Priority: Built Environments
Performance Measure and Annual Objective
SPM 1: Percent of children ages 0-17 years who live in a supportive neighborhood. The annual objective for reporting year 2024 is 55.5%.

Resource Allocation to Advance this Priority
For the upcoming reporting period, MCH Block Grant funds will continue to be braided with CDC funding for physical activity, nutrition, comprehensive cancer prevention, violence and injury prevention, state tobacco tax funds, and state general funds to implement the state action plan for this priority. MCH Block Grant dollars will continue to support approximately 0.6 FTE in the Healthy, Equitable, Livable Communities (HELC) Unit (also referred to as "built environment staff") for action planning, implementation, technical assistance, and community engagement support. The strategies planned for the upcoming year for this priority are summarized below. For a more detailed description, refer to the state action plan.

Strategy Implementation
In the coming year, built environment staff will continue to implement the state action plan for safe and connected built environments that reflect upstream collaborative work. The strategies to create safe and connected built environments will

continue to include: 1) build cross-sector partnerships to increase capacity for implementing place-based policy strategies that promote equity, community safety, and activity-friendly routes; and 2) provide technical assistance for the implementation of equity-driven, evidence-based, policy strategies to increase activity-friendly routes, community safety, and opportunities for social interaction.

Built environment staff will continue to identify opportunities for implementing cross-priority work with prosocial connections and positive child and youth development to engage families and youth in built environment efforts. In the coming year, staff will increase internal coordination of built environment strategies by expanding partnerships with community-based youth coalitions to fund low-cost, community-driven projects that support social connectedness and safe and connected built environments.The team will continue to implement a funding opportunity for communities to implement small-scale built environment projects, such as story walks at libraries, improvements to play spaces, and streetscape enhancements for safety. In alignment with the racial equity and community inclusion strategic anchors, the built environment team will partner with Bicycle Colorado and Denver Streets Partnership to develop training for Spanish-speaking populations to assess and advocate for improvements to transit access. The team will continue to partner with the Environmental Health Tracking Program and the Environmental Justice Unit within CDPHE to increase awareness of and use of Colorado enviroscreen, a data mapping tool that will be released to help identify communities disproportionality impacted by environmental contaminants.

Built environment staff will continue to collaborate with state, local and regional partners to to increase capacity for implementing place-based policy strategies that promote equity, community safety, and activity-friendly routes. CDPHE will support the Colorado Department of Transportation in the implementation of the Policy Directive 1610 equity framework, selection of local communities for Revitalizing Main Streets funding, and development of the Safe Routes to School Strategic plan and the Strategic Highway Safety Plan. Revitalizing Main Streets staff at the Department of Transportation, plan to revise the program evaluation criteria and CDPHE's built environment team will support this process by recommending health and equity indicators to include. Built environment staff will continue to collaborate with the Colorado Department of Local Affairs on the development of Model Land Use Codes for use by Colorado communities and implementation of the Innovative Affordable Housing Program, Colorado Resiliency Framework, and Strong Communities Program. Built environment staff will support the Department of Natural Resources to update the State Comprehensive Outdoor Recreation Plan and implement the Safe Routes to Parks Action Plan.

Built environment staff will continue to provide technical assistance on best practices for safe and connected built environments to local public health agencies and other community-based organizations in urban and rural areas of Colorado. To support technical assistance and to build local capacity for upstream work, built environment staff will collect and share information about built environment funding resources, develop and disseminate data and mapping tools, and create an environmental scan of local built environment policies to support safe transportation, access to nutritious foods, park access, and healthy and affordable housing. The built environment team will collaborate with the Safe Routes Partnership at the Department of Transportation to facilitate additional training with communities to implement the Colorado Community Engagement toolkit. Built environment staff will provide technical assistance to metropolitan planning organizations to integrate public health and equity data into funding prioritization processes for bicycle, pedestrian, and transit projects; engage community members that represent diverse perspectives; and integrate transportation, land use, and housing best practices in plans/policies. Built environment staff will expand the universally accessible play space map and data gathered through engagement with parents of children with special needs to explore the development of a statewide multi-sector workgroup to support expanding inclusive access to safe places for play and recreation. Built environment staff will leverage knowledge and resources at CDPHE to ensure technical assistance resources are linguistically accessible and culturally competent. The team will work with partners across state agencies to develop and disseminate best practice resource guides to help communities implement built environment policies, such as Complete Streets and Vision Zero policies.

III.F. Public Input

Colorado's approach to public input occurs through several mechanisms that reflect the program's strong commitment to the MCH strategic anchor of community inclusion. A more robust description of how public and community input is gathered throughout all stages of MCH planning, implementation and evaluation, is included below as well as in the ***Family Partnership section (III.E.2.b.ii.)***.

Youth, Family and Community Input
As described in the ***Family Partnership section***, Colorado's MCH program convenes two community input groups: the Youth Partnership for Health and the Community Advisory Board. The MCH program also contracts with Parent to Parent of Colorado to ensure the parent/caregiver/family perspective is included throughout MCH work.

Local Public Health Agency Input
MCH staff offered a structured customer service survey for local public health agencies, which was distributed in July 2022. This survey focused on processes including contracting, budgeting, training and technical assistance offered, data products, reporting requirements, customer service and related topics on the effectiveness of the state office in administering the MCH funds. At the time of submission, results have been aggregated and analyzed to identify opportunities for ongoing quality improvement.

The MCH Local Support team has been using local public health agency customer service satisfaction survey results (from last July) to inform local agency support. In response to a request for clearer expectations around reporting we improved instructions, integrated the strategic anchors into reporting documents, and added an example 4-square report. In response to concerns that were shared, we convened a community workgroup to inform the Picturing Colorado MCH storytelling project (See ***Section III.C. Five Year Needs Assessment Summary*** for more about the storytelling project). In response to community inclusion being named the top local workforce need, the January local learning community centered on the topic. The next customer service survey will be administered in July 2024.

Stakeholder Communication
Colorado's MCH Digest, a monthly online newsletter created for a broad system of external partners, continues to be an effective way to share news and updates with local partners. The format includes regular direct messages from MCH leadership, highlights of statewide MCH priority work, and content spotlighting the synergy between state and local MCH efforts. Recently, two new sections were added: a local public health corner to share local success stories and a workforce development section to share updates and resources. Over the past year, among the 433 subscribers, the average open rate was 50.4%, which is up 8% from last year (industry average is 28.77%, overall average 21.33%) and the average click rate was 8.6% (industry average is 3.99%, overall average 2.62%).

Additional MCH-supported newsletters are developed and disseminated specifically for audiences focused on maternal wellness, obesity prevention, breastfeeding promotion, CYSHCN, and other topics.

To familiarize the general public with MCH programmatic efforts, the final copy of the Title V block grant report/application is posted on the MCH website upon completion, along with user-friendly resources to describe MCH programmatic work.

III.G. Technical Assistance

Approaches to Local Funding Formulas Across States
The MCH program will continue to be exploring opportunities for strengthening and refining the current local funding formula. This area of interest was identified in 2020, however, was put on hold to prioritize the transition to the 2021-2025 priorities, as well as the public health response to the pandemic. The purpose of this technical assistance is to receive support to identify and document formulas across the national network of MCH programs to assist Colorado, and other interested states, in maintaining up-to-date and relevant formulaic distributions in a changing public health landscape.

Goal 1: Conduct an environmental scan of current MCH local funding formulas being used across the country.
Objective: Scan similar states for formula composition including information such as:

- Percent of funds used for state programming versus passed through to sub recipients such as local public health agencies
- Whether funding is formulaic, competitive, or a combination of the two
- Minimum and maximum funding levels (floors and ceilings) within formulas
- Formula variables included, such as Federal Poverty Level or equity-centered variables

Progress: In January 2020, AMCHP, in collaboration with Colorado and Washington, distributed a survey to states to explore funding formulas including the questions above. The survey received 22 responses. AMCHP was planning to conduct key informant interviews to follow up on survey responses and prepare a report to disseminate to the network. This has been on hold given the limited bandwidth of many state MCH programs' involvement throughout the public health response to the COVID-19 pandemic. Colorado is interested in revisiting this conversation in the upcoming year.

Goal 2: Based on results of the environmental scan and feedback from MCH staff and partners, identify if there are any needed recommendations to improve the Colorado MCH program that would be appropriate to be addressed with the formula.

Progress: Due to COVID-19 and the launch of the 2021-2025 MCH priorities, MCH staff decided that it was important to keep funding levels as consistent as possible to support local public health agencies already experiencing large amounts of change in the current economic and social climate. However, Colorado MCH will begin exploring this again in the upcoming year.

Goal 3: Incorporate an equity lens into the Colorado MCH formula. This may include data principles for consideration, the creation of a statewide equity index using social vulnerability data from the State Demography Office, or other practices.

Progress: In winter of 2022-23, MCH met with staff from CDPHE's Office of Public Health Practice, Planning and Local Partnerships (OPHP) to learn about their updates to their funding formula practices and how they incorporated equity into their funding formula. Additional research to address this goal will happen in the upcoming year.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - Medicaid Agreement with Email.pdf

V. Supporting Documents

No Supporting documents were provided by the state.

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - CDPHE MCH Org Charts combined.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Colorado

	FY 24 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 7,403,131	
A. Preventive and Primary Care for Children	$ 2,319,050	(31.3%)
B. Children with Special Health Care Needs	$ 3,064,373	(41.3%)
C. Title V Administrative Costs	$ 350,668	(4.8%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 5,734,091	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 5,552,349	
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)	$ 5,552,349	
A. Your State's FY 1989 Maintenance of Effort Amount $ 4,736,061		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 12,955,480	
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)	$ 2,288,800	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 15,244,280	

OTHER FEDERAL FUNDS	FY 24 Application Budgeted
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventing Maternal Deaths: Supporting Maternal Mortality Review Committees	$ 375,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Pediatric Mental Health Care Access Program	$ 445,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Maternal Health Innovation Program	$ 1,000,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Essentials for Childhood	$ 311,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Sudden Unexpected Infant Death (SUID) Case Registry Program	$ 57,800

	FY 22 Annual Report Budgeted		FY 22 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 7,346,989 (FY 22 Federal Award: $ 7,403,131)		$ 7,403,131	
A. Preventive and Primary Care for Children	$ 2,670,106	(36.3%)	$ 2,319,050	(31.3%)
B. Children with Special Health Care Needs	$ 2,614,402	(35.6%)	$ 3,064,373	(41.3%)
C. Title V Administrative Costs	$ 375,419	(5.1%)	$ 350,668	(4.8%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 5,659,927		$ 5,734,091	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 5,510,242		$ 5,552,349	
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)	$ 5,510,242		$ 5,552,349	
A. Your State's FY 1989 Maintenance of Effort Amount $ 4,736,061				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 12,857,231		$ 12,955,480	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$ 1,175,000		$ 1,299,024	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 14,032,231		$ 14,254,504	

OTHER FEDERAL FUNDS	FY 22 Annual Report Budgeted	FY 22 Annual Report Expended
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventing Maternal Deaths: Supporting Maternal Mortality Review Committees	$ 375,000	$ 357,675
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Pediatric Mental Health Care Access Program	$ 700,000	$ 473,821
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000	$ 100,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Maternal Health Innovation Program		$ 0
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Essentials for Childhood		$ 311,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Sudden Unexpected Infant Death (SUID) Case Registry Program		$ 56,528

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**1. FEDERAL ALLOCATION**
	Fiscal Year:	**2024**
	Column Name:	**Application Budgeted**
	Field Note: 7403131	
2.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children**
	Fiscal Year:	**2024**
	Column Name:	**Application Budgeted**
	Field Note: The MCH program at CDPHE expects to maintain the recommended minimum threshold for local public health agency spending on the Preventive and Primary Care for Children population and the Children with Special Heath Care Needs population.	
3.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs**
	Fiscal Year:	**2024**
	Column Name:	**Application Budgeted**
	Field Note: The MCH program at CDPHE expects to maintain the recommended minimum threshold for local public health agency spending on the Preventive and Primary Care for Children population and he Children with Special Health Care Needs population.	
4.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs**
	Fiscal Year:	**2024**
	Column Name:	**Application Budgeted**
	Field Note: Colorado's definition of administrative costs includes operating costs and personnel time for the division's centralized services that support the MCH program. This includes fiscal, compliance, contracts, operations, and communications support. These cost have consistently remained between 5-9%. Annual variations are contingent upon the status of the Prevention Services Division's overall budget for centralized services, which is impacted by changes in Federally negotiated indirect rates, centralized services staffing and availability of resources from other funding streams.	
5.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventing Maternal Deaths: Supporting Maternal Mortality Review Committees**

	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**
	Field Note: Requested Carryforward $17,325	
6.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Pediatric Mental Health Care Access Program**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**
	Field Note: Awarded $445,000. Received Carryforward request of $49,700. Total = 494,700. Amount Spent = $473,821.	
7.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Maternal Health Innovation Program**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**
	Field Note: CDPHE received this award in FY23. No expenses to report for FY22	
8.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Sudden Unexpected Infant Death (SUID) Case Registry Program**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**
	Field Note: Requested Carryforward of $1,272	

Data Alerts:

- The value in Line 1A, Preventive And Primary Care Expended, Annual Report Expended is greater or less than 10% of the Annual Report Budgeted. Please correct or add a field level note indicating the reason for the discrepancy.
- The value in Line 1B, Children with Special Health Care Needs, Annual Report Expended is greater or less than 10% of the Annual Report Budgeted. Please correct or add a field level note indicating the reason for the discrepancy.

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

State: Colorado

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY 24 Application Budgeted	FY 22 Annual Report Expended
1. Pregnant Women	$ 842,601	$ 842,601
2. Infants < 1 year	$ 826,439	$ 826,439
3. Children 1 through 21 Years	$ 2,319,050	$ 2,319,050
4. CSHCN	$ 3,064,373	$ 3,064,373
5. All Others	$ 0	$ 0
Federal Total of Individuals Served	$ 7,052,463	$ 7,052,463

IB. Non-Federal MCH Block Grant	FY 24 Application Budgeted	FY 22 Annual Report Expended
1. Pregnant Women	$ 152,245	$ 152,245
2. Infants < 1 year	$ 21,861	$ 21,861
3. Children 1 through 21 Years	$ 2,944,347	$ 2,944,347
4. CSHCN	$ 95,564	$ 95,564
5. All Others	$ 2,338,332	$ 2,338,332
Non-Federal Total of Individuals Served	$ 5,552,349	$ 5,552,349
Federal State MCH Block Grant Partnership Total	$ 12,604,812	$ 12,604,812

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

None

Data Alerts: None

Form 3b
Budget and Expenditure Details by Types of Services

State: Colorado

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY 24 Application Budgeted	FY 22 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	$ 1,340,850	$ 1,340,850
3. Public Health Services and Systems	$ 6,062,281	$ 6,062,281
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	$ 7,403,131	$ 7,403,131

IIB. Non-Federal MCH Block Grant	FY 24 Application Budgeted	FY 22 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	$ 1,340,850	$ 1,340,850
3. Public Health Services and Systems	$ 6,062,281	$ 6,062,281
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 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	$ 7,403,131	$ 7,403,131

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: 63,541 **Data Source Year: 2021**

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Valid Screen	(B) Aggregate Total Number of Out-of-Range Results	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	63,005 (99.2%)	2,577	77	77 (100.0%)

Program Name(s)				
3-Hydroxy-3-Methyglutaric Aciduria	3-Methylcrotonyl-Coa Carboxylase Deficiency	Argininosuccinic Aciduria	Biotinidase Deficiency	Carnitine Uptake Defect/Carnitine Transport Defect
Citrullinemia, Type I	Classic Galactosemia	Classic Phenylketonuria	Congenital Adrenal Hyperplasia	Cystic Fibrosis
Glutaric Acidemia Type I	Homocystinuria	Isovaleric Acidemia	Long-Chain L-3 Hydroxyacyl-Coa Dehydrogenase Deficiency	Maple Syrup Urine Disease
Medium-Chain Acyl-Coa Dehydrogenase Deficiency	Methylmalonic Acidemia (Cobalamin Disorders)	Methylmalonic Acidemia (Methylmalonyl-Coa Mutase)	Primary Congenital Hypothyroidism	Propionic Acidemia
S, ßeta-Thalassemia	S,C Disease	S,S Disease (Sickle Cell Anemia)	Severe Combined Immunodeficiences	Spinal Muscular Atrophy Due To Homozygous Deletion Of Exon 7 In SMN1
ß-Ketothiolase Deficiency	Trifunctional Protein Deficiency	Tyrosinemia, Type I	Very Long-Chain Acyl-Coa Dehydrogenase Deficiency	

2. Other Newborn Screening Tests

Program Name	(A) Total Number Receiving at Least One Screen	(B) Total Number Presumptive Positive Screens	(C) Total Number Confirmed Cases	(D) Total Number Referred for Treatment
Newborn hearing screening	61,160 (96.3%)	1,015	161	161 (100.0%)
Argininemia	63,005 (99.2%)	0	0	0 (0%)
Short-chain acyl-CoA dehydrogenase deficiency	63,005 (99.2%)	39	0	0 (0%)
Glutaric acidemia type II	63,005 (99.2%)	11	0	0 (0%)
Carnitine palmitoyltransferase type I deficiency	63,005 (99.2%)	7	0	0 (0%)
Carnitine palmitoyltransferase type II deficiency and Carnitine acylarnitine translocase deficiency	63,005 (99.2%)	1	0	0 (0%)

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

The state health department contracts with sub-specialty clinics at Children's Hospital Colorado and Rocky Mountain Pediatric Endocrinology, so that every child identified with a critical presumed positive result is referred directly to these clinics for consultation and further evaluation. There is no formal long-term follow-up by the state health department.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

1.	**Field Name:**	**Total Births by Occurrence**
	Fiscal Year:	**2022**
	Column Name:	**Total Births by Occurrence Notes**
	Field Note: The total births by occurrence is the number of occurrent births in Colorado in calendar year 2021.	
2.	**Field Name:**	**Data Source Year**
	Fiscal Year:	**2022**
	Column Name:	**Data Source Year Notes**
	Field Note: These data represent newborn screening data from calendar year 2021.	
3.	**Field Name:**	**Core RUSP Conditions - Total Number Receiving At Least One Screen**
	Fiscal Year:	**2022**
	Column Name:	**Core RUSP Conditions**
	Field Note: Colorado added Glycogen Storage Disease Type II (Pompe), Mucopolysaccaridosis Type 1, and X-linked adrenoleukodystrophy to the newborn bloodspot screening panel population testing in March 2021. Data collection commenced with 2022 births.	

Data Alerts: None

Form 5
Count of Individuals Served by Title V & Total Percentage of Populations Served by Title V

State: Colorado

Annual Report Year 2022

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

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	975	32.0	2.0	64.0	2.0	0.0
2. Infants < 1 Year of Age	140	33.0	1.0	61.0	5.0	0.0
3. Children 1 through 21 Years of Age	18,856	37.0	2.0	57.0	4.0	0.0
3a. Children with Special Health Care Needs 0 through 21 years of age^	612	84.0	1.0	15.0	0.0	0.0
4. Others	14,975	42.0	0.0	15.0	43.0	0.0
Total	34,946					

Form 5b – Total Percentage of Populations Served by Title V (Direct, Enabling, and Public Health Services and Systems)

Populations Served by Title V	Reference Data	Used Reference Data?	Denominator	Total % Served	Form 5b Count (Calculated)	Form 5a Count
1. Pregnant Women	62,949	No	62,356	100.0	62,356	975
2. Infants < 1 Year of Age	63,560	No	63,038	97.0	61,147	140
3. Children 1 through 21 Years of Age	1,480,392	No	1,498,344	87.2	1,306,556	18,856
3a. Children with Special Health Care Needs 0 through 21 years of age^	308,147	No	312,237	100.0	312,237	612
4. Others	4,271,336	No	4,296,330	5.9	253,483	14,975

^Represents a subset of all infants and children.

Form Notes for Form 5:

Forms 5A and 5B represent Reporting Year 2022 (October 1, 2021 - September 30, 2022).

5A: Total served are mainly derived from match sources and the Colorado Family Healthline.

5B: Colorado reported the number from the strategy that has the largest reach in an effort to avoid duplication for pregnant women, infants, and children with special health care needs. For children and others, the total count for each strategy was summed to calculate total served, although it is unknown if duplication exists across strategies.

The majority of Colorado's efforts are focused on public health services and systems activities rather than direct and enabling services. We anticipate direct and enabling services to continue to decrease as MCH work continues to shift to public health services and systems work.

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2022**
	Field Note: Sum of pregnant women who received family planning services during calendar year 2022 (396) based on percent of family planning funding from match (39%) plus total pregnant people served by the Colorado Family Healthline in fiscal year 2021-2022 (242) plus pregnant women enrolled in Baby & Me Tobacco Free in fiscal year 2021-2022 (217) plus pregnant women who received QuitLine services in fiscal year 2021-2022 (120). Family planning match percentage decreased from the previous year (65%). Insurance distribution for pregnant women is from the 2021 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:	**2022**
	Field Note: Infants served by the Colorado Family Healthline in fiscal year 2021-2022 (140). Insurance distribution for infants is from the 2021 Pregnancy Risk Assessment Monitoring System, and is based on responses to the question that asks about insurance at time of survey.	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2022**
	Field Note: Sum of children and youth served by school-based health centers (SBHC) during state fiscal year 2021-2022 (13,117) based on percent of SBHC funding from match (38%) plus total number of male youth and non-pregnant female youth ages <22 years who received family planning services during calendar year 2022 (4,839 (excluding pregnant women <22 yrs)) plus total children and youth served by the Colorado Family Healthline in fiscal year 2021-2022 (289) plus total children and youth ages 0-21 years with special health care needs who received HCP care coordination during federal fiscal year 2021-2022 (612). Family planning match percentage decreased from the previous year (65%). Insurance distribution is from the 2021 Colorado Health Access Survey, which is administered every other year.	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**

	Fiscal Year:	**2022**

Field Note:
Total children and youth ages 0-21 years with special health care needs who received HCP care coordination during federal fiscal year 2021-2022 (612). Fewer children with special health care needs received care coordination compared to the previous year (672). Insurance distribution for children and youth with special health care needs is from the HCP data system.

5.	**Field Name:**	**Others**
	Fiscal Year:	**2022**

Field Note:
Sum of number of men and non-pregnant women ages 22+ years who received family planning services during calendar year 2022 (11,777 (excluding pregnant women 22+ yrs)) plus total men and women (age unknown) served by the Colorado Family Healthline in fiscal year 2021-2022 (3,198). Family planning match percentage decreased from the previous year (65%). Insurance distribution for others is from the Family Planning Annual Report 2021 National Summary.

6.	**Field Name:**	**Total_TotalServed**
	Fiscal Year:	**2022**

Field Note:
It is unknown if duplication exists among pregnant women who received family planning services, those served by the Colorado Family Healthline, those enrolled in Baby & Me Tobacco Free, and those receiving QuitLine services. It is unknown if duplication exists among children and youth with special health care needs served by HCP care coordination, children and youth served in school-based health centers, children and youth served by the Colorado Family Healthline and youth receiving family planning services. It is unknown if duplication exists among men and non-pregnant women ages 22+ years who received family planning services and those served by the Colorado Family Healthline. Total served in reporting year 2022 is lower compared to reporting year 2021 due to the decrease in the family planning match.

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women Total % Served**
	Fiscal Year:	**2022**

Field Note:
Total Colorado resident births in 2022 (62,356) (strategies with the largest reach include pregnancy-related depression and anxiety statewide media campaign and Tough as a Mother (substance use during pregnancy) statewide media campaign).

Colorado MCH priority work: Social emotional well-being priority: pregnancy-related depression and anxiety statewide media campaign (number of live resident births statewide) (62,356); Colorado Alliance for Innovation on Maternal Health (AIM): substance use disorder learning collaborative (number of live births in 17 participating hospitals) (30,597) (five additional hospitals joined the collaborative in 2022 increasing the total number of births in participating hospitals); Tough as a Mother (substance use during pregnancy) statewide media campaign (number of live resident births statewide) (62,356).

2.	**Field Name:**	**Pregnant Women Denominator**

	Fiscal Year:	**2022**
	Field Note: Denominator: 2022 resident live births (Colorado Vital Statistics Program).	
3.	**Field Name:**	**Infants Less Than One Year Total % Served**
	Fiscal Year:	**2022**
	Field Note: Total live births receiving newborn hearing screening in 2022 (61,160) (strategy with the largest reach is newborn hearing screening). Colorado MCH priority work: Promote positive child and youth development priority: Baby-Friendly hospital certification (number of live births in 13 delivering hospitals certified as Baby-Friendly) (22,005). The Colorado newborn hearing screening program is again partnering with MCH. This explains the increase in infants served (97%) compared to earlier reporting years.	
4.	**Field Name:**	**Infants Less Than One Year Denominator**
	Fiscal Year:	**2022**
	Field Note: Denominator: 2022 occurrent live births (Colorado Vital Statistics Program).	
5.	**Field Name:**	**Children 1 through 21 Years of Age Total % Served**
	Fiscal Year:	**2022**
	Field Note: Total number of children ages 1-21 years in Colorado in 2022 served by three priorities plus estimated number of children with special health care needs ages 0-21 in Colorado in 2022 (1,306,865) (strategy with the largest reach is Colorado Pediatric Psychiatry Consultation and Access Program (CoPPCAP)); we summed all strategy counts plus the estimated number of children with special health care needs ages 0-21 to get total children and youth ages 1-21 served). Colorado MCH priority work: Prosocial connection priority: Forward Together statewide media campaign (number of youth ages 12-17 years in 2022 multiplied by 59% aware of the campaign (awareness % is new for reporting year 2022) (260,923); suicide prevention and LGBTQ+ school climate work in schools (number of school-aged children and youth enrolled in participating schools and districts) (177,609); Access to supports priority: Colorado Pediatric Psychiatry Consultation and Access Program (CoPPCAP) (number of patients at CoPPCAP enrolled practices) (555,150); Positive child and youth development priority: Farm to Early Childhood Education (ECE) mini grants (number of children served by mini grants) (946). The percentage of children ages 1 through 21 years served in reporting year 2022 (87.2%) increased from reporting year 2021 (62.4%) due to the inclusion of the estimated number of children with special health care needs ages 0-21.	
6.	**Field Name:**	**Children 1 through 21 Years of Age Denominator**
	Fiscal Year:	**2022**

	Field Note: Denominator: Total children 1-21 years (2022, Colorado State Demography Office).	
7.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age Total % Served**
	Fiscal Year:	**2022**
	Field Note: Estimated number of children with special health care needs ages 0-21 in Colorado in 2022 (312,237) (strategy with largest reach is CYSHCN policy agenda). Colorado MCH priority work: Access to supports priority: CYSHCN policy agenda (number of children with special health care needs statewide) (312,237); developmental screening and referral priority (number of children ages 0-3 referred to Early Intervention Colorado in 2021) (17,150); Social emotional well-being priority: Healthy Steps (child development program) (number of children ages 0-3 served by Healthy Steps in 2021) (33,130). The CYSHCN policy agenda contains policy recommendations that have statewide impact on Colorado's population of children and youth with special health care needs. CDPHE, guided by the policy agenda, funded 54 SBHCs across the state, including 17 to implement SBIRT (Screening Brief Intervention, Referral and Treatment). In addition to SBHCs, expanding the reach of Psychiatric Access Programs is also included in the policy agenda. For additional information on the CYSHCN policy agenda, please reference the Improve Access to Supports Annual Report.	
8.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age Denominator**
	Fiscal Year:	**2022**
	Field Note: Denominator: 2020-2021 CYSHCN ages 0-17 prevalence (National Survey of Children's Health) applied to total children 0-21 years (2022, Colorado State Demography Office).	
9.	**Field Name:**	**Others Total % Served**
	Fiscal Year:	**2022**
	Field Note: Total number of adults ages 22 years of age and older in Colorado in 2022 served by three priorities (255,103) (strategy with largest reach is Forward Together statewide media campaign which has a parent focus; we summed all strategy counts to get total adults ages 22 years of age and older served) Colorado MCH priority work: Economic mobility priority: VITA sites assisted child tax credit (CTC) and earned income tax credit (EITC) claims (49 funded-VITA sites reported providing assistance with 2,816 CTC claims and 4,189 EITC claims) (7,005); Social emotional well-being priority: pregnancy-related depression and anxiety statewide media campaign with focus on support system (number of live resident births statewide) (62,356); Prosocial connection priority: Forward Together statewide media campaign with parent focus (number of youth (assuming one parent per youth) ages 12-17 years in 2022 multiplied by 42% aware of the campaign (awareness % is new for reporting year 2022)) (185,742). The percentage of others served in reporting year 2022 (5.9%) is down from reporting year 2021 (12.3%) due to a change in economic mobility metrics and a decrease in the count of parents exposed to the Forward Together campaign (count % of parents aware of the Forward Together campaign rather than entire population 12-17).	

10.	**Field Name:**	**Others Denominator**
	Fiscal Year:	**2022**

Field Note:
Denominator: Total adults ages 22+ years (2022, Colorado State Demography Office).

Data Alerts: None

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

State: Colorado

Annual Report Year 2022

I. Unduplicated Count by Race/Ethnicity

	(A) Total	(B) Non-Hispanic White	(C) Non-Hispanic Black or African American	(D) Hispanic	(E) Non-Hispanic American Indian or Native Alaskan	(F) Non-Hispanic Asian	(G) Non-Hispanic Native Hawaiian or Other Pacific Islander	(H) Non-Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	62,356	34,722	2,931	18,941	322	2,452	198	1,688	1,102
Title V Served	62,356	34,722	2,931	18,941	322	2,452	198	1,688	1,102
Eligible for Title XIX	19,829	7,753	1,051	9,597	555	476	0	0	397
2. Total Infants in State	62,356	34,722	2,931	18,941	322	2,452	198	1,688	1,102
Title V Served	61,160	34,056	2,875	18,578	316	2,405	194	1,656	1,080
Eligible for Title XIX	27,536	10,767	1,459	13,327	771	661	0	0	551

Form Notes for Form 6:

None

Field Level Notes for Form 6:

1.	**Field Name:**	**1. Total Deliveries in State**
	Fiscal Year:	**2022**
	Column Name:	**Total**
	Field Note: 2022 births to Colorado residents.	
2.	**Field Name:**	**1. Title V Served**
	Fiscal Year:	**2022**
	Column Name:	**Total**
	Field Note: 2022 births to Colorado residents.	
3.	**Field Name:**	**1. Eligible for Title XIX**
	Fiscal Year:	**2022**
	Column Name:	**Total**
	Field Note: Percent with prenatal care paid for by Medicaid from 2021 Colorado Pregnancy Risk Assessment Monitoring System.	
4.	**Field Name:**	**2. Total Infants in State**
	Fiscal Year:	**2022**
	Column Name:	**Total**
	Field Note: 2022 births to Colorado residents.	
5.	**Field Name:**	**2. Title V Served**
	Fiscal Year:	**2022**
	Column Name:	**Total**
	Field Note: Number of infants screened for hearing in 2021.	
6.	**Field Name:**	**2. Eligible for Title XIX**
	Fiscal Year:	**2022**
	Column Name:	**Total**
	Field Note: Total <1 year of age eligible for EPSDT from FY22 Form CMS-416: Annual EPSDT Participation Report.	

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

State: Colorado

A. State MCH Toll-Free Telephone Lines	2024 Application Year	2022 Annual Report 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"	Tara Entwistle	Candace Davis
4. Contact Person's Telephone Number	(303) 692-2407	(303) 692-2414
5. Number of Calls Received on the State MCH "Hotline"		4,482

B. Other Appropriate Methods	2024 Application Year	2022 Annual Report Year
1. Other Toll-Free "Hotline" Names		
2. Number of Calls on Other Toll-Free "Hotlines"		
3. State Title V Program Website Address	https://cdphe.colorado.gov/mchcolorado	https://cdphe.colorado.gov/mchcolorado
4. Number of Hits to the State Title V Program Website		4,189
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	Rachel Hutson
Title	Children, Youth and Families Branch Director
Address 1	4300 Cherry Creek Drive South
Address 2	
City/State/Zip	Denver / CO / 80246
Telephone	(303) 692-2365
Extension	
Email	rachel.hutson@state.co.us

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Jennie Munthali
Title	CYSHCN Section Manager
Address 1	4300 Cherry Creek Drive South
Address 2	
City/State/Zip	Denver / CO / 80246
Telephone	(303) 692-2435
Extension	
Email	jennie.munthali@state.co.us

3. State Family Leader (Optional)	
Name	Nichole Arp
Title	Program Manager
Address 1	13407 W. 67th Dr.
Address 2	
City/State/Zip	Arvada / CO / 80246
Telephone	(720) 317-3843
Extension	
Email	narpp2p@abilityconnectioncolorado.org

4. State Youth Leader (Optional)	
Name	
Title	
Address 1	
Address 2	
City/State/Zip	
Telephone	
Extension	
Email	

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: Colorado

Application Year 2024

No.	Priority Need
1.	Increase prosocial connection
2.	Create safe and connected built environments
3.	Improve access to supports
4.	Increase social emotional well-being
5.	Promote positive child and youth development
6.	Increase economic mobility
7.	Reduce racial inequities

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 9 State Priorities – Needs Assessment Year – Application Year 2021

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Increase prosocial connection	New
2.	Create safe and connected built environments	New
3.	Improve access to supports	New
4.	Increase social emotional well-being	New
5.	Promote positive child and youth development	New
6.	Increase economic mobility	New
7.	Reduce racial inequities	New

Form 10
National Outcome Measures (NOMs)

State: Colorado

Form Notes for Form 10 NPMs, NOMs, SPMs, SOMs, and ESMs.

None

NOM 1 - Percent of pregnant women who receive prenatal care beginning in the first trimester

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	81.9 %	0.2 %	50,593	61,761
2020	80.0 %	0.2 %	48,120	60,180
2019	80.4 %	0.2 %	49,299	61,345
2018	79.2 %	0.2 %	48,644	61,449
2017	78.7 %	0.2 %	49,772	63,258
2016	77.4 %	0.2 %	50,657	65,409
2015	76.1 %	0.2 %	49,608	65,173
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% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 1 - Notes:

None

Data Alerts: None

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

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	103.1	4.3	586	56,855
2019	90.7	4.0	531	58,547
2018	80.0	3.7	472	59,004
2017	77.7	3.6	467	60,073
2016	74.9	3.5	470	62,713
2015	81.2	4.2	382	47,046
2014	80.4	3.6	495	61,600
2013	86.4	3.8	521	60,290
2012	87.0	3.8	529	60,786
2011	87.5	3.8	532	60,832
2010	92.6	3.9	573	61,850
2009	75.6	3.4	489	64,702
2008	67.0	3.2	444	66,261

Legends:

Indicator has a numerator ≤10 and is not reportable

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

NOM 2 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2021	15.9	2.3	50	314,579
2016_2020	13.5	2.1	43	318,243
2015_2019	12.1	1.9	39	323,330
2014_2018	12.0	1.9	39	326,291

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 3 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2021	9.5 %	0.1 %	5,939	62,678
2020	9.3 %	0.1 %	5,670	61,233
2019	9.4 %	0.1 %	5,911	62,698
2018	9.4 %	0.1 %	5,906	62,852
2017	9.1 %	0.1 %	5,848	64,350
2016	9.0 %	0.1 %	5,961	66,583
2015	9.0 %	0.1 %	6,001	66,550
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% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 4 - Notes:

None

Data Alerts: None

NOM 5 - Percent of preterm births (<37 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2021	9.7 %	0.1 %	6,133	62,913
2020	9.1 %	0.1 %	5,619	61,455
2019	9.6 %	0.1 %	6,004	62,843
2018	9.2 %	0.1 %	5,795	62,860
2017	8.8 %	0.1 %	5,638	64,355
2016	8.9 %	0.1 %	5,898	66,590
2015	8.7 %	0.1 %	5,770	66,564
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	8.8 %	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% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 5 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2021	27.6 %	0.2 %	17,392	62,913
2020	26.9 %	0.2 %	16,537	61,455
2019	26.0 %	0.2 %	16,334	62,843
2018	24.9 %	0.2 %	15,676	62,860
2017	24.5 %	0.2 %	15,746	64,355
2016	23.8 %	0.2 %	15,876	66,590
2015	23.5 %	0.2 %	15,625	66,564
2014	23.0 %	0.2 %	15,145	65,814
2013	23.0 %	0.2 %	14,911	64,971
2012	23.8 %	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% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 6 - Notes:

None

Data Alerts: None

NOM 7 - Percent of non-medically indicated early elective deliveries

Data Source: CMS Hospital Compare

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2021/Q1-2021/Q4	1.0 %			
2020/Q4-2021/Q3	1.0 %			
2020/Q3-2021/Q1	1.0 %			
2019/Q4-2020/Q3	3.0 %			
2019/Q1-2019/Q4	2.0 %			
2018/Q4-2019/Q3	2.0 %			
2018/Q3-2019/Q2	1.0 %			
2018/Q2-2019/Q1	1.0 %			
2018/Q1-2018/Q4	1.0 %			
2017/Q4-2018/Q3	1.0 %			
2017/Q3-2018/Q2	1.0 %			
2017/Q2-2018/Q1	1.0 %			
2017/Q1-2017/Q4	1.0 %			
2016/Q4-2017/Q3	1.0 %			
2016/Q3-2017/Q2	1.0 %			
2016/Q2-2017/Q1	1.0 %			
2016/Q1-2016/Q4	1.0 %			
2015/Q4-2016/Q3	1.0 %			
2015/Q3-2016/Q2	1.0 %			
2015/Q2-2016/Q1	1.0 %			
2015/Q1-2015/Q4	1.0 %			
2014/Q4-2015/Q3	1.0 %			
2014/Q3-2015/Q2	2.0 %			

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:

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
2020	4.9	0.3	301	61,630
2019	5.2	0.3	326	63,041
2018	5.1	0.3	320	63,039
2017	4.9	0.3	319	64,530
2016	5.5	0.3	368	66,799
2015	5.7	0.3	378	66,767
2014	5.5	0.3	366	66,003
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
2020	4.8	0.3	295	61,494
2019	4.9	0.3	305	62,869
2018	4.8	0.3	299	62,885
2017	4.5	0.3	289	64,382
2016	4.8	0.3	317	66,613
2015	4.7	0.3	310	66,581
2014	4.8	0.3	315	65,830
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**
2020	3.2	0.2	199	61,494
2019	3.1	0.2	193	62,869
2018	3.3	0.2	205	62,885
2017	3.0	0.2	196	64,382
2016	3.2	0.2	214	66,613
2015	3.5	0.2	233	66,581
2014	3.6	0.2	237	65,830
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**
2020	1.6	0.2	96	61,494
2019	1.8	0.2	112	62,869
2018	1.5	0.2	94	62,885
2017	1.4	0.2	93	64,382
2016	1.5	0.2	103	66,613
2015	1.2	0.1	77	66,581
2014	1.2	0.1	78	65,830
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
2020	180.5	17.2	111	61,494
2019	157.5	15.8	99	62,869
2018	178.1	16.8	112	62,885
2017	149.1	15.2	96	64,382
2016	157.6	15.4	105	66,613
2015	196.8	17.2	131	66,581
2014	159.5	15.6	105	65,830
2013	190.7	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 - 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
2020	71.6	10.8	44	61,494
2019	81.1	11.4	51	62,869
2018	65.2	10.2	41	62,885
2017	54.4	9.2	35	64,382
2016	55.5	9.1	37	66,613
2015	40.6	7.8	27	66,581
2014	72.9	10.5	48	65,830
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 - Percent of women who drink alcohol in the last 3 months of pregnancy

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	15.7 %	1.2 %	9,617	61,126
2020	15.4 %	1.3 %	9,266	60,018
2019	15.6 %	1.4 %	9,494	60,945
2018	14.4 %	1.2 %	8,738	60,890
2017	14.7 %	1.1 %	9,168	62,300
2016	17.3 %	1.4 %	11,199	64,676
2015	12.1 %	1.1 %	7,769	64,483
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 confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM 10 - Notes:

None

Data Alerts: None

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

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	5.6	0.3	272	48,937
2019	4.4	0.3	198	45,262
2018	5.2	0.3	243	46,607
2017	6.2	0.4	303	48,987
2016	5.1	0.3	273	53,066
2015	3.9	0.3	163	41,442
2014	2.9	0.2	160	54,417
2013	3.1	0.2	179	57,388
2012	2.9	0.2	171	59,183
2011	2.6	0.2	152	59,370
2010	2.4	0.2	142	59,358
2009	1.4	0.2	91	63,543
2008	1.3	0.1	84	64,222

Legends:

Indicator has a numerator ≤10 and is not reportable

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

NOM 11 - Notes:

None

Data Alerts: None

NOM 12 - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

Federally available Data (FAD) for this measure is not available/reportable.

NOM 12 - Notes:

None

Data Alerts: None

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

Federally available Data (FAD) for this measure is not available/reportable.

NOM 13 - Notes:

None

Data Alerts: None

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	10.7 %	0.9 %	126,208	1,182,659
2019_2020	10.2 %	1.1 %	120,993	1,187,327
2018_2019	9.7 %	1.2 %	115,034	1,186,085
2017_2018	9.3 %	1.2 %	107,315	1,158,723
2016_2017	11.0 %	1.2 %	126,810	1,148,433
2016	12.5 %	1.6 %	143,827	1,154,883

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 14 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2021	13.8	1.5	82	592,684
2020	9.6	1.3	58	606,358
2019	11.9	1.4	73	614,423
2018	18.6	1.7	115	618,682
2017	15.4	1.6	95	618,642
2016	14.9	1.6	93	623,117
2015	13.9	1.5	87	624,099
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**
2021	47.2	2.5	349	740,094
2020	48.0	2.6	349	727,811
2019	39.0	2.3	284	728,987
2018	35.8	2.2	261	728,742
2017	38.8	2.3	279	719,586
2016	34.6	2.2	247	714,069
2015	34.2	2.2	242	706,659
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**
2019_2021	12.5	1.1	138	1,105,306
2018_2020	12.1	1.1	132	1,095,198
2017_2019	13.0	1.1	141	1,085,262
2016_2018	14.1	1.1	151	1,074,208
2015_2017	13.0	1.1	138	1,059,669
2014_2016	11.3	1.0	118	1,046,507
2013_2015	10.4	1.0	107	1,031,620
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**
2019_2021	21.8	1.4	241	1,105,306
2018_2020	21.5	1.4	236	1,095,198
2017_2019	21.0	1.4	228	1,085,262
2016_2018	19.8	1.4	213	1,074,208
2015_2017	20.4	1.4	216	1,059,669
2014_2016	17.6	1.3	184	1,046,507
2013_2015	16.0	1.3	165	1,031,620
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 (CSHCN), ages 0 through 17

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	20.0 %	1.0 %	250,234	1,250,807
2019_2020	18.0 %	1.2 %	226,196	1,258,808
2018_2019	18.6 %	1.4 %	234,693	1,261,392
2017_2018	18.8 %	1.5 %	237,019	1,258,421
2016_2017	18.0 %	1.4 %	225,707	1,254,258
2016	17.7 %	1.5 %	220,964	1,250,919

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.1 - Notes:

None

Data Alerts: None

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

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	12.2 %	1.6 %	30,513	250,234
2019_2020	14.4 %	2.5 %	32,475	226,196
2018_2019	14.1 %	2.7 %	33,135	234,693
2017_2018	13.1 %	2.6 %	31,079	237,019
2016_2017	17.4 %	2.9 %	39,205	225,707
2016	20.2 %	4.0 %	44,543	220,964

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	2.7 %	0.5 %	28,005	1,044,247
2019_2020	1.9 %	0.4 %	20,460	1,055,975
2018_2019	2.6 %	0.6 %	27,248	1,040,765
2017_2018	2.9 %	0.7 %	29,543	1,016,942
2016_2017	1.9 %	0.5 %	19,775	1,032,984
2016	1.8 %	0.5 %	19,302	1,043,770

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.3 - Notes:

None

Data Alerts: None

NOM 17.4 - Percent of children, ages 3 through 17, diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	8.2 %	0.7 %	85,535	1,042,218
2019_2020	6.9 %	0.8 %	72,599	1,057,972
2018_2019	7.3 %	1.0 %	75,323	1,031,454
2017_2018	8.8 %	1.5 %	88,174	998,878
2016_2017	8.2 %	1.3 %	83,059	1,018,903
2016	7.3 %	1.2 %	75,059	1,031,739

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.4 - Notes:

None

Data Alerts: None

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	53.2 %	3.5 %	89,583	168,355
2019_2020	57.7 %	4.4 %	71,419	123,881
2018_2019	61.9 %	5.6 %	75,466	121,856
2017_2018	65.6 %	6.5 %	81,793	124,592
2016_2017	56.8 %	6.3 %	61,715	108,587
2016	43.9 %	6.7 %	44,233	100,647

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 18 - Notes:

None

Data Alerts: None

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	93.2 %	0.7 %	1,164,048	1,249,471
2019_2020	92.2 %	0.9 %	1,159,906	1,257,447
2018_2019	92.0 %	1.1 %	1,158,625	1,259,334
2017_2018	91.5 %	1.4 %	1,149,378	1,256,776
2016_2017	90.7 %	1.3 %	1,131,696	1,248,223
2016	91.2 %	1.4 %	1,130,374	1,238,849

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 19 - Notes:

None

Data Alerts: None

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	8.6 %	0.2 %	1,867	21,702
2018	8.6 %	0.2 %	2,630	30,642
2016	8.1 %	0.2 %	2,524	31,307
2014	8.5 %	0.2 %	2,794	33,057
2012	8.9 %	0.2 %	3,343	37,411
2010	9.6 %	0.2 %	3,786	39,612
2008	9.6 %	0.2 %	3,033	31,710

Legends:

Indicator has a denominator <20 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	10.6 %	1.9 %	22,135	208,078
2019	10.3 %	0.9 %	22,007	214,259
2017	9.5 %	1.0 %	19,621	207,344
2011	7.3 %	1.1 %	13,698	187,217
2009	6.9 %	1.0 %	13,382	193,239
2005	9.6 %	1.4 %	20,089	209,512

Legends:

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	10.8 %	1.2 %	59,594	549,448
2019_2020	11.2 %	1.9 %	61,814	553,099
2018_2019	10.9 %	2.2 %	61,997	567,790
2017_2018	10.7 %	2.2 %	58,353	546,760
2016_2017	10.7 %	2.0 %	56,164	524,155
2016	9.0 %	1.7 %	46,712	518,651

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children, ages 0 through 17, without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	4.5 %	0.3 %	56,479	1,241,351
2019	5.0 %	0.4 %	63,126	1,253,572
2018	4.6 %	0.4 %	58,256	1,266,027
2017	4.1 %	0.3 %	51,463	1,258,729
2016	4.2 %	0.3 %	52,438	1,259,927
2015	4.1 %	0.3 %	51,670	1,257,521
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 >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 21 - Notes:

None

Data Alerts: None

NOM 22.1 - Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	67.8 %	4.1 %	43,000	64,000
2017	70.1 %	4.4 %	46,000	66,000
2016	71.3 %	4.2 %	48,000	67,000
2015	70.6 %	3.8 %	48,000	68,000
2014	76.8 %	3.6 %	52,000	67,000
2013	73.1 %	3.8 %	49,000	67,000
2012	72.0 %	3.5 %	49,000	67,000
2011	66.2 %	3.8 %	45,000	68,000

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths >20 or that are inestimable might not be reliable

NOM 22.1 - Notes:

None

Data Alerts: None

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

Data Source: National Immunization Survey (NIS) – Flu

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2022	66.8 %	1.5 %	784,226	1,174,067
2020_2021	64.7 %	1.7 %	766,404	1,184,550
2019_2020	70.9 %	1.6 %	841,991	1,187,575
2018_2019	64.5 %	1.6 %	766,629	1,189,309
2017_2018	62.4 %	1.8 %	739,243	1,185,294
2016_2017	63.4 %	2.6 %	750,153	1,183,580
2015_2016	62.4 %	2.1 %	726,982	1,164,475
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 because the relative standard error is >0.3.

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.2 - Notes:

None

Data Alerts: None

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

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	80.0 %	2.9 %	293,142	366,318
2020	81.6 %	2.5 %	299,066	366,700
2019	80.2 %	3.2 %	291,211	363,000
2018	77.2 %	3.2 %	278,176	360,303
2017	72.1 %	2.8 %	257,269	357,018
2016	63.5 %	3.4 %	225,162	354,845
2015	64.2 %	3.0 %	223,303	347,668

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.3 - Notes:

None

Data Alerts: None

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

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	90.2 %	2.3 %	330,261	366,318
2020	90.0 %	2.1 %	330,081	366,700
2019	91.3 %	2.3 %	331,483	363,000
2018	90.3 %	2.1 %	325,347	360,303
2017	88.6 %	2.2 %	316,374	357,018
2016	87.5 %	2.4 %	310,460	354,845
2015	93.3 %	1.5 %	324,295	347,668
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 width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.4 - Notes:

None

Data Alerts: None

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

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	84.8 %	2.8 %	310,482	366,318
2020	87.3 %	2.3 %	320,264	366,700
2019	89.4 %	2.3 %	324,450	363,000
2018	84.9 %	2.8 %	306,023	360,303
2017	82.4 %	2.4 %	294,248	357,018
2016	77.5 %	2.9 %	274,957	354,845
2015	85.6 %	2.2 %	297,497	347,668
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 width/estimate >1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.5 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	11.4	0.3	2,059	180,785
2020	12.5	0.3	2,223	177,849
2019	13.9	0.3	2,471	177,225
2018	14.3	0.3	2,522	176,272
2017	16.1	0.3	2,790	172,981
2016	17.8	0.3	3,068	171,952
2015	19.4	0.3	3,270	168,944
2014	20.4	0.4	3,377	165,863
2013	23.3	0.4	3,834	164,546
2012	25.3	0.4	4,154	164,234
2011	28.7	0.4	4,734	164,662
2010	33.3	0.5	5,474	164,524
2009	37.7	0.5	6,203	164,549

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 23 - Notes:

None

Data Alerts: None

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

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	11.4 %	1.1 %	6,860	60,329
2020	11.6 %	1.2 %	6,950	59,828
2019	11.9 %	1.2 %	7,187	60,581
2018	11.1 %	1.2 %	6,754	60,921
2017	11.4 %	1.1 %	7,103	62,519
2016	9.9 %	1.0 %	6,384	64,611
2015	12.4 %	1.1 %	8,005	64,460
2013	11.0 %	1.1 %	6,903	62,860
2012	9.0 %	1.1 %	5,653	62,929

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM 24 - Notes:

None

Data Alerts: None

NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	3.5 %	0.5 %	43,322	1,248,894
2019_2020	4.0 %	0.8 %	50,295	1,257,620
2018_2019	3.7 %	0.9 %	46,439	1,259,943
2017_2018	2.4 %	0.7 %	30,093	1,257,467
2016_2017	2.5 %	0.6 %	31,374	1,249,093
2016	3.3 %	0.9 %	40,596	1,241,527

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 25 - Notes:

None

Data Alerts: None

Form 10
National Performance Measures (NPMs)

State: Colorado

NPM 4A - Percent of infants who are ever breastfed

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	92.1	92.1	90	90.5	91
Annual Indicator	90.9	89.7	92.2	90.1	94.0
Numerator	58,722	57,030	51,548	57,471	50,538
Denominator	64,623	63,579	55,918	63,762	53,772
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2015	2016	2017	2018	2019

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	91.5	92.0	92.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**

Field Note:
It is expected that roughly 1 in 10 families will decide not to or be unable to initiate breastfeeding.

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

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	35.3	26	27	28	32
Annual Indicator	22.4	27.3	34.1	37.3	32.1
Numerator	14,311	17,330	18,695	22,829	16,627
Denominator	63,830	63,405	54,859	61,261	51,807
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2015	2016	2017	2018	2019

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	36.0	38.0	40.0

Field Level Notes for Form 10 NPMs:

None

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	51	51.5	51	45.5	42
Annual Indicator	49.9	50.5	45.2	39.0	39.6
Numerator	73,016	89,845	76,174	53,733	55,492
Denominator	146,238	177,856	168,605	137,773	140,204
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	42.5	43.0	43.5

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**

Field Note:
The data for this measure has a wide 95% confidence interval (14.8 percentage points) as a result of the small sample size (340 children, ages 9-35 months).

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

Federally Available Data					
Data Source: Youth Risk Behavior Surveillance System (YRBSS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	23	22.5	22	21.5	19.5
Annual Indicator	22.8	22.8	21.2	21.2	23.9
Numerator	53,094	53,094	50,864	50,864	57,049
Denominator	232,406	232,406	239,788	239,788	238,257
Data Source	YRBSS	YRBSS	YRBSS	YRBSS	YRBSS
Data Source Year	2017	2017	2019	2019	2021

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - Perpetration					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective		22.5	22	21.5	19.5
Annual Indicator		16.6	19.1	18.3	13.9
Numerator		69,342	80,754	79,073	59,520
Denominator		416,926	423,583	430,963	429,083
Data Source		NSCHP	NSCHP	NSCHP	NSCHP
Data Source Year		2018	2018_2019	2019_2020	2020_2021

Previous NPM-9 NSCH data for survey years 2016 and 2017 that was pre-populated under the 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable to 2018 survey data given major wording and response option changes.

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - Victimization					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective		22.5	22	21.5	19.5
Annual Indicator		50.7	46.1	39.2	38.2
Numerator		212,730	195,148	168,451	164,060
Denominator		419,974	423,321	429,650	429,371
Data Source		NSCHV	NSCHV	NSCHV	NSCHV
Data Source Year		2018	2018_2019	2019_2020	2020_2021

Previous NPM-9 NSCH data for survey years 2016 and 2017 that was pre-populated under the 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable to 2018 survey data given major wording and response option changes.

State Provided Data					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	23	22.5	22	21.5	19.5
Annual Indicator	24.1	22.7	22.7	16.4	16.4
Numerator					
Denominator					
Data Source	Healthy Kids Colorado Survey	Healthy Kids Colorado Survey	Healthy Kids Colorado Survey	Healthy Kids Colorado Survey	Healthy Kids Colorado Survey
Data Source Year	2017	2019	2019	2021	2021
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	19.0	18.5	18.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: This indicator is the percent of high school students who report that they were bullied on school property or electronically in the past year. The Healthy Kids Colorado Survey is administered every other year.	
2.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: This indicator is the percent of high school students who report that they were bullied on school property or electronically in the past year. The Healthy Kids Colorado Survey is administered in odd years. The 2019 administration was a mix of paper and online data collection modes.	
3.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: This indicator is the percent of high school students who report that they were bullied on school property or electronically in the past year. The Healthy Kids Colorado Survey is administered in odd years. The 2019 administration was a mix of paper and online data collection modes.	
4.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: This indicator is the percent of high school students who report that they were bullied on school property or electronically in the past year. The Healthy Kids Colorado Survey is administered in odd years. The 2021 administration was online data collection only.	
5.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: This indicator is the percent of high school students who report that they were bullied on school property or electronically in the past year. The Healthy Kids Colorado Survey is administered in odd years, so the RY2021 annual indicator is reported for RY2022.	

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

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	46	47	41	41	42
Annual Indicator	46.2	40.9	37.2	39.7	44.0
Numerator	104,246	97,057	87,287	89,834	110,170
Denominator	225,707	237,019	234,693	226,196	250,234
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	44.0	44.0	45.0

Field Level Notes for Form 10 NPMs:

None

NPM 14.1 - Percent of women who smoke during pregnancy

Federally Available Data					
Data Source: National Vital Statistics System (NVSS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	6	6	5.9	5	4.9
Annual Indicator	6.1	5.9	5.1	4.7	3.7
Numerator	3,940	3,683	3,183	2,909	2,325
Denominator	64,193	62,614	62,644	61,384	62,846
Data Source	NVSS	NVSS	NVSS	NVSS	NVSS
Data Source Year	2017	2018	2019	2020	2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	4.5	4.3	4.0

Field Level Notes for Form 10 NPMs:

None

Form 10
State Performance Measures (SPMs)

State: Colorado

SPM 1 - Percent of children ages 0-17 years who live in a supportive neighborhood

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			57.8	54.5
Annual Indicator	57.2	53.8	54.1	57.2
Numerator				
Denominator				
Data Source	National Survey of Childrens Health	National Survey of Childrens Health	National Survey of Childrens Health	National Survey of Childrens Health
Data Source Year	2017-2018	2018-2019	2019-2020	2020-2021
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	55.0	55.5	56.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
The data from 2017-2018 represent baseline for this SPM.

SPM 2 - Percent of households that spend more than 30% of household income on housing costs

Measure Status:	Inactive - Replaced			
State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			31	31
Annual Indicator	31.7	31.4	31.4	32.6
Numerator				
Denominator				
Data Source	American Community Survey	American Community Survey	American Community Survey	American Community Survey
Data Source Year	2018	2019	2019	2021
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: The 2018 data represent baseline for this SPM.	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Repeated 2019 annual indicator for reporting year 2021 since 2020 American Community Survey data collection was disrupted by pandemic and is not available.	

SPM 3 - Number of points for racial equity related policy, practices and systems changes implemented at the program, division and department level

Measure Status:			Active	
State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			3	6
Annual Indicator	0	0	3	9
Numerator				
Denominator				
Data Source	Racial Equity Specialist	Racial Equity Specialist	Racial Equity Specialist	Racial Equity Specialist
Data Source Year	2019	2020	2021	2021
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	9.0	12.0	15.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Data for 2020 represent baseline for this SPM.	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Work on the reduce racial inequities priority starts in 2021.	
3.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: CDPHE became a member of the Government Alliance on Race and Equity (GARE) (department level = 3 points)	
4.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: BIPOC Connection Employee Resource Group formalized (3 points) Use of screening questions for MMRC retreat facilitator selection (1 point) Implementation of regulation strategies into team meeting structure (1 point) MCH hiring managers send interview questions 24 hours in advance to candidates and integrating IDEA specific questions in interview panels (1 point)	

SPM 4 - Percent of women of reproductive age (18-44 years) who report good mental health

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			45	72
Annual Indicator	44.9	44.1	40.4	69
Numerator				
Denominator				
Data Source	Behavioral Risk Factor Surveillance System	Behavioral Risk Factor Surveillance System	Behavioral Risk Factor Surveillance System	Behavioral Risk Factor Surveillance System
Data Source Year	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	73.0	75.0	77.0

Field Level Notes for Form 10 SPMs:

1. **Field Name:** **2019**

   Column Name: **State Provided Data**

   Field Note:
   The 2018 data represent baseline for this SPM.

2. **Field Name:** **2022**

   Column Name: **State Provided Data**

   Field Note:
   For reporting year 2022, the numerator was modified to represent seven or less days of poor mental health in the past 30 days (instead of zero days of poor mental health). Annual indicators for reporting years 2019-2022 are not comparable to annual indicators for reporting years 2022 and forward.

SPM 5 - Percent of children in poverty according to the supplemental poverty measure

Measure Status:	Active

State Provided Data	
	2022
Annual Objective	
Annual Indicator	8.1
Numerator	
Denominator	
Data Source	Current Population Survey
Data Source Year	2019-2021
Provisional or Final ?	Final

Annual Objectives		
	2024	2025
Annual Objective	7.9	7.7

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: The 2019-2021 data represents baseline.	
2.	**Field Name:**	**2025**
	Column Name:	**Annual Objective**
	Field Note: The 2025 annual objective represents a 5% improvement from baseline.	

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

State: Colorado

ESM 4.1 - Percent of births insured by Medicaid at Baby-Friendly hospitals

Measure Status:			Active	
State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			38.7	36
Annual Indicator	38.2	37.9	35.5	36
Numerator	8,993	8,418	7,969	7,953
Denominator	23,546	22,212	22,447	22,118
Data Source	Birth Certificate	Birth Certificate	Birth Certificate	Birth Certificate
Data Source Year	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	37.0	37.5	38.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: ESM baseline is 2019 data.	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: One hospital decided not to maintain Baby-Friendly designation in 2021.	
3.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: One new hospital designated in December 2022.	

ESM 6.1 - Percent of children referred to early intervention who do not complete an evaluation

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			40	35
Annual Indicator	40.7	40	32.3	22.2
Numerator	14,999	5,598	4,857	3,808
Denominator	36,885	14,007	15,019	17,150
Data Source	Early Intervention Colorado	Early Intervention Colorado	Early Intervention Colorado	Early Intervention Colorado
Data Source Year	2018-2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	22.0	21.0	20.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: The 2018-2019 indicator represents baseline data for this ESM.	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: The numerator represents children who did not complete an evaluation due to parent decline or the attempt to contact was unsuccessful. Previous annual indicators may have included deceased children or other reasons for a missed evaluation, so the 2021 annual indicator is more accurate.	
3.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: The numerator represents children who did not complete an evaluation due to parent decline or the attempt to contact was unsuccessful.	

ESM 9.1 - Percent of youth who identify as transgender who have a trusted adult to go to for help with a serious problem

Measure Status:	Active			
State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			45.8	57.5
Annual Indicator	45.3	57.9	57.4	57.4
Numerator				
Denominator				
Data Source	Healthy Kids Colorado Survey	Healthy Kids Colorado Survey	Healthy Kids Colorado Survey	Healthy Kids Colorado Survey
Data Source Year	2017	2019	2021	2021
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	58.0	58.5	59.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: The 2017 data represent baseline for this ESM.	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: The 2019 administration was a mix of paper and online data collection modes.	
3.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: The 2021 administration was online data collection only.	
4.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: The Healthy Kids Colorado Survey is administered in odd years, so the RY2021 annual indicator is reported for RY2022.	

ESM 9.2 - Percent of youth of color who have a trusted adult to go to for help with a serious problem

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			69.9	70.4
Annual Indicator	69.4	68.3	68.4	68.4
Numerator				
Denominator				
Data Source	Healthy Kids Colorado Survey	Healthy Kids Colorado Survey	Healthy Kids Colorado Survey	Healthy Kids Colorado Survey
Data Source Year	2017	2019	2021	2021
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	70.9	71.4	71.9

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: The 2017 data represent baseline for this ESM.	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: The 2019 administration was a mix of paper and online data collection modes.	
3.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: The 2021 administration was online data collection only.	
4.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: The Healthy Kids Colorado Survey is administered in odd years, so the RY2021 annual indicator is reported for RY2022.	

ESM 11.1 - Percent of children with special health care needs ages 0-17 years who receive family-centered care

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			87	84
Annual Indicator	86.9	84.2	82.9	85.4
Numerator				
Denominator				
Data Source	National Survey of Childrens Health	National Survey of Childrens Health	National Survey of Childrens Health	National Survey of Childrens Health
Data Source Year	2017-2018	2018-2019	2019-2020	2020-2021
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	86.0	87.0	88.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
The 2017-2018 data represent baseline for this ESM.

ESM 14.1.1 - Percent of pregnant people insured by Medicaid who smoke during the last three months of pregnancy

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			12.8	11.1
Annual Indicator	14.4	13.4	10	8.3
Numerator				
Denominator				
Data Source	Pregnancy Risk Assessment Monitoring System	Pregnancy Risk Assessment Monitoring System	Pregnancy Risk Assessment Monitoring System	Pregnancy Risk Assessment Monitoring System
Data Source Year	2018	2019	2020	2021
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	9.4	7.7	6.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
Data from 2018 represent the baseline for this ESM.

Form 10
State Performance Measure (SPM) Detail Sheets

State: Colorado

SPM 1 - Percent of children ages 0-17 years who live in a supportive neighborhood
Population Domain(s) – Cross-Cutting/Systems Building

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the percent of children ages 0-17 years who live in a supportive neighborhood to 56.0% (2025). (2025 objective was adjusted down after a decline in the indicator.)</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of children, ages 0 through 17, who are reported by their parents to live in a supportive neighborhood</td></tr>
<tr><td>Denominator:</td><td>Number of children ages 0 through 17</td></tr>
</table>
</td></tr>
<tr><td>Healthy People 2030 Objective:</td><td>PA-10 Increase the proportion of adults who walk or bike to get places

PA-11 Increase the proportion of adolescents who walk or bike to get places

IVP-06 Reduce deaths from motor vehicle crashes

AH-10 Reduce the rate of minors and young adults committing violent crimes

AH-R11 Reduce the rate of adolescent and young adult victimization from violent crimes</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>National Survey of Children's Health (NSCH)</td></tr>
<tr><td>Significance:</td><td>This measure indicates availability of support via neighbors and places to go for help. This measure indicates perception of safety and connection to community and may indicate availability of safe places to walk, bicycle, and wheelchair roll.</td></tr>
</table>

SPM 2 - Percent of households that spend more than 30% of household income on housing costs
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Inactive - Replaced
Goal:	Decrease the percent of households that spend more than 30% of household income on housing costs from 31.7% (2018) to 28.5% (2025).
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of occupied housing units in Colorado that spend more than 30% of household income on housing costs **Denominator:** Number of occupied housing units in Colorado
Healthy People 2030 Objective:	SDOH-04 Reduce the proportion of families that spend more than 30 percent of income on housing
Data Sources and Data Issues:	American Community Survey
Significance:	As housing costs have outpaced local incomes, households not only struggle to acquire and maintain adequate shelter, but also face difficult trade-offs in meeting other basic needs. The more money Coloradans spend on housing, the less money they have to spend on other critical needs, particularly those that impact health such as healthy food, recreation, and health care. Families with children are particularly at risk for housing insecurity. Affordability and stability are some of the chief challenges for families with children, especially if the children are younger than school age. Rising housing costs can affect health in a number of ways. As the Joint Center for Housing Studies notes, “The lack of low-cost housing options undermines quality of life for these families, forcing difficult tradeoffs in both housing quality and spending on other vital needs.”1 In areas without sufficient affordable housing, people utilize a variety of strategies in response to rising rents. These strategies include: remaining in their current housing but paying higher rents; finding other affordable housing options; consolidating homes with other people; moving multiple times; moving to less safe neighborhoods; moving far away; losing their housing entirely; losing social networks; and forgoing necessary health care. 1. Harvard Joint Center for Housing Studies (2020). America’s rental housing 2020. https://www.jchs.harvard.edu/sites/default/files/Harvard_JCHS_Americas_Rental_Housing_2020.pdf

SPM 3 - Number of points for racial equity related policy, practices and systems changes implemented at the program, division and department level
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	Increase the number of points for racial equity related policy, practices and systems changes implemented at the program, division and department level from 0 (2020) to 15 (2025).
Definition:	**Unit Type:** Count **Unit Number:** 50 **Numerator:** Number of points for racial equity related policy, practices and systems changes **Denominator:**
Healthy People 2030 Objective:	MICH-02 Reduce the rate of infant deaths MICH-04 Reduce maternal deaths ECBP-D07 Increase the number of community organizations that provide prevention services
Data Sources and Data Issues:	Racial Equity Specialist, MCH Workforce Development Section, Colorado Department of Public Health and Environment
Significance:	This measure directly correlates with assessing how the Colorado MCH program meets its goal. By tracking changes to policies and practices, the MCH program can directly assess potential impacts those changes may have on our MCH communities. Systemic and institutional changes are more sustainable over long periods of time and thus should have a larger impact. Every change will have points associated with it: Programmatic changes=1 point, division level change=2 points, and department level change=3 points. *Note: Program represents the Title V program, which includes local public health agencies.

SPM 4 - Percent of women of reproductive age (18-44 years) who report good mental health
Population Domain(s) – Women/Maternal Health

Measure Status:	Active
Goal:	Increase the percent of women of reproductive age (18-44 years) who report good mental health from 76.5% (2018) to 77.0% (2025).
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of women, ages 18 through 44, who report good mental health (defined as 0-7 days of poor mental health in the past 30 days) **Denominator:** Number of women ages 18 through 44
Healthy People 2030 Objective:	MHMD-07 Increase the proportion of people with substance use and mental health disorders who get treatment for both MICH-11 Increase abstinence from illicit drugs among pregnant women
Data Sources and Data Issues:	Behavioral Risk Factor Surveillance System (BRFSS)
Significance:	This measure represents an indicator of mental wellbeing in a key population for the health and wellness of families. This indicator is available at a population level and can therefore serve as an early indicator for worsening longer term health outcomes such as substance use and maternal mortality.

SPM 5 - Percent of children in poverty according to the supplemental poverty measure
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	Decrease the percent of children in poverty according to the supplemental poverty measure from 8.1% (2019-2021) to 7.7% (2025).
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of children ages 0 through 17 years living in poverty according to the supplemental poverty measure **Denominator:** Number of children ages 0 through 17 years
Healthy People 2030 Objective:	SDOH-01 Reduce the proportion of people living in poverty
Data Sources and Data Issues:	Current Population Survey Three years of data are aggregated for state estimates.
Significance:	The poverty line is defined as “the minimum level of resources that are adequate to meet basic needs” (food, clothing, shelter, utilities, and telecommunications). The United States Census Bureau releases a Supplemental Poverty Measure (SPM) to assess a household's level of economic need. This measure is based on cash resources and noncash benefits (tax credits, housing subsidies, utility and nutrition assistance) from the government. It also takes into account necessary household expenses (work expenses, child care expenses, taxes, medical expenses) and regional variation in cost of living.1 The SPM “provides an important opportunity to gauge the effectiveness of government anti-poverty interventions.”2 Poverty is associated with worse health outcomes for the MCH population, including greater risk of adverse childhood experiences (ACEs)3, higher rates of preterm birth, higher proportion of infants born with low birth weight, higher infant mortality rate4, and even lower life expectancy5. Our work leverages directly on this metric. Tax credit outreach and co-enrollment with social services increases the amount of money families living in low income have to spend, or reduces their spending on essential goods by connecting them to social services. 1. U.S. Census Bureau. How the Census Bureau Measures Poverty. 2. The Annie E. Casey Foundation. Kids Count Data Center. 3. Walsh D, McCartney G, Smith M, Armour G. Relationship between childhood socioeconomic position and adverse childhood experiences (ACEs): a systematic review. J Epidemiol Community Health 2019;73:1087–1093. 4. Hamad R, Rehkopf DH. Poverty, pregnancy and birth outcomes: A study of the earned income tax credit. Paediatr Perinat Epidemiol 2015;9(5):444-452. 5. Chetty R, Stepner M, Abraham S. The association between income and life expectancy in the United States 2001-2014. JAMA 2016;315(16):1750-1776.

Form 10
State Outcome Measure (SOM) Detail Sheets

State: Colorado

No State Outcome Measures were created by the State.

Form 10
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: Colorado

ESM 4.1 - Percent of births insured by Medicaid at Baby-Friendly hospitals
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the percent of births insured by Medicaid at Baby-Friendly designated hospitals to 38.0% (2025).</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of live births inured by Medicaid in Baby-Friendly designated hospitals</td></tr>
<tr><td>Denominator:</td><td>Number of live births insured by Medicaid</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Birth Certificates, Vital Statistics Program, Colorado Department of Public Health and Environment</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>Research shows as the number of evidence-based Baby-Friendly Hospital Initiative’s Ten Steps to Successful Breastfeeding practices increase in a hospital, breastfeeding rates increase as well (1-3). This is especially true for families with Medicaid health insurance or no insurance and families participating in the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), where significant increases in breastfeeding initiation and long term success is shown when Baby-Friendly policies were in place at a hospital (4,5).
1. U.S. Department of Health and Human Services. The Surgeon General’s Call to Action to Support Breastfeeding. Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General, 2011.
2. Baby-Friendly USA. 10 Steps and international code: The Ten Steps to Successful Breastfeeding. Available at https://www.babyfriendlyusa.org/for-facilities/practice-guidelines/10-steps-and-international-code/ (accessed May 18, 2021).
3. Perez-Escamilla R, Martinez JL, Segura-Perez S. Impact of the Baby-Friendly Hospital Initiative on breastfeeding and child health outcomes: A systematic review. Matern Child Nutr 2016;12:402–17.
4. Mercier RJ, Burcher TA, Horowitz R, Wolf A. Differences in Breastfeeding Among Medicaid and Commercially Insured Patients: A retrospective cohort study. Breastfeed Med 2018;13(4):286-91.
5. Jung S, Nobari TZ, Whaley SE. Breastfeeding Outcomes Among WIC-Participating Infants and Their Relationships to Baby-Friendly Hospital Practices. Breastfeed Med 2019;14(6):424-31.</td></tr>
<tr><td>Significance:</td><td>Families experiencing low socioeconomic status have greater breastfeeding disparities, are more likely to experience barriers to breastfeeding, and thus have lower breastfeeding rates (6). Baby-Friendly Hospital Initiative policies and practices significantly impact breastfeeding rates for all births, thus increasing the number of designated hospitals that serve high proportions of Medicaid paid births will positively impact breastfeeding rates for low-income families in Colorado and decrease related health disparities in this population.
6. Odom EC, Li R, Scanlon KS, et al. Reasons for earlier than desired cessation of breastfeeding. Pediatrics 2013;131:e726–e732.</td></tr>
</table>

ESM 6.1 - Percent of children referred to early intervention who do not complete an evaluation
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Decrease the percent of children referred to early intervention who do not complete an evaluation from 40.7% (2018-2019) to 20.0% (2025).</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of children referred to early intervention who do not complete an evaluation (parent decline or attempt to contact unsuccessful)</td></tr>
<tr><td>Denominator:</td><td>Number of children referred to early intervention</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Early Intervention Colorado</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>Specific to this NPM, the integration of technology strategies will increase communication and coordination between Early Intervention Colorado and health systems. The evidence for this strategy is predominantly captured in the research that is focused on state tobacco e-referral platforms.1 There is additional emerging evidence focused on the impact of e-referrals conducted through social-health information exchange platforms.2
1. Baker TB, et al. Closed-loop electronic referral from primary care clinics to a state tobacco cessation quitline: Effects using real-world implementation training. Am J Prev Med. March 2021;60(3)(2):S113-S122.
2. Nguyen OK, Chan CV, Makam A, Stieglitz H, Amarasingham R. Envisioning a social-health information exchange as a platform to support a patient-centered medical neighborhood: A feasibility study. J Gen Intern Med. Jan 2015;30(1):60-67.</td></tr>
<tr><td>Significance:</td><td>In Colorado 40% of children who received a developmental screening and were referred to Early Intervention do not complete an evaluation. Developmental screening is critical to identify a child’s potential developmental delay and need for developmental services. Barriers between child and family-serving systems in Colorado make it difficult to access and share data to know when children are screened, referred and are able to access recommended services. This results in children and families not receiving appropriate and timely services, and providers being unable to coordinate care.

The purpose of exploring a developmental screening and e-referral pilot project is to improve communication and coordination among providers, partners, and families to: ensure appropriate and timely services; reduce the burden on families; allow the outcome of Early Intervention evaluations to be shared with the child’s medical home, and allow for bi-directional exchange of information between service providers, families and other members of the child’s care team. The pilot will inform policy, as well as state and local investments. The value is measured by the implementation and outcomes from the pilot.</td></tr>
</table>

ESM 9.1 - Percent of youth who identify as transgender who have a trusted adult to go to for help with a serious problem
NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Measure Status:	Active
Goal:	Increase the percent of youth who identify as transgender who have a trusted adult to go to for help with a serious problem from 45.3% (2017) to 59.0% (2025).
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of youth who identify as transgender who have a trusted adult to go to for help with a serious problem **Denominator:** Number of youth who identify as transgender
Data Sources and Data Issues:	Healthy Kids Colorado Survey (HKCS) The HKCS is administered every other year.
Evidence-based/informed strategy:	According to research and HKCS data, young people who have a trusted adult in their life are less likely to experience bullying.1 Implementing Positive Youth Development and Gender Sexuality Alliances are evidence-based strategies to increase trusted adults in young people's lives.2,3 1. Healthy Kids Colorado Survey. Colorado Department of Public Health and Environment, Colorado Department of Education, Colorado Department of Human Services, and Colorado Department of Public Safety. https://cdphe.colorado.gov/healthy-kids-colorado-survey-data-tables-and-reports 2. Ciocanel O, Power K, Eriksen A, Gillings K. Effectiveness of positive youth development interventions: A meta-analysis of randomized controlled trials. J Youth Adolescence. March 2017;46(3):483-504. 3. Porta CM, Singer E, Mehus CJ, Gower AL, Saewyc E, Fredkove W, Eisenberg ME. LGBTQ youth's views on gay-straight alliances: Building community, providing gateways, and representing safety and support. The Journal of School Health. 2017;87(7):489–497.
Significance:	Data and research has shown that youth who have a trusted adult are less likely to experience bullying, as well as other health outcomes like suicide and substance use. Research also shows that if prevention efforts are focused and centered on those who are most disproportionately impacted, it will also improve the outcomes for other youth as well.

ESM 9.2 - Percent of youth of color who have a trusted adult to go to for help with a serious problem
NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Measure Status:	Active
Goal:	Increase the percent of youth of color who have a trusted adult to go to for help with a serious problem from 69.4% (2017) to 71.9% (2025).
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of youth of color who have a trusted adult to go to for help with a serious problem **Denominator:** Number of youth of color
Data Sources and Data Issues:	Healthy Kids Colorado Survey (HKCS) The HKCS is administered every other year.
Evidence-based/informed strategy:	According to research and HKCS data, young people who have a trusted adult in their life are less likely to experience bullying.1 Implementing Positive Youth Development and Gender Sexuality Alliances are evidence-based strategies to increase trusted adults in young people's lives.2,3 1. Healthy Kids Colorado Survey. Colorado Department of Public Health and Environment, Colorado Department of Education, Colorado Department of Human Services, and Colorado Department of Public Safety. https://cdphe.colorado.gov/healthy-kids-colorado-survey-data-tables-and-reports 2. Ciocanel O, Power K, Eriksen A, Gillings K. Effectiveness of positive youth development interventions: A meta-analysis of randomized controlled trials. J Youth Adolescence. March 2017;46(3):483-504. 3. Porta CM, Singer E, Mehus CJ, Gower AL, Saewyc E, Fredkove W, Eisenberg ME. LGBTQ youth's views on gay-straight alliances: Building community, providing gateways, and representing safety and support. The Journal of School Health. 2017;87(7):489–497.
Significance:	Data and research has shown that youth who have a trusted adult are less likely to experience bullying, as well as other health outcomes like suicide and substance use. Research also shows that if prevention efforts are focused and centered on those who are most disproportionately impacted, it will also improve the outcomes for other youth as well.

ESM 11.1 - Percent of children with special health care needs ages 0-17 years who receive family-centered care
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	Increase family-centered care among children ages 0-17 years with special health care needs who receive family-centered care from 86.9% (2017-2018) to 88.0% (2025).
Definition:	<table><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>Number of children with special health care needs ages 0 through 17 years who had a health care visit in the past 12 years and received family-centered care</td></tr><tr><td>**Denominator:**</td><td>Number of children with special health care needs ages 0 through 17 years who had a health care visit in the past 12 years</td></tr></table>
Data Sources and Data Issues:	National Survey of Children's Health
Evidence-based/informed strategy:	As outlined in the National Standards for CYSHCN1, It's essential that families are kept at the center of their care and inform design and evaluation of programs and services. The Colorado MCH program supports inclusion of diverse community and family members to identify barriers to access to a medical home, including access to specialty care, and to implement equitable solutions to address these barriers. Additionally, the MCH program will continue to work with key statewide partners (such as the state's Medicaid program, school-based health centers and Children's Hospital Colorado) to identify and influence upstream policy recommendations that support strong co-management principles and family engagement principles.2 1. National Standards for CYSHCN 2. The ABCs of Health Equity for Children and Youth with Special Health Care Needs: A Policy Agenda for Colorado
Significance:	When policies, systems, and providers use the family-centered approach, families are more likely to access meaningful supports & services, thereby creating environments where families are engaged, involved, and supported. Strategies will focus on investing in and influencing people, process and technology to adopt family-centered practices to increase equitable access to and use of specialty care; enhance provider and system capacity to bridge healthcare and other partners; support communication and collaboration between community-based programs and partners; and use data to identify, illuminate, and address access, utilization, and outcome inequities.

ESM 14.1.1 - Percent of pregnant people insured by Medicaid who smoke during the last three months of pregnancy
NPM 14.1 – Percent of women who smoke during pregnancy

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Reduce the prevalence of pregnant people insured by Medicaid who smoke during the last three months of pregnancy from 14.4% (in 2018) to 6.0% (in 2025).</td></tr>
<tr><td>Definition:</td><td><table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of pregnant people insured by Medicaid who smoke during the last three months of pregnancy</td></tr>
<tr><td>Denominator:</td><td>Number of pregnant people insured by Medicaid</td></tr>
</table></td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Pregnancy Risk Assessment Monitoring System (PRAMS)</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>People who smoke during pregnancy are more likely to experience a fetal death or deliver a low birth weight baby. Infants who are exposed to caregiver tobacco use have an increased risk of poor health outcomes and sudden unexplained infant death.1

Data from the 2019 PRAMS survey showed that among pregnant Coloradans on Medicaid for prenatal care 13.4% smoked during the last 3 months of pregnancy, significantly higher than those enrolled in private insurance (2.0%). The prevalence of smoking rises after delivery, putting infants at risk of secondhand smoke exposure. Among pregnant Coloradans on Medicaid,16.4% reported smoking after their baby was born compared to 2.9% of those not on Medicaid.2

Quit rates for QuitLine average 28-36% vs. 4-7% for unaided quit attempts. Users are up to seven times more successful than people who try to quit unaided. Of the total number of pregnant persons who enrolled in QuitLine services, 61% self-reported having Medicaid, and 4% reported having no insurance coverage.3 The high proportion of Medicaid and uninsured enrollees is evidence that the QuitLine is serving Colorado’s most vulnerable pregnant population.

A study of the Colorado Baby and Me Tobacco Free Program found program participants saw a 24% to 28% reduction in the risk of preterm birth and a 24% to 55% reduction in the risk of neonatal intensive care unit admissions.4

1. Smoking During Pregnancy. Centers for Disease Control and Prevention. https://www.cdc.gov/tobacco/basic_information/health_effects/pregnancy/index.htm
2. Colorado Pregnancy Risk Assessment Monitoring System, Colorado Department of Public Health and Environment.
3. National Jewish Health, 2020 Quitline Data.
4. Polinski KJ, Wolfe R, Peterson A, Juhl A, Perraillon MC, Levinson AH, Crume TL. Impact of an incentive-based prenatal smoking cessation program for low-income women in Colorado. Public Health Nursing, November 2019;37:39-49.</td></tr>
<tr><td>Significance:</td><td>Reducing the disproportionate burden of tobacco use among pregnant and postpartum Medicaid members promotes equity for all Coloradans. The year over year steady decline in prevalence of tobacco use among pregnant Coloradans on Medicaid for prenatal care indicates that providing barrier-free access to community-based resources like the Baby and Me tobacco Free Program (BMTFP) and the QuitLine Pregnancy Protocol Program works.</td></tr>
</table>

Form 11
Other State Data

State: Colorado

The Form 11 data are available for review via the link below.

Form 11 Data

Form 12
MCH Data Access and Linkages

State: Colorado

Annual Report Year 2022

	Access				Linkages	
Data Sources	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
1) Vital Records Birth	Yes	Yes	Daily	0		
2) Vital Records Death	Yes	Yes	Daily	0	Yes	
3) Medicaid	Yes	Yes	Monthly	3	No	
4) WIC	Yes	Yes	Monthly	1	No	
5) Newborn Bloodspot Screening	Yes	Yes	Annually	4	No	
6) Newborn Hearing Screening	Yes	Yes	Annually	4	No	
7) Hospital Discharge	Yes	Yes	Annually	3	No	
8) PRAMS or PRAMS-like	Yes	Yes	Annually	5	No	

Form Notes for Form 12:

Colorado MCH maintains access to timely, electronic data for all eight systems listed in Form 12. The MCH epidemiologist sits in the same branch as the vital statistics section, so she has direct access to vital records birth and death data for provisional and final analysis. The MCH epidemiologist also serves as the Colorado Pregnancy Risk Assessment Monitoring System (PRAMS) coordinator and has direct access to all weighted PRAMS datasets. The epidemiologist oversees edits to the interagency agreement with Colorado Medicaid each year and has direct access to their data transfer systems. The epidemiologist also works closely with the WIC evaluator and newborn screening data managers, so access to these data are available as needed. Various epidemiology and evaluation staff have direct access to the emergency department visit and hospital discharge data sets and can run analysis upon request for MCH needs. In addition, Colorado MCH has direct access to other MCH-related electronic data sets including Health eMoms, an oversample of the National Survey of Children's Health, the Healthy Kids Colorado Survey, the Pregnancy Mortality Surveillance System, and the Maternal Mortality Review Committee data.

Data sources can be linked to vital records birth certificate when there is an approved surveillance or research need.

Field Level Notes for Form 12:

Data Source Name:	**1) Vital Records Birth**
	Field Note: Provisional birth data sets are updated daily.
Data Source Name:	**2) Vital Records Death**
	Field Note: Provisional death data sets are updated daily. Infant death record can be linked to the infant birth record for linked analysis.
Data Source Name:	**3) Medicaid**
	Field Note: Medicaid data are matched with vital records birth data for various projects.
Data Source Name:	**8) PRAMS or PRAMS-like**
	Field Note: PRAMS respondents are sampled from the birth certificate. The weighted dataset includes several variables from vital records birth. The weighted dataset can be linked to the vital records birth for projects.