

National Performance Measures

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

Tracking Performance Measures

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	117	119	106	118	115
Denominator	117	119	106	118	115
Data Source				WI St Lab Hyg 2009.	WI St Lab Hyg 2010.

Check this box if you cannot report the numerator because

1. There are fewer than 5 events over the last year, and
2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.

Is the Data Provisional or Final?

	2010	2011	2012	Final 2013	Final 2014
Annual Performance Objective	100	100	100	100	100

Notes - 2009

Source: Numerator: NBS program, State Lab of Hygiene, Wisconsin, 2009. The number of infants that were confirmed with a condition through newborn screening and who receive appropriate follow-up care. Denominator: NBS program, State Lab of Hygiene, Wisconsin, 2008. The number of screened through NBS and confirmed with a condition. Wisconsin screens for 47 congenital disorders. Every newborn with an abnormal NBS result is tracked by the NBS Program to a normal result or appropriate clinical care.

Notes - 2008

Source: Numerator: NBS program, State Lab of Hygiene, Wisconsin, 2008. The number of infants that were confirmed with a condition through newborn screening and who receive appropriate follow-up care. Denominator: NBS program, State Lab of Hygiene, Wisconsin, 2008. The number of screened through NBS and confirmed with a condition. Wisconsin screens for 47 congenital disorders. Every newborn with an abnormal NBS result is tracked by the NBS Program to a normal result or appropriate clinical care.

Notes - 2007

Source: Numerator: NBS program, State Lab of Hygiene, Wisconsin, 2007. The number of infants that were confirmed with a condition through newborn screening and who receive appropriate follow-up care. Denominator: NBS program, State Lab of Hygiene, Wisconsin, 2008. The number of screened through NBS and confirmed with a condition. Wisconsin screens for 47 congenital disorders. Every newborn with an abnormal NBS result is tracked by the NBS Program to a normal result or appropriate clinical care.

a. Last Year's Accomplishments

1. Newborn Screening--Population-Based Services--Infants

In 2009, 69,533 infants were screened for 47 different congenital disorders. 115 infants were confirmed with a condition screened for by the NBS Program and 100% were referred for appropriate follow-up care.

The NBS Coordinator organized the biannual NBS Advisory Group (Umbrella Committee) and six subcommittee meetings.

2. Diagnostic Services--Direct Health Care Services--Infants

The Department provided necessary diagnostic services, special dietary treatment as prescribed by a physician and follow-up counseling for the patient and his or her family through contracts with specialty clinics and local agencies. Five cystic fibrosis centers, three metabolic clinics, one sickle cell comprehensive care center, one genetics center, and a local health department receive these contracts. The DPH Newborn Screening Coordinator worked with the contracted agencies to promote and improve the NBS Program through the establishment and evaluation of performance-based objectives. Work with the contract agencies includes the coordination and tracking of nutritional products for congenital disorders patients.

3. Development of Educational Materials--Enabling Services--Pregnant women and families with infants.

A Newborn screening tool kit was developed for educators and health care providers to provide information about newborn screening and newborn screening resources. Quarterly newsletters were sent to birth hospital coordinators with regular updates and reminders about newborn screening.

The Wisconsin NBS Program continued to participate in the HRSA "Region 4 Genetics Collaborative" grant with Wisconsin representatives in all workgroups. The regional collaborative allows states to share expertise in new technologies and best practice models to maximize available newborn screening resources.

National Performance Measures Summary Sheet Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Newborn Screening			X	
2. Diagnostic Services	X			
3. Development of Educational Materials		X		

b. Current Activities

1. Newborn Screening--Population-Based Services--Infants

The Wisconsin NBS Program currently screens all infants for 47 congenital disorders.

The NBS Program is working with Wisconsin Sound Beginnings EHDI, Vital Records, and Birth Defects Surveillance System to explore linking newborn screening data with other birth data. WSB is exploring the addition of NBS results on the notification report sent to primary care providers identified on the blood card.

The NBS Coordinator organizes the biannual NBS Advisory Group (Umbrella Committee) and six subcommittee meetings.

2. Diagnostic Services--Direct Health Care Services--Infants

The DPH NBS Coordinator establishes and monitors objectives with agencies contracted to provide direct services. The 4 focus areas of the contracts include: diagnosis; referral for services and clinical care; care coordination; and transitions.

3. Development of Educational Materials--Enabling Services--Pregnant women and families with infants

Education to birth hospital coordinators, midwives, care providers continues through the dissemination of quarterly newsletters, the WI NBS Brochure, and the NBS DVD and NBS Educational toolkit.

The NBS program works with the Region IV Genetic Collaborative to share the web-based programming. A link to the Guide for Families developed by the Medical Home Education Workgroup will be shared with families and health care providers

(http://region4genetics.org/information_pages/Region_4_Medical_Home_Guide.pdf)

c. Plan for the Coming Year

1. Newborn Screening--Population-Based Services--Infants

In 2011, all infants born in WI will continue to be screened at birth for a minimum of 47 congenital disorders.

The NBS Advisory Group (Umbrella Committee) and its Cystic Fibrosis/Molecular, Metabolic, Hemoglobinopathy, Endocrine, Immunodeficiency, and Education subcommittees will meet at least biannually to advise the Department regarding emerging issues and technology in NBS. Two additional Subcommittees will be added in 2011: Hearing Screening and Genetic Diseases of Childhood.

2. Diagnostic Services--Direct Health Care Services--Infants

DHS will continue to implement a paper-based tracking system for NBS dietary services in preparation for a web-based system. Tracked services will include the provision of dietary formulas and medical food products to children with conditions screened for by NBS by dieticians at contracted specialty centers. Performance based contracts will be reviewed and revised to continue to promote Medical Home implementation strategies such as care coordination and transition planning.

3. Development of Educational Materials--Enabling Services--Pregnant women and families with infants

The NBS Advisory Group Education subcommittee will continue to educate the public and medical providers about Severe Combined Immunodeficiency (SCID) and other disorders. The subcommittee will continue to improve communication with the NBS program and hospitals through e-newsletters and other means. The subcommittee will continue to provide an educational tool kit for childbirth educators and health care providers with information about newborn screening and newborn screening resources. The subcommittee will use the NBS DVD as an education piece in a variety of settings to educate about Newborn Screening.

Wisconsin Sound Beginnings staff will continue to coordinate outreach and education to hospitals.

The NBS program will work with the Region IV Genetics Collaborative to share developed resources like the Guide for Families with Wisconsin partners.

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM #01.

Type of Screening Tests:	Total Births by Occurrence: 69,533		(B) No. of Presumptive Positive Screens	(C) No. of Confirmed Cases (2)	(D) Needing Treatment that Received Treatment (3)	
	Reporting Year: 2009					
	(A) Receiving at least one Screen (1)					
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	69,533	100.0	6	3	3	100.0
Congenital Hypothyroidism (Classical)	69,533	100.0	347	58	58	100.0
Galactosemia (Classical)	69,533	100.0	3	1	1	100.0
Sickle Cell Disease	69,533	100.0	11	11	11	100.0
Biotinidase Deficiency	69,533	100.0	1	1	1	100.0
Congenital Adrenal Hyperplasia	69,533	100.0	295	5	5	100.0
Cystic Fibrosis	69,533	100.0	201	16	16	100.0
Fatty Acid Oxidation	69,533	100.0	186	7	7	100.0
Organic Acidemia	69,533	100.0	205	12	12	100.0
Aminoacidopathies	69,533	100.0	52	1	1	100.0

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

Tracking Performance Measures

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	69.6	70	70.5	71	71.5
Annual Indicator	66.6	65.3	65.3	65.3	65.3
Numerator	47819	132074	132074	132074	132074
Denominator	71816	202257	202257	202257	202257
Data Source				SLAITS CSHCN.	SLAITS CSHCN.

Check this box if you cannot report the numerator because

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2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.

Is the Data Provisional or Final?

	2010	2011	2012	Final 2013	Final 2014
Annual Performance Objective	72	72.5	71	71	71

Notes - 2009

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM #02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2008

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM #02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM #02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

a. Last Year's Accomplishments

1. Family Support Services--Enabling Services--CYSHCN

In 2009, the following services were provided: 117 families were matched through the WI Parent to Parent Program; 160 families received health education through Family Voices of WI (FVW)/Family to Family Health Information Network; and 1,861 families received individual information and assistance through the five Regional Centers for CYSHCN and their subcontracted agencies, which enhanced the capacity of parents to be decision makers, supported partners as leaders and offered parents an avenue to develop an informal network of support.

2. Coordination with Family Leadership and Support--Population-Based Services--CYSHCN

In 2009, the CYSHCN Program contracted with FVW to provide: a newsletter, which is distributed both electronically and hard copy, three times per year, and went out to 1,400 individuals; technical assistance to Regional Centers; policy updates and notifications of opportunities for involvement in a variety of issues, which went to about 500 individuals; and health benefits training targeting CYSHCN from under-represented populations. The outreach to underserved populations resulted in non-English speaking families receiving both Parent to Parent and Family Voices trainings and materials in Spanish.

3. Participation of Families on Advisory Committees to the MCH and CYSHCN Program--Infrastructure Building Services--CYSHCN

Parents continued to be utilized in a variety of advisory capacities including a listening session for parents at the annual Circles of Life Conference. At the 2009 Conference, FVW received feedback from parents on the questions: "What are your concerns in navigating systems of support around health care, community supports and education?" and "If you can think of things that would work better, what would they be?" FVW used information gathered from this listening session to inform its work as well as the State's MCH Program with policy makers to improve care and coverage for CYSHCN. Also, each Regional Center and FVW supported parents to be linked to councils at the local, regional and state levels. The staff at the Regional Centers, FVW and Parent to Parent all serve on a range of councils and committees to advance the performance measure to address families as partners in decision-making at all levels.

In 2008 the CYSHCN Program was awarded a MCHB-Combating Autism Act Initiative State Implementation grant. As part of this initiative, a Community of Practice on Autism Spectrum Disorders and other Developmental Disabilities continued to meet in 2009, with a parent of a young child with Autism Spectrum Disorder as Co-Chair of the Community of Practice. Participants in the Community of Practice include a number of parents and parent organizations, and a Practice Group on Parent Supports has been established. FVW, Parent to Parent, and the Regional Centers for CYSHCN are all members of the Community of Practice.

Wisconsin also had a family delegate on the AMCHP Family and Youth Leadership Committee in 2009. That person participates on the national AMCHP Committee as well. Preliminary work was done to involve more families in AMCHP.

4. Family Partnerships--Infrastructure Building Services--CYSHCN

In 2009, parents of CYSHCN were part of the staff of the State CYSHCN Program, all five Regional Centers, Parent to Parent and FVW, making parents integral to the ongoing decision-making, program implementation and evaluation. CYSHCN partners continue to meet as a Collaborators Network which communicates regularly to share resources, problem solve difficult issues and identify unmet needs in the

state. A subgroup of the Network consists of staff providing information and referral services to families and this group holds monthly teleconferences and has a listserv to increase the level of communication. FVW tracks policies that impact families and was effective in bringing the needs of CYSHCN on waiting lists to the attention of policy makers resulting in new funding for long term care.

Table 4a National Performance Measures Summary Sheet Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Family Support Services		X		
2. Coordination with Family Leadership and Support			X	
3. Participation of Families on Advisory Committees to the MCH and CYSHCN Program				X
4. Family Partnerships				X

b. Current Activities

1. Family Support Services--Enabling Services--CYSHCN

In 2010 families receive parent matching, training, information and assistance.

2. Coordination with Family Leadership and Support--Population-Based Services--CYSHCN

In 2010 the CYSHCN Program contracts with FVW to provide: a newsletter 3 times per year; listserv; policy updates; and health benefits training for under-represented populations including Great Lakes Inter-Tribal Council's (GLITC) parents.

3. Participation of Families on Advisory Committees to the MCH and CYSHCN Program--Infrastructure Building Services--CYSHCN

Parents continue to be utilized in a variety of advisory capacities including: Parents on the Community of Practice for Autism Spectrum Disorders and other Developmental Disabilities; parents serving as advisors to Newborn Screening Program, Wisconsin Sound Beginnings, Birth Defects and Surveillance Program, and MCH Advisory Committee. FVW also works with each Regional Center to identify and strengthen parent leaders.

4. Family Partnerships--Infrastructure Building Services--CYSHCN

In 2010 parents continue to be part of staffing at all levels of the CYSHCN Program. The CYSHCN Collaborators Network met in April to share experiences and best practices, and plan ways to grow and improve existing collaborations and reach out to new partners. FVW tracks policies that impact families and is effective in bringing the needs of CYSHCN on waiting lists to the attention of policy makers.

c. Plan for the Coming Year

1. Family Support Services--Enabling Services--CYSHCN

In 2011, families will continue to be matched through the WI Parent to Parent Program, receive health education through FVW, and be offered information and assistance through the Regional Centers. Families will continue to be members of the Community of Practice on Autism Spectrum Disorders and other Developmental Disabilities and the Community of Practice on Transition. Both groups have family members in leadership roles and include practice groups on parent supports.

2. Coordination with Family Leadership and Support--Population-Based Services--CYSHCN

In 2011, the CYSHCN Program will continue to contract for the services provided by FVW and dovetail these activities with those of the Family to Family Health Information Network grant that FVW has through MCHB. The contractee will provide: a newsletter three times per year; health benefits training targeting CYSHCN from under-represented populations; data collection, analysis and dissemination of unmet needs; and assistance in Regional Center transition to adult health care trainings. The contractee will

continue to build a parent network with these activities. Outreach to underserved populations will continue to target African American and Native American families through established cultural brokers. Parent to Parent will continue to work with the Southeast Regional Center and Alianza, an organization that works with Latino families of CYSHCN, to reach out to the Latino CYSHCN population in Southeastern WI. Non-English speaking families will be trained to be Parent to Parent support parents and efforts will be made to identify non-English speaking match parents.

3. Participation of Families on Advisory Committees to the MCH and CYSHCN Program--Infrastructure Building Services--CYSHCN

Parents will continue to be utilized in a variety of advisory capacities through Regional Centers and other partners and collaborators who support parents will be linked to a council or committee at a local, regional, or state level. The staff at the Regional Centers, Parent to Parent and other partner and collaborating agencies will continue to serve on a range of councils and committees to advance the performance measure on parents as decision makers.

4. Family Partnerships--Infrastructure Building Services--CYSHCN

In 2011, parents will continue to be part of the staffing at all levels of the CYSHCN Program. The CYSHCN Collaborators Network will meet annually in person and by phone so the CYSHCN system for building parents as partners can be coordinated across programs. The Information and Referral group will continue with regular contact so that staff understand the ever-changing health benefits system and can educate families about community resources and benefits eligibility. The new contractee for the Family Voices project will continue to track unmet needs in collaboration with CYSHCN partners so that family needs are articulated on a policy level.

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

Tracking Performance Measures

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	60.1	60.5	61	55	57
Annual Indicator	57.1	54.6	54.6	54.6	54.6
Numerator	98758	110432	110432	110432	110432
Denominator	173017	202257	202257	202257	202257
Data Source				SLAITS CSHCN.	SLAITS CSHCN.

Check this box if you cannot report the numerator because

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2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.

Is the Data Provisional or Final?

	2010	2011	2012	Final 2013	Final 2014
Annual Performance Objective	58	59	60	60	60

Notes - 2009

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM #03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2008

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions

to the questions used to generate the NPM #03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM #03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

a. Last Year's Accomplishments

1. Medical Home Education and Training--Population-Based Services--CYSHCN

The Medical Home Toolkit was disseminated using a variety of methods, including face-to-face presentations at primary practice offices and at variety of meetings with different stakeholder groups.

The Program also included promotion of best practice, evidence-based developmental screening within context of a medical home. In partnership with Regional Centers and the UW-Waisman Center, 14 primary care providers were recruited in 2008 and then were trained in 2009 to spread implementation of Ages and Stages Questionnaire developmental screening tool.

2. Medical Home Outreach--Population-Based Services--CYSHCN

As part of Spread, dissemination of concepts of Medical Home continued to be integrated in Wisconsin Sound Beginnings (Early Hearing Detection and Intervention) and Congenital Disorders (blood spot newborn screenings) Programs. Medical Home Local Capacity Building grants, administered by each CYSHCN Regional Center, were in the final year of their second cycle. We created and issued a RFP to fund local communities to support local implementation of medical home. These ten local capacity grants targeted underserved populations such as racial and ethnic populations and rural areas. The Medical Home Toolkit website, <http://wimedicalhometoolkit.aap.org/toolkit/index.cfm>, continues to be well-utilized by its intended target audience.

3. Medical Home and Community Supports--Infrastructure Building Services--CYSHCN

CYSHCN Regional Centers continued to develop relationships with individual providers in their region to assist with community connections, information and referrals. The State CYSHCN Program continued its collaborative efforts with Division of Health Care Access and Accountability. A Medical Home Practice Group continued in conjunction with Community of Practice on Autism Spectrum Disorders and other Developmental Disabilities.

National Performance Measures Summary Sheet Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Medical Home Education and Training			X	
2. Medical Home Outreach			X	
3. Medical Home and Community Supports				X

b. Current Activities

1. Medical Home Education and Training--Population-Based Services--CYSHCN

The CYSHCN Program continues to update and improve its Medical Home Toolkit as needed. FVW and Regional Centers for CYSHCN continue to integrate Medical Home concepts and strategies into their information-sharing and training.

2. Medical Home Outreach--Population-Based Services--CYSHCN

Medical Home Care Coordination mini-grants, administered by the Southern Regional Center, have been awarded to six grantees. Medical Home spread activities continue to dovetail with other CYSHCN initiatives to maximize spread.

3. Medical Home and Community Supports--Infrastructure Building Services--CYSHCN

Physicians recruited in 2008 were trained in 2009 to train other physicians in implementation of the ASQ developmental screening tool in context of medical home. These trained physicians can now train others across the state. The trainings are in partnership with the Regional Centers and local Birth-3 Programs. The Regional Centers also continue to reach out to new providers in their regions, led and coordinated by the Northeastern Regional Center, to assist with community connections, information and referrals. The CYSHCN Program partners with the Medical Home Learning Collaborative so that lessons learned and products developed are shared with partners and included in the Toolkit.

c. Plan for the Coming Year

1. Medical Home Education and Training--Enabling Services--CYSHCN

The CYSHCN Program will maintain and update its Medical Home Toolkit as needed. The State CYSHCN Program will continue to work with Wisconsin Academy of Family Physicians and Wisconsin Chapter of the American Academy of Pediatrics to promote the concept of medical home for CYSHCN and foster its growth and spread in communities across the state. Staff will maintain connections to a variety of medical home activities around the state to continue to keep the needs of CYSHCN as a focus, and will work to influence stakeholder groups as Wisconsin continues to move toward patient-centered medical home implementation. We will work to maintain our presence and influence regarding CYSHCN and medical home.

2. Medical Home Outreach--Population-Based Services--CYSHCN

The State CYSHCN Program will be pursuing a mini-grant process for one year of funding. Local grants will enable primary care practices to implement one or more quality improvement strategies in an individual practice, resulting in measurable outcomes for children and youth with special health care needs and their families. A dedicated staff person assigned to strengthening Wisconsin's Medical Home Initiative will promote a coordinated, comprehensive approach to Medical Home spread. These mini-grants will continue and build on our efforts to support practice-based developmental screening and other medical home implementation strategies for CYSHCN. These will continue to function as a partnership between the State program and our Regional Centers for CYSHCN. Dollars will also be earmarked to continue our support of community and family involvement in the Latino community in SE Wisconsin.

3. Medical Home and Community Supports--Infrastructure Building Services--CYSHCN

The State CYSHCN Program and its contracted agencies will continue to promote Medical Home spread and offer technical assistance supports through work with key partners on the local, regional and state levels. Promotion will include targeting children's hospitals and pediatric units within hospitals; primary care practices; LHDs; state and community partners; and parents of CYSHCN. Regional Centers will reach out to new providers in their regions to assist with community connections, information and referrals. The CYSHCN Program will partner with the Medical Home Learning Collaborative so that lessons learned and products are shared with partners and included in the Toolkit.

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

Tracking Performance Measures

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	68.6	69	69.5	64	65
Annual Indicator	66.6	63.0	63.0	63.0	63.0
Numerator	117664	127442	127442	127442	127442
Denominator	176641	202257	202257	202257	202257
Data Source				SLAITS CSHCN.	SLAITS CSHCN.

Check this box if you cannot report the numerator because

1. There are fewer than 5 events over the last year, and
2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.

Is the Data Provisional or Final?

	2010	2011	2012	Final 2013	Final 2014
Annual Performance Objective	66	67	68	68	68

Notes - 2009

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM #04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2008

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM #04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM #04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

a. Last Year's Accomplishments

1. Health Benefits Services--Enabling--CYSHCN

The Regional Center network continued health benefits training via webcasts which are archived and available for viewing. The Regional Centers and Family Voices of Wisconsin (FVW) have joined ABC for Health's HealthWatch group. Parent trainers of FVW continued to offer families training regarding health insurance and community supports.

2. Access to Health Insurance--Infrastructure Building Services--CYSHCN

The Regional Centers continued assisting families to secure health insurance through information, referral and follow-up.

3. Access to Dental Care Services--Infrastructure Building Services--CYSHCN

The Oral Health Program continued to provide technical assistance and guidance to CHAW to administrator a HRSA grant that provides didactic and clinical training to dental health professionals to increase knowledge and skills in the treatment of CYSHCN. During 2009, there were 3 trainings with 65 oral health professionals attending. The grant supports 6 regional CYSHCN oral health consultants.

4. Mental Health Services for CYSHCN--Infrastructure Building Services--CYSHCN

The Infant Mental Health Leadership Team (IMHLT) 2010 annual report was completed to address the Governor's Kids First Initiative supporting Infant and Early Childhood Care with a focus on the DC: 0-3R is incorporated into the Long Term Functional Screen.

The IMHLT and the Children's Mental Health Committee of the Wisconsin Council on Mental Health continue to address mental health screening in primary care and the shortage of child and adolescent psychiatrists. Wisconsin was 1 of 35 states with less than the national average of psychiatrists for its youth population - 8.2 per 100,000 with optimum care of 14.38 per 100,000.

5. Autism Insurance Coverage--Enabling Services--CYSHCN

Wisconsin's budget included a mandate for disability insurance policies and self-insured health plans cover certain services for anyone with an autism spectrum disorder. This includes coverage for intensive in-home treatment (currently funded by CLTC waivers) as well as other autism-related services. The mandate became effective in November 2009 with the provision that insurers would implement the coverage as policies are renewed (<http://oci.wi.gov/rules/0336em09.pdf>).

6. Health Insurance Coverage for young adults up to age 27--Enabling Services--CYSHCN

Wisconsin's budget included the expansion of health insurance coverage for young adults over 17 but less than 27; not married; and not eligible for health coverage through their employer or whose premium is greater than the amount the parent is required to pay to add the young adult to the plan. The statute went into effect for policies issued or renewed beginning on January 1, 2010 (<http://oci.wi.gov/rules/0334em09.pdf>).

7. Health Insurance Coverage for Cochlear Implants--Enabling Services--CYSHCN

Through Act 14 S.B. 27/A.B 16, Wisconsin became one of the first states to require insurance companies to cover the cost of cochlear implants for children 18 years old or younger. The law covers hearing aids, related professional services and aural rehabilitation.

8. Children's Long-Term Support Home and Community-Based Medicaid Waivers--Direct Health Care Services--CYSHCN

In 2009, the Bureau of Long Term Support reported that 848 children were waiting for intensive in-home autism services and 1,377 children transitioned from intensive services to on-going services. Overall, 4,209 children received direct services with the following disabilities as eligibility: developmental disabilities, 2,775; physical disabilities, 297; and severe emotional disturbances, 1,137. There were: 1,210 children receiving services through locally matched waivers; 50 children in pilot slots; 95 children in crisis slots; and 629 children in special state-funded slots. There were a total of 4,209 children receiving service through the CLTS Waivers.

National Performance Measures Summary Sheet Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Health Benefits Services		X		
2. Access to Health Insurance				X
3. Access to Dental Care Services				X
4. Mental Health Services for CYSHCN				X
5. Autism Insurance Coverage		X		
6. Health Insurance Coverage for Young Adults to age 27		X		
7. Health Insurance Coverage for Cochlear Implants, related services and rehabilitation services		X		
8. Children's Long-Term Support Home and Community-Based	X			

Table 4a National Performance Measures Summary Sheet Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
Medicaid Waivers				

b. Current Activities

1. Health Benefits Services--Enabling--CYSHCN

We continue to partner with ABC for Health and ABC for Rural Health.

2. Access to Health Insurance--Infrastructure Building--CYSHCN

The Medicaid Purchase Plan (MAPP) offers people with disabilities who are working or interested in working the opportunity to buy health care coverage through the Wisconsin Medicaid Program. Depending on an individual's income, a premium payment may be required for this health care coverage.

Under MAPP, participants:

- receive the same health benefits offered through the Medicaid (MA) Program;
- may earn more income, than another group of MA recipients, without the risk of losing health care coverage; and
- are allowed increased personal and financial independence through saving opportunities, known as Independence Accounts.

3. Access to Dental Care Services--Infrastructure Building Services--CYSHCN

DHS continues to provide technical assistance and guidance to CHAW. In 2010 there have been five didactic and one clinical training held for 139 oral health professionals, targeting treatment concerns related to CYSHCN. Training evaluations show marked increase in knowledge, skills and comfort level treating CYSHCN.

c. Plan for the Coming Year

1. Health Benefits Services--Enabling--CYSHCN

We plan to continue to partner with ABC for Health and participate in HealthWatch.

2. Access to Health Insurance--Infrastructure Building--CYSHCN

The Regional Centers will continue as one of their core services in assisting families to secure health insurance through information, referral and follow-up and health benefits counseling as appropriate, and provide training and technical assistance to the CYSHCN Collaborators Network partners on health access and coverage issues including the Health Competency Self Assessment relevant to children and youth with special needs. In addition they will help to monitor the progress of national health care reform as it pertains to the CYSHCN program and they will integrate activities with the Bright Futures Initiative statewide by provide training and technical assistance to support community level collaborations that address children and youth with special health care needs.

Through the Nourishing Special Needs WIC/CYSHCN Network, we will continue to problem-solve access to nutritional services for CYSHCN.

3. Access to Dental Care Services--Infrastructure Building Services--CYSHCN

The Department will continue to provide CHAW with technical assistance and guidance related to grant activities to increase the knowledge and skills of dental health providers in the treatment of CYSHCN. There are plans for at least 5 training sessions in various regions across the state. We will be specifically targeting CHC's and FQHC's for program attendance and on-site, ongoing technical support.

4. Access to Mental Health Services for CYSHCN--Infrastructure Building Services--CYSHCN

The following goals will continue to be addressed through the Children's Mental Health Committee. Expand collaborative systems of care (i.e., wraparound), with a goal of children's wraparound systems in each of Wisconsin's 72 counties within 6 years. Create financial incentives to increase family advocacy and support for counties with a Coordinated Services Team (CST) initiative. Increase mental health early intervention activities directed toward children and youth. Increase children's mental health training and available consultation for teachers and preschool/daycare providers. Take steps to increase the availability of qualified mental health providers throughout Wisconsin, particularly in underserved areas.

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

Tracking Performance Measures

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	83.7	84	84.5	91	91
Annual Indicator	80.7	90.0	90.0	90.0	90.0
Numerator	57768	182031	182031	182031	182031
Denominator	71620	202257	202257	202257	202257
Data Source				SLAITS CSHCN.	SLAITS CSHCN.

Check this box if you cannot report the numerator because

1. There are fewer than 5 events over the last year, and
2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.

Is the Data Provisional or Final?

	2010	2011	2012	2013	2014
Annual Performance Objective	92	92	93	Final 93	Final 93

Notes - 2009

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM #05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2008

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM #05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM #05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

a. Last Year's Accomplishments

1. Access to Individual/Household Services--Enabling Services--CYSHCN

Individuals, families, and providers who contact the 5 CYSHCN Regional Centers and their subcontracted agencies received direct assistance, referrals to other professionals, or other interventions by Center and local staff. In 2009, according to data entered in SPHERE, there were 4,993 CYSHCN-funded contacts

and services provided, with 2,131 individual/household interventions and 2,862 brief contacts. "Brief contacts" include consultations that are face-to-face, on the telephone, and/or in writing.

2. Community Based Services--Population-Based Services--CYSHCN

Partnerships at the local, regional and state levels were advanced through co-sponsored events, established cross-referral plans and collaborative efforts to serve identified target populations. The CYSHCN Program and its Regional Centers have delineated key committees and conferences where CYSHCN representation is critical and an outreach plan specifies responsibilities over the state.

3. Planning and Implementing Community Based Projects--Infrastructure Building Services--CYSHCN

There is an established Collaborators Network, and the CYSHCN Program continues to work collaboratively with many partners to assure that CYSHCN are identified early, receive coordinated care, and that their families have access to the supports they need. These collaborative partnerships include: Parent to Parent; Family Voices of WI; Great Lakes Inter-Tribal Council; ABC for Health and ABC for Rural Health; First Step; Wisconsin Chapters of the AAP and WAFP; Early Intervention ICC; Wisconsin Early Childhood Collaborating Partners; Department of Public Instruction's Wisconsin Statewide Parent-Educator Initiative; the Parent Training and Information Center - WI FACETS; statewide Wisconsin Asthma Coalition; Wisconsin Infant Mental Health Association; and the Circles of Life Planning Conference.

Working in partnership with other funding sources, the state CYSHCN Program has established a network of 9 WIC nutritionists who work with the Regional Centers to improve nutritional services for CYSHCN. They meet regularly and are also part of the Collaborators Network. These 9 are mentoring others so that by 2010 there will be 17 WIC sites that are part of the Network.

Wisconsin was awarded a MCH Targeted Oral Health Service Systems Grant entitled "Wisconsin Community-based System of Oral Health for CYSHCN." This four-year grant is administered through the Children's Health Alliance of Wisconsin. They are part of our Collaborators Network and did trainings for providers regarding oral health and CYSHCN around the state.

Table 4a National Performance Measures Summary Sheet Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Access to Individual/Household Services		X		
2. Community Based and System Based Services			X	
3. Planning and Implementing Community Based Projects				X

b. Current Activities

1. Access to Individual/Household Services--Enabling Services--CYSHCN

In 2010, the 5 Regional Centers and their delegate agencies continue to provide information and assistance to families and providers. LHDs continue to have the option of providing these services at a local level. Families are linked to trainings and parent support opportunities to meet their needs.

2. Community Based and System Based Services--Population-Based Services--CYSHCN

The Southern Regional Center for CYSHCN is administering 6 Medical Home mini-grants allowing communities to build upon assets and develop local systems of care for CYSHCN.

3. Planning and Implementing Community Based Projects--Infrastructure Building Services--CYSHCN

The Regional Centers meet with the regional oral health consultants from the Wisconsin Community-based System of Oral Health for CYSHCN. Centers also continue to access their WIC-nutrition regional consultants who also are working with their LHDs.

Regional Centers continue to respond to local requests for training, outreach and assistance. The Collaborators Network continues to share resources, problem-solve, and cross-refer.

c. Plan for the Coming Year

1. Access to Case Management, Consultation and Referral and Follow-up Services--Direct Health Care Services--CYSHCN

In 2011, the 5 Regional Centers for CYSHCN and their delegate agencies will continue to provide information and assistance to families and providers. Families will be linked to trainings and parent support opportunities to meet their needs. The LHDs will have the option to choose serving CYSHCN through MCH Consolidated Contracting.

CYSHCN staff will begin planning for the next five-year cycle based on outcomes from a MCH needs assessment that is occurred in 2009. We will do this in collaboration with our partners and members of our Collaborators Network.

2. Community Based and System Based Services--Population-Based Services--CYSHCN

Regional Centers will continue to be involved in building local medical home capacity across the state by working closely with the recipient of the Medical Home Mini-Grant. The Regional Centers will attend trainings and introduce the Center as a resource; assist with provider recruitment; provide community-related resource information to practice sites within their region; coordinate these and other Medical Home activities with partners; and assist with practice site follow up.

3. Planning and Implementing Community Based Projects--Infrastructure Building Services--CYSHCN

In partnership with other funding sources, the CYSHCN Program will plan and implement the following projects in 2011: continue to implement the Regional Center for CYSHCN model; and provide technical assistance to recipients of local community capacity grants to monitor, evaluate and support the objectives of the grant. The Collaborators Network will continue to share resources, problem-solve, and cross-refer.

The CYSHCN Program will continue to work to increase our program's visibility, focus more attention on early identification and screening and broaden the stakeholder group that meets regularly. We will continue to market our program and our collaborators as a network through common marketing themes and the use of common design elements in our materials.

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

Tracking Performance Measures

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	7.8	8	7	50	52
Annual Indicator	5.8	44.5	44.5	44.5	44.5
Numerator	64727	90004	90004	90004	90004
Denominator	1116374	202257	202257	202257	202257
Data Source				SLAITS CSHCN.	SLAITS CSHCN.

Check this box if you cannot report the numerator because

1. There are fewer than 5 events over the last year, and
2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.

Is the Data Provisional or Final?

	2010	2011	2012	Final 2013	Final 2014
Annual Performance Objective	54	55	56	56	56

Notes - 2009

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM #06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2008

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM #06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM #06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

a. Last Year's Accomplishments

1. State Partnership Building--Infrastructure Building Services--CYSHCN

The CYSHCN Program continued to support the Community of Practice on Transition (CoT) in collaboration with Department of Public Instruction. This collaborative group has representatives from over 40 state programs and community partners with transition-related interests. The state CYSHCN Program continued as part of the core leadership team for the CoT. The Regional Centers for CYSHCN continued to support transition activities at the local and regional level through their involvement in the CoT, with practice teams on CYSHCN-specific areas. In February 2009, the CYSHCN Program sponsored an annual CoT meeting with a focus on health. The Health Care Checklist was finalized, printed and disseminated to key stakeholders, including posting it on the WI Medical Home Toolkit and sharedwork.org websites.

2. Outreach and Training--Training Infrastructure Building Services and Outreach Population-Based Services--CYSHCN

The Transition to Adult Health Care curriculum was printed and disseminated to further prepare YSHCN, their families and providers for the move from pediatrics to adult health care. The Regional Centers for CYSHCN and Family Voices parent trainers received a train-the-trainer session on the revised Health Care Transition curriculum. Following this training, there will be opportunities for youth, parents, and providers to attend trainings and receive targeted support in a clinical or one-to-one setting in all five DPH regions.

3. Access to Transition Information--Enabling Services--CYSHCN

The CYSHCN Program disseminated quality information to families and providers using web-based, hard copy, oral and face-to-face approaches. Through the Community of Practice, the Regional Centers have developed key partnerships and extensive knowledge of the Wisconsin and national resources on transition which has enhanced the Centers ability to either answer the parents question, problem solve solutions and/or refer families to the appropriate entity. Booklets on health-related transition topics were disseminated at conferences, the Community of Practice on Transition, youth and parent trainings. These materials were posted on the Waisman Center's website and were available for easy download.

Regional Centers answer calls directly answer questions about transition, as well as responding to parents on-site who walk-in and ask questions.

Table 4a National Performance Measures Summary Sheet Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. State Partnership Building				X
2. Training (IB) and Outreach (PBS)			X	X
3. Access to Transition Information		X		

b. Current Activities

1. State Partnership Building--Infrastructure Building Services--CYSHCN

The CYSHCN Program continues to share leadership for the Community of Practice on Transition with staff attending the National Community meeting in May 2010. The CYSHCN Program's Statewide Implementation Grant for Autism Spectrum Disorders (ASD) created a Community of Practice on ASD and other developmental disabilities (DD). Plans are under way to have a combined Community of Practice (Transition and ASD/DD) in October 2010. The CYSHCN Program utilizes www.sharedwork.org and a State Implementation grant electronic repository to catalogue information and resources for this Community work. This site includes a health care transition webcast with a parent and young adult presenting. The Regional CYSHCN Centers continue to support transition activities at the local and regional level through their involvement in the CoT, with practice teams on CYSHCN-specific areas.

2. Outreach and Training--Training Infrastructure Building Services and Outreach Population-Based Services--CYSHCN

The CYSHCN Transition to Adult Health Care materials, promoting the move from pediatrics to adult health care, went into a second printing and is being disseminated to key stakeholders, including sessions at the annual statewide transition, rehabilitation and Circles of Life conferences for professionals and parents, and through the Family to Family Health Information Center.

c. Plan for the Coming Year

1. State Partnership Building--Infrastructure Building Services--CYSHCN

In 2011, there will be a new approach to this work, though much of the work will continue as previously described. The CYSHCN Collaborators Network comprised of Wisconsin CYSHCN-funded entities including the five Regional Centers, Family to Family Health Information Center, Family Voices, Parent to Parent, will all be involved in disseminating information and resources to families, youth and providers. Through a competitive process, a contract will be awarded to provide statewide leadership to the state around transition. The grantee will take a leadership role in the Community of Practice on Transition, its facilitator team and the Practice Group on Health and work closely with the Collaborators Network. The statewide work will establish a hub of expertise, keeping current and disseminating national information to Wisconsin stakeholders. This model follows the national MCH model of having one training and technical assistance center for each NPO.

2. Outreach and Training--Training Infrastructure Building Services and Outreach Population-Based Services--CYSHCN

The grantee for statewide transition work will collaborate with all five Regional Centers, be integrated into the CYSHCN Collaborators Network, and providing training and technical assistance to youth, parents, health care providers, community providers and educators. The work will include the continued use and dissemination of the five transition materials that the CYSHCN Program developed in 2009 and 2010 including the following: Transition to Adult Health Care: A Training Guide, My Pocket Guide, The Health Care Checklist, The Youth Workbook, Health and the IEP CD (<http://www.waisman.wisc.edu/wrc/pub.html>). These materials and content will be disseminated at the three primary transition-related state conferences (transition, rehabilitation and Circles of Life). The

Pocket Guide will be translated into Spanish and Hmong. Plans will be developed for spreading the Children's Hospital of Wisconsin on-line transition curriculum for health care providers to other hospitals.

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

Tracking Performance Measures

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	83.5	83.2	83.4	83.5	83.6
Annual Indicator	83.0	82.3	79.3	79.3	83.6
Numerator	730	724	349	349	368
Denominator	880	880	440	440	440
Data Source				CDC Nat Imm Surv 2009.	CDC Nat Imm Surv 2010.

Check this box if you cannot report the numerator because

1. There are fewer than 5 events over the last year, and
2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.

Is the Data Provisional or Final?

	2010	2011	2012	2013	2014
Annual Performance Objective	83.7	83.7	83.7	83.7	83.8

Notes - 2009

The source of these data is the National Immunization Survey of a random sample of Wisconsin children who were born between January 2005 and June 2007.

Notes - 2008

The data entered for 2008 are from the National Immunization Survey for CY 2007. For Wisconsin children 19-35 months of age who had received 4 DTaP, 3 polio, 1 MMR, 3 Hep B and 3 Hib vaccine doses, the estimate was 79.4% with confidence intervals plus or minus 6.4%. Although the 2007 survey's immunization rate estimate for Wisconsin is slightly lower than the 2006 estimate, the difference is not statistically significant. Also, in prior survey years, large urban areas in 15 states (inc. Wisconsin) were over-sampled. When this aspect of the sampling methodology was discontinued in 2007, 14 of these states (inc. Wisconsin) experienced lower rate estimates. While the precise effect of the methodological change is unknown, overall study results suggest a potentially negative impact.

Notes - 2007

The 2007 data from the National Immunization Survey show that Wisconsin's immunization estimated coverage rates for 4 DTaP, 3 Polio, 1 MMR, 3 Hep B, and 3 Hib among kids 19-35 months of age rose from 83.0% in 2005 to 86.8% in 2006. This increase may be due to acceptance and use of the Wisconsin Immunization Registry (WIR).

a. Last Year's Accomplishments

1. Providing, Monitoring and Assuring Immunizations--Direct Health Care Services--Children, including CYSHCN

The estimated coverage among Wisconsin children 19-35 months of age for 2008 with 4 DTaP, 3 polio, 1 MMR, 3 Hep B and 3 Hib (4:3:1:3:3) doses is 83.6%. The source of this data is from the National Immunization Survey of a random sample of Wisconsin children who were born between January 2005 and June 2007. Data from 2009 is not yet available and will be impacted as there was a national Hib vaccine shortage through 2008 and CDC recommended deferring the last dose.

2. Coordination with WIC and the State Immunization Programs and Enrollment in the Wisconsin Immunization Registry (WIR)--Infrastructure Building Services--Pregnant women, mothers, infants and children, including CYSHCN

The State Immunization Program continued to partner with the Title V MCH/CYSHCN Program, LHDs, the WIC Program, the Medicaid Program, tribes, and CHCs. The WIR supports and maintain WIC sites as registry program participants.

3. Tracking and Sharing Policy Changes or Clinical Practices by the State Immunization Program--Infrastructure Building Services--Pregnant women, mothers, infants and children, including CYSHCN

National and international circumstances that result in subsequent policy changes or clinical practices are tracked by the State Immunization Program. Information updates were shared by the state Immunization Program with key partners as indicated via email and at spring communicable disease seminars held in each of the five DPH regions.

4. Quality improvement of Vaccines for Children program--Infrastructure Building Services--Children, including CYSHCN

QI efforts for providers in 2009 occur through site visits by Immunization Program personnel to 25% of all VFC sites in Wisconsin. One of the topics of continued interest is provider participation with the WIR and the appropriate use of the reminder/recall function. The performance based contract template objective for LHDs is to raise immunization levels of all preschool children within their service areas. The CDC goal is 90% series complete (4 DTaP, 3 Polio, 1 MMR, 3 Hepatitis B, 3 Hib and 1 varicella) by 24 months of age. The Wisconsin Immunization Registry (WIR) benchmark reports are used to measure this objective.

Table 4a National Performance Measures Summary Sheet Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Providing, Monitoring, and Assuring Immunizations	X			
2. Coordination with WIC and the State Immunization Programs and Enrollment in the Wisconsin Immunization Registry (WIR)				X
3. Tracking and Sharing Policy Changes or Clinical Practices by the State Immunization Program				X
4. Quality Improvement of Vaccines for Children Program				X

b. Current Activities

1. Providing, Monitoring and Assuring Immunizations--Direct Health Care Services--Children, including CYSHCN

Title V staff continue to support LHDs primary prevention activities that include immunization monitoring, and support compliance with State Immunization Program fund requirements.

2. Coordination with WIC and the State Immunization Programs and Enrollment in the Wisconsin Immunization Registry (WIR)--Infrastructure Building Services--Pregnant women, mothers, infants and children, including CYSHCN

State Immunization Program will continue to partner with Title V MCH/CYSHCN Program, LHDs, WIC Program, Medicaid Program, tribes, and CHCs.

3. Tracking and Sharing Policy Changes or Clinical Practices by the State Immunization Program--Infrastructure Building Services--Pregnant women, mothers, infants and children, including CYSHCN

National and international circumstances that result in recommended changes in the immunization schedule continue to be tracked by the State Immunization Program during 2010 with policy sharing occurring as appropriate.

4. Quality improvement of Vaccines for Children Program--Infrastructure Building Services--Children, including CYSHCN

During 2010, quality improvement efforts for providers occur with site visits by staff in the State Immunization Program.

c. Plan for the Coming Year

1. Providing, Monitoring and Assuring Immunizations--Direct Health Care Services--Children, including CYSHCN

Title V MCH Program staff will continue to support LHDs primary prevention activities that include immunization monitoring and support compliance with State Immunization Program funding requirements. Data required enabling MCH to monitor and report this measure will continue to be provided by the state Immunization Program.

2. Coordination with WIC and the State Immunization Programs and Enrollment in the Wisconsin Immunization Registry (WIR)--Infrastructure Building Services--Pregnant women, mothers, infants and children, including CYSHCN

State Immunization Program will continue to partner with Title V MCH/CYSHCN Program, LHDs, WIC Program, Medicaid Program, tribes, and CHCs.

3. Tracking and Sharing Policy Changes or Clinical Practices by the State Immunization Program--Infrastructure Building Services--Pregnant women, mothers, infants and children, including CYSHCN

National and international circumstances that result in recommended changes in the immunization schedule will continue to be tracked by the State Immunization Program during 2010 with policy sharing occurring as appropriate.

4. Quality improvement of Vaccines for Children Program--Infrastructure Building Services--Children, including CYSHCN

During 2011, quality improvement efforts for providers will be maintained through site visits by staff in the State Immunization Program.

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

Tracking Performance Measures

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	15.1	14.8	14.7	14.9	16.1
Annual Indicator	14.9	15.6	16.0	15.4	15.4
Numerator	1776	1840	1874	1783	1783
Denominator	119124	118012	117042	115440	115440
Data Source				WI DHS/ OHI 2009.	WI DHS/OHI 2010.

Check this box if you cannot report the numerator because

1. There are fewer than 5 events over the last year, and
2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.

Is the Data Provisional or Final?

	2010	2011	2012	2013	2014
Annual Performance Objective	16.1	15.9	15.9	15.8	15.6

Notes - 2009

Data issue: Data for 2009 will not be available from the Office of Health Informatics until 2011.

Notes - 2008

Data notes: There were 76 births to teens <15 years in 2009. Source: Office of Health Informatics, Division of Public Health, Wisconsin Department of Health and Family Services. Source: Wisconsin Dept. of Health Services, Division of Public Health, Bureau of Health Information and Policy. Wisconsin Interactive Statistics on Health (WISH) data query system, <http://dhs.wisconsin.gov/wish>, Birth Counts and Population Modules, accessed 03/07/10.

Notes - 2007

Data notes: There were 80 births to teen <15 years in Wisconsin in 2007. Source: Bureau of Health Information and Policy, Division of Public Health, Wisconsin Department of Health and Family Services. Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Wisconsin Interactive Statistics on Health (WISH), <http://dhs.wisconsin.gov/wish>, Birth Counts Module, accessed 04/07/2009. Denominator: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Bureau of Health Information and Policy. Wisconsin Interactive Statistics on Health (WISH), <http://dhs.wisconsin.gov/wish>, Population Module, accessed 03/21/2009.

a. Last Year's Accomplishments

1. Milwaukee Adolescent Pregnancy Prevention Partnership (MAPPP)--Enabling Services--Adolescents

In 2009, the Milwaukee Adolescent Pregnancy Prevention Partnership (MAPPP) Initiative completed its third grant year signed up over 400 clients to the Family Planning Waiver. This initiative increased public information directed to sexually active youth to increase awareness about resources in the community to reduce the risk of unintended pregnancy and STDs. Referral-related communication was enhanced to assist clients to make connections with appropriate health resources. Progress has been seen, reflected in the performance measurement, however further reductions in adolescent pregnancy must be a priority, including Milwaukee which has one of the highest rates of adolescent pregnancy.

2. Dual Protection Initiative--Population-Based Services--Adolescents

The DHS Dual Protection Initiative continued in collaboration with the City of Milwaukee Health Department's STD clinic. Clients presenting to the STD clinics were provided the opportunity to enroll in

the FPW, receive dual protection supplies, and receive a referral to a community-based clinic for ongoing reproductive/sexual health care.

3. Coalition--Population-Based Services--Adolescents

DHS established a new collaborative group called Adolescent Sexual Health Coalition of Milwaukee (ASHCOM) that includes all the key teen pregnancy prevention coalition leaders. This was initiated to coordinate adolescent pregnancy prevention activities of stakeholder groups. Increased coordination, and consistent messages and intervention activities are required to reduce adolescent pregnancy.

4. State Health Plan--Infrastructure Building Services--Adolescents

Key stakeholders were involved with the planning for Wisconsin's 2020 state health plan: Healthiest Wisconsin 2020. Reproductive/Sexual Health was one of the priority areas. Recommendations by this group will provide the framework for future reproductive/sexual health priorities, plans, and activities. These recommendations will be presented to the DHS Secretary for consideration in 2010. Recommendations included the need to articulate new norms of behavior related to reproductive/sexual health, similar to the norms recommended in the Institute of Medicine's report, "Best of Intentions". Sexual activity without consideration of the pregnancy (and STD/HIV) consequences must be addressed as a central issue. Along with this renewed emphasis, access to information and services and supplies must be increased. Increased attention to patient responsive services and disparities must occur. These elements are essential parts of a reproductive justice approach to improved outcomes, including reduction of adolescent pregnancy.

Table 4a National Performance Measures Summary Sheet Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Milwaukee Adolescent Pregnancy Prevention Partnership (MAPPP)		X		
2. Dual Protection Initiative			X	
3. Coalition			X	
4. State Health Plan				X

b. Current Activities

1. Milwaukee Adolescent Pregnancy Prevention Partnership (MAPPP)--Enabling Services--Adolescents

The MAPPP group in Milwaukee is working to improve referral-related communications and support to successfully connect youth with appropriate health services. A primary goal is to connect youth to "medical (health care) homes" for ongoing reproductive/sexual health and other primary/preventive care.

2. Coalition--Population-Based Services--Adolescents

The Adolescent Sexual Health Coalition is establishing goals and meeting bimonthly.

3. State Health Plan--Infrastructure Building Services--Adolescents

Objectives and measures for HW2020 were identified for the focus area of reproductive/sexual health. Major themes include the focus on reproductive justice and establishing new social norms for reproductive/sexual health behavior, similar to those recommended in the Institute of Medicine's report "Best of Intentions". Access to evidence-based information (for informed decisions) and services is a cornerstone of reproductive justice.

4. Family Planning Waiver--Infrastructure Building Services--Adolescents

Coverage under the FPW was expanded to include males. Launching these new services and promoting dual protection as a standard of care will be a major focus in 2010.

5. Data--Infrastructure Building Services--Adolescents

The Division of Public Health is completing a YRBS-LGBT disparity report for the DHS Secretary.

c. Plan for the Coming Year

1. Milwaukee Adolescent Pregnancy Prevention Partnership (MAPPP)--Enabling Services--Adolescents

Outreach to males through the Milwaukee Adolescent Pregnancy Prevention Partnership will be a major focus of activities in 2011 promoting Wisconsin's expanded coverage to males under the Family Planning Waiver (FPW). Community engagement (including public information), actively managed referrals among community-based clinics, and patient responsive services will be among the highest priorities.

2. Dual Protection Initiative--Population-Based Services--Adolescents

Dual protection (the simultaneous intervention to reduce the risk of unintended pregnancy and STD) will continue to be a priority standard of practice and strategy. Standardized messages and services/supplies will be aggressively promoted to health care providers. A model of this dual protection intervention will continue to be collaboration through the Milwaukee Dual Protection Partnership Initiative. Collaboration will increase between the Milwaukee Health Department's STD clinic and community-based clinics to provide access to FPW enrollment, immediate dual protection supplies and services, and actively managed referrals for a reproductive/sexual health care home for continuing preventive care.

3. Coalition--Population-Based Services--Adolescents

"Adolescent Sexual Health" will be promoted as the new focus for the Milwaukee ASHCOM and Teen Pregnancy Prevention Oversight Committee activities. Improved coordination and collaboration among community stakeholders will be a renewed priority. Implementation of the Healthiest Wisconsin 2020 new reproductive health goals will provide the framework for activities in 2011 and beyond.

4. Family Planning/Reproductive Health Services--Direct Health Care--Adolescent

2011 begins a new 5 year grant cycle for the Wisconsin MCH-Family Planning and Reproductive/Sexual Health Program. Priorities will include increased access (and patient convenience) to services and supplies, improved patient messaging in core knowledge areas, and increased patient responsive services. Priority practice areas, key standards of practice (including dual protection), and new personnel requirements will be promoted. Quality assurance in these areas will be a major emphasis in 2011 (through 2015). Establishing sexually active youth with a reproductive/sexual health care home (for on-going care) will be one of the foundation principal in system development.

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

Tracking Performance Measures

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	50	50	50	50	51
Annual Indicator	47.0	47.0	47.0	50.8	50.8
Numerator	34134	34134	34134	35806	35806
Denominator	72626	72626	72626	70484	70484
Data Source				WI DHS/DPH 2009.	WI DHS/DPH 2010.

Check this box if you cannot report the numerator because

1. There are fewer than 5 events over the last year, and
2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-

year moving average cannot be applied.

Is the Data Provisional or Final?

	2010	2011	2012	Final 2013	Final 2014
Annual Performance Objective	51	52	52	53	54

Notes - 2009

Data issue: Numerator and denominator are weighted estimates from the Wisconsin Division of Public Health "Make Your Smile Count, The Oral Health of Wisconsin's Children" survey of third grade children, 2007-08. The unweighted data are: 2,212 and 4,353.

Notes - 2008

Data issue: Numerator and denominator are weighted estimates from the Wisconsin Division of Public Health "Make Your Smile Count, The Oral Health of Wisconsin's Children" survey of third grade children, 2007-08. The unweighted data are: 2,212 and 4,353.

Notes - 2007

Source: Numerator: calculated by taking 2001's indicator, the Wisconsin Division of Public Health "Make Your Smile Count" survey of third grade children, 2001-2002. Denominator: the number of third grade children enrolled in public and private schools. We are currently conducting another third grade survey, therefore, for next year we will have updated information/data.

a. Last Year's Accomplishments

1. Healthy Smiles for Wisconsin Seal-A-Smile Sealant Program--Direct Health Care Services--Children

The Wisconsin Seal-A-Smile (SAS) statewide school-based, school-linked dental sealant program initially provided grant funding to 20 LHDs and community-based agencies. Through a Health Resources and Services Administration grant award of \$325,000/yr for three years with private sector matching funds of \$214,000 for the same three years the program has experienced significant growth. In addition to the originally funded projects an additional 6 new projects are either already operating or are in the development phase. In 2008/09 school year, the 20 Seal-A-Smile projects held 176 events, screened 9,777 children and provided 16,118 dental sealants to 6,266 children. The Seal-A-Smile program average for sealant placement per child was \$7.04, however the cost per cavity averted, according to the Centers for Disease Control and Prevention health economists is \$45.95. The Oral Health Program continued to contract with the Children's Health Alliance of Wisconsin to administer and monitor the Seal-A-Smile program. Through a Centers for Disease Control and Prevention Cooperative Agreement the Oral Health Program in late 2009 was able to hire a dedicated Dental Sealant Coordinator. The Coordinator works in collaboration with the Alliance to administer and monitor the SAS program. In addition, the Coordinator provides technical assistance in program development to LHDs, agencies and individuals interested in establishing a SAS program in their communities. The HRSA and Delta Dental funding will target areas of the state with the highest need and little to no current programming. The goal is to be able to provide school-based, school-linked dental sealant programs in each of the 717 schools in the state with federal Free and Reduced Lunch Program participation rates of 35% or greater. In 2008-09 SAS grantees were operating efficient programs in 60 schools meeting the criteria. With additional staff and funding Wisconsin is well positioned to meet our SAS program goals.

2. Healthy Smiles for Wisconsin Oral Health Infrastructure Support--Infrastructure Building Services--Children including CYSHCN

In 2008 the Wisconsin Oral Health Program was the recipient of a CDC Cooperative Agreement award. The award is designed to increase capacity and build infrastructure to ensure Wisconsin has an adequate oral health workforce to successfully address statewide needs. The award allows for the creation of a Dental Sealant Coordinator position to enhance and expand the program. We successfully recruited and hired a dedicated Dental Sealant Coordinator in late 2009. The Oral Health Program is now at full capacity and positioned to meet the growing needs of our state.

3. Technical Assistance--Enabling Services--Children, including CYSHCN

Technical assistance was provided to the 26 statewide grantees in collaboration with the Children's Health Alliance, Oral Health Program Manager. The Oral Health Program Dental Sealant Coordinator provides ongoing project specific technical assistance and outreach to potential expansion grantees. The State Chief Dental Officer and the State Public Health Dental Hygienist assist in monitoring grantee contracts, review of grantee proposals and provide technical support as needed.

4. Oral Health Surveillance--Population Based Services--Children, including CYSHCN

In 2008 the Wisconsin Division of Public Health Oral Health Program conducted its second "Make Your Smile Count Survey" oral health assessment of third grade students. The total sample of children evaluated was 4,355. The survey data revealed that 50.8% of Wisconsin third grade students had evidence of dental sealants on at least one permanent tooth, exceeding the Healthy People 2010 objective for sealants. It is the intention of the Oral Health Program to continue to exceed national objectives related to dental sealants, monitor progress and evaluate program effectiveness.

In 2009, the Oral Health Program completed the second statewide "Healthy Teeth for a Healthy Head Start" oral health assessment of Head Start children.

National Performance Measures Summary Sheet Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Wisconsin Seal-A-Smile Program	X			
2. Healthy Smiles for Wisconsin Infrastructure Support				X
3. Technical Assistance		X		
4. Oral Health Surveillance			X	

b. Current Activities

1. Healthy Smiles for Wisconsin Seal-A-Smile (SAS) Sealant Program--Direct Health Care Services--Children

The Seal-A-Smile program provides nearly \$600,000 in funding to support 26 grantee projects, an increase of over \$450,000 from last year. New funding will allow for substantial programmatic growth.

2. Healthy Smiles for Wisconsin Oral Health Infrastructure Support--Infrastructure Building Services--Children including CYSHCN

MCH funding was provided to 6 LHDs to provide oral health assessments and sealant placement for 445 children.

3. Technical Assistance--Enabling Services--Children, including CYSHCN

Technical assistance is being provided to 32 (6 MCH funded) statewide grantees primarily in cooperation with the Children's Health Alliance. The Oral Health Program is also currently working with the CYSHCN program to incorporate a vetted national questionnaire on CYSHCN into the SAS consent forms. This will allow for valuable baseline data for both programs.

4. Oral Health Surveillance--Population-Based Services--Children, including CYSHCN

The 2008 third grade oral health survey demonstrated WI has met or exceeded the Healthy People 2010 objectives related to dental sealant prevalence. The results of the second statewide Head Start oral health assessment will be published.

c. Plan for the Coming Year

1. Healthy Smiles for Wisconsin Seal-A-Smile Sealant Program--Direct Health Care Services--Children

We anticipate funding at least 30 community and school-based dental sealant programs. A substantial increase in funds will actively engage LHDs, agencies and individuals to establish and or expand programs. The Oral Health Program will be working with Children's Health Alliance on the goals and objectives of the HRSA funded "WI Community Based System of Oral Health with CYSHCN", specifically targeting school based opportunities to reach children.

2. Healthy Smiles for Wisconsin Oral Health Infrastructure Support--Infrastructure Building Services--Children including CYSHCN

The Program will continue to contract with Children's Health Alliance to administer the Seal-A-Smile program and provide training and guidance to new staff. The Oral Health Program will work closely with the CYSHCN program to implement the collection of data on dental sealant program participants who report as CYSHCN.

3. Technical Assistance--Enabling Services--Children, including CYSHCN

Technical assistance will be provided to at least 30 statewide project grantees in cooperation with the Children's Health Alliance. The State Chief Dental Officer and Public Health Dental Hygienist will continue to play an active role in the Wisconsin Oral Health Coalition (WOHC). The State Public Health Dental Hygienist will continue to develop regional WOHC meetings engaging diverse partners and directing outcomes.

4. Oral Health Surveillance--Population-Based Services--Children, including CYSHCN

Data from the Healthy Teeth for a Healthy Head Start oral health assessment of Head Start students will be disseminated. In conjunction with the WI Oral Health Coalition the 2008 Make Your Smile Count third grade oral health assessment will be used to provide a framework for program and policy development and community advocacy. Regional Coalition meetings will be held to engage additional partners and as an avenue to promote the successes of the Seal-A-Smile program. Regional meetings have a strong LHD attendance. This will allow for Oral Health Program staff to meet 1 on 1 with LHDs and gauge their interest in developing new dental sealant programs or expanding current programs.

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

Tracking Performance Measures

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	3.2	3.1	2.8	2.8	2.5
Annual Indicator	2.8	1.8	2.5	2.0	2.0
Numerator	30	19	27	22	22
Denominator	1062378	1078955	1086602	1086686	1086686
Data Source				WI DHS/OHI 2010.	WI DHS/OHI 2010.

Check this box if you cannot report the numerator because

1. There are fewer than 5 events over the last year, and
2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.

Is the Data Provisional or Final?

Final

Provisional

	2010	2011	2012	2013	2014
Annual Performance Objective	2.5	2.5	2.5	2.5	1.9

Notes - 2009

Data issue: Data for 2009 will not be available from the Office of Health Informatics until 2011.

Notes - 2008

Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Bureau of Health Information. Wisconsin Interactive Statistics on Health (WISH), <http://dhs.wisconsin.gov/wish>, Injury Mortality Module, accessed 04/08/2010.

Notes - 2007

Data issues: Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Bureau of Health Information. Wisconsin Interactive Statistics on Health (WISH), <http://dhs.wisconsin.gov/wish>, Injury Mortality Module, accessed 04/08/2009.

a. Last Year's Accomplishments

1. Car Seat Safety Education and Fitting/Inspections--Enabling Services--Infants and children

In 2009, 32 LHDs conducted checks for proper installation and use of car seat restraints through the MCH performance-based contracts. This was the most commonly selected objective.

2. Community Education and Outreach--Population-Based Services--Infants and children

Education to support the proper use of child passenger safety seats continued in 2009. Staff from DPH provided technical assistance to LHDs for implementation and sustainability of CPS programs including offering a webinar that allowed technicians to receive 1 CEU to help them maintain technician status.

3. Enhancement and Expansion of Partnerships--Infrastructure Building Services--Infants and children

LHDs continued to utilize partnerships with DOT, law enforcement agencies, local hospitals, EMS, SAFE KIDS and local businesses to support their efforts to provide education and services pertaining to child passenger safety. Money was also available from DOT for staff training and education and for purchasing car seats for low income families. Further, MCH staff participated on a workgroup to help develop the DOT Strategic Highway Safety Plan.

Table 4a National Performance Measures Summary Sheet Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Car Seat Safety Education and Fitting/Inspections		X		
2. Community Education and Outreach			X	
3. Enhancement and Expansion of Partnerships				X

b. Current Activities

1. Car Seat Safety Education and Fitting/Inspections--Enabling Services--Infants and children

In 2010, 38 LHDs are conducting checks for proper installation and use of car seat restraints through the MCH performance-based contracts. This is the most commonly selected objective. We are continuing to evaluate this objective to assure that it meets the needs of both LHDs and the MCH Program.

2. Community Education and Outreach--Population-Based Services--Infants and children

Education to support the proper use of child passenger safety seats continues in 2010. The number of LHDs who selected this objective rose between 2009 and 2010. We strongly encourage partnership with local organizations, such as SAFE KIDS, hospitals, fire departments and local business to support this activity within their communities. We continued our technical assistance to LHDs by providing 1 CEUs to technicians free of charge through the MCH program webinar series.

3. Enhancement and Expansion of Partnerships--Infrastructure Building Services--Infants and children

LHDs continue to utilize partnerships with DOT, law enforcement agencies, local hospitals, EMS, and SAFE KIDS to support their efforts to provide education and services pertaining to child passenger safety. Money is also available from DOT for staff training and education and for purchasing car seats for low income families.

c. Plan for the Coming Year

1. Car Seat Safety Education and Fitting/Inspections--Enabling Services--Infants and children

MCH will continue to support the reduction of MVC related injuries and deaths in children through a continued emphasis on local coordination and support of child passenger safety technicians, safety seat checks and the provision of seats to at-risk families.

2. Community Education and Outreach--Population-Based Services--Infants and children

Education to support the proper use of child passenger safety seats will continue. We strongly encourage partnership with local organizations, such as SAFE KIDS, hospitals, fire departments and local business to support this activity and ensure consistent messaging. MCH will continue to provide technical assistance to LHDs and explore additional options for communities to support these services.

3. Enhancement and Expansion of Partnerships--Infrastructure Building Services--Infants and children

Additional expectations include working within community institutions to identify organization policies that may enhance motor vehicle safety for children (i.e. hospital policy requiring a CPS technician to check all seats before a new baby is discharged). Further, via the new Keeping Kids Alive Initiative, additional data will be available to track outcomes and engage new partners. It is expected that MCH staff will again work on the Strategic Highway Safety Plan.

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

Tracking Performance Measures

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		40	25	26	28
Annual Indicator	25.0	26.0	26.6	27.1	27.5
Numerator	2810	3309	3622	3784	3901
Denominator	11238	12726	13616	13963	14185
Data Source				CDC PedNSS 2009.	CDC PedNSS 2010.

Check this box if you cannot report the numerator because

1. There are fewer than 5 events over the last year, and
2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.

Is the Data Provisional or Final?

	2010	2011	2012	Final 2013	Final 2014
Annual Performance Objective	29	29	30	31	32

Notes - 2009

Source: 2009 Pediatric Nutrition Surveillance System (PedNSS), Centers for Disease Control and Prevention.

Notes - 2008

Source: 2008 Pediatric Nutrition Surveillance System (PedNSS), Centers for Disease Control and Prevention.

Notes - 2007

Source: 2007 Pediatric Nutrition Surveillance System (PedNSS), Centers for Disease Control and Prevention.

a. Last Year's Accomplishments**1. Breastfeeding Education, Promotion, and Support--Direct Services--Pregnant and breastfeeding women**

In 2009, 21 LHDs worked on the 10 Steps to Breastfeeding Friendly Health Departments multi-year template objective. This process included completion of a self-assessment tool and all 10 Steps and accompanying required activities to protect promote and support breastfeeding within the community. Title V staff provided statewide training on achieving this template objective and collaborated with regional office MCH and WIC staff to revise the Breastfeeding Friendly Health Department objective to direct efforts towards establishing a community focus on breastfeeding support rather than individual services.

2. Breastfeeding Peer Counseling and Breast Pump Distribution--Enabling Services--Pregnant and breastfeeding women

The State WIC Breastfeeding Coordinator manages the Breastfeeding Peer Counseling Program (BFPCP) and the WIC Breast Pump Program. In 2008 and 2009, more than 8,000 breast pumps were purchased and distributed by WIC. In CY 2009, the WIC Program trained 25 new breastfeeding peer counselors who provided prenatal breastfeeding counseling and postpartum support in 37 local WIC projects statewide. The WIC Breastfeeding Incidence and Duration Report indicated improved breastfeeding rates with the BFPCP initiation and 6 month duration rates at 68.4% and 26.3% compared to the State average of 66.2% and 25.5%.

3. Wisconsin Partnership for Activity & Nutrition--Population-Based Services--Pregnant and breastfeeding women

The WIC Breastfeeding Coordinator co-chaired the State Breastfeeding Committee of the Wisconsin Partnership for Activity & Nutrition (WI PAN). A key obesity prevention focus area of WI PAN is the promotion and support of breastfeeding. The Breastfeeding Committee of WI PAN promoted and distributed the "10 Steps to Breastfeeding Friendly Childcare Centers" module. This guide was used by breastfeeding coalitions and public health professionals to train childcare staff.

4. Collaboration and Partnerships: Breastfeeding Coalitions--Infrastructure Building--Pregnant and breastfeeding women

The Breastfeeding Committee of WI PAN developed, distributed, and evaluated a survey for the local breastfeeding coalitions. This survey which had a 92% response rate, assessed specific breastfeeding coalition needs, best means to address needs and optimal approaches for networking. The Breastfeeding Committee of WI PAN and the Milwaukee County Breastfeeding Coalition (MCBC) were selected for the 2009-2010 Business Case for Breastfeeding training grant. The WIC Breastfeeding Coordinator presided as the proctor and network coordinator for the CDC bimonthly State Breastfeeding Coalition conference calls in 2009.

Table 4a**National Performance Measures Summary Sheet Activities****Pyramid Level of Service****DHC ES PBS IB**

	DHC	ES	PBS	IB
1. Breastfeeding Education, Promotion and Support	X			
2. Breastfeeding Peer Counseling and Breast Pump Distribution		X		
3. Wisconsin Partnership for Activity and Nutrition			X	
4. Collaboration and Partnerships-Local Breastfeeding Coalitions				X

b. Current Activities

1. Performance Based Contracting--Direct Health Care Services--Breastfeeding Promotion and Support

- 21 LHDs working towards 10 Steps to Breastfeeding Friendly Health Departments
- 2 LHDs recognized for achieving Breastfeeding Friendly status
- MCH & LHD staff provide statewide education on achieving the 10 steps

2. Breastfeeding Peer Counseling and Breast Pump Distribution--Enabling Services--Breastfeeding Peer Counseling

- US Department of Agriculture Food and Nutrition Service (USDA/FNS) infrastructure grant focus on breastfeeding competencies for local WIC staff providing 6 regional trainings for 500 staff
- WIC Program trained 50 new breastfeeding peer counselors in 52 local WIC projects
- Quarterly continuing education conference calls provided for breastfeeding peer counselors and BFPCP Coordinators

3. Wisconsin Partnership for Activity & Nutrition--Population-Based Services--Pregnant and the general public

Breastfeeding Committee supported Right to Breastfeed legislation (AB-57/SB-16) signed into law March 10, 2010

4. Collaboration and Partnerships: Local Breastfeeding Coalitions--Infrastructure Building--Pregnant and breastfeeding women

WI PAN Breastfeeding Committee will sponsor Business Case for Breastfeeding training. Participants trained to provide effective outreach, education, and technical assistance for employers in their communities thereby increasing workplace lactation support.

c. Plan for the Coming Year

1. Performance Based Contracting--Direct Health Care Services--Breastfeeding Promotion and Support

Title V MCH Program will be directing efforts to building systems of support for families in Wisconsin Bright Futures Initiative will incorporate breastfeeding messages. Increased capacity within Wisconsin WIC will continue to provide individual breastfeeding support.

2. Statewide Breastfeeding Activities--Enabling Services--Breastfeeding Peer Counseling

State WIC Breastfeeding Coordinator will continue to manage Breastfeeding Peer Counseling Program (BFPCP) and the WIC Breast Pump Program. The CY 2011 goal will be to continue to expand the BFPCP to all counties in WI and institutionalize peer counseling in WIC as a core service focused on increasing breastfeeding rates among WIC participants.

3. Wisconsin Partnership for Activity & Nutrition--Population-Based Services--Pregnant and the general public

WIC Breastfeeding Coordinator will continue to co-chair State Breastfeeding Committee of the WI Partnership for Activity & Nutrition (WI PAN) and participate in the Coalition Support Team Committee. Right to Breastfeed in public cards are will be developed, printed, and distributed to breastfeeding

mothers by WIC Projects, local breastfeeding coalitions, hospitals, businesses, etc. In response to the Health Care Reform legislation inclusion of breastfeeding protection for working mothers, efforts towards bringing the Business Case for Breastfeeding to employers in Wisconsin will expand.

4. Collaboration and Partnerships: Local Breastfeeding Coalitions--Infrastructure Building--Pregnant and breastfeeding women

State Breastfeeding Committee of WI PAN will provide local breastfeeding coalitions ongoing technical assistance, consultation, and training on designing evidence-based strategies as defined by the 'CDC Guide to Breastfeeding Interventions' and work to increase number of local breastfeeding coalitions in WI.

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

Tracking Performance Measures

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	95	95	95	97.5	97.5
Annual Indicator	95.6	94.5	97.2	96.5	95.7
Numerator	65780	66675	69364	68382	66688
Denominator	68785	70519	71389	70862	69654
Data Source				WI WETRAC 2009.	WI WETRAC 2010.

Check this box if you cannot report the numerator because

1. There are fewer than 5 events over the last year, and
2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.

Is the Data Provisional or Final?

	2010	2011	2012	2013	2014
Annual Performance Objective	96	96	96.5	97	97.5

Notes - 2009

Hearing screening results are reported on the Wisconsin State Lab of Hygiene (WSLH) newborn blood screening card. Data are entered into the WSLH database and messaged to the Wisconsin Early Hearing Detection and Intervention Tracking Referral and Coordination (WE-TRAC) system. Processing logic within WE-TRAC filters incoming records and hearing screening results. Records with PASS/PASS results are archived and records for infants with REFER or missing results are placed on a birth hospital queue for follow-up. Hospitals continue to submit delayed hearing screening results via fax to the WSLH. Wisconsin State Senate Bill 323 was passed during the 2009 legislative session. The bill requires the physician, nurse-midwife, or certified professional midwife who attends a birth to ensure that the infant is screened and that parents are advised of the results. Wisconsin Sound Beginnings, the State of Wisconsin's early hearing detection and intervention (EHDI) program, collaborated with others on the revisions of the bill to include support for follow up services. This bill was signed into law in May 2010.

Notes - 2008

Data on hearing screening are reported on one page of the newborn blood-spot card that goes to the Wisconsin State Lab of Hygiene (WSLH). The data are electronically messaged daily to the Wisconsin Early Hearing Detection and Intervention Tracking Referral and Coordination (WE-TRAC) system. Records for infants who show PASS/PASS results are archived; records for infants who REFER in one or both ears are queued for follow-up by the birth hospital. Reports started being generated directly from the WE-TRAC system for 2007 data. This method has allowed issues that occurred in the past, such as duplicate records that were difficult to identify as duplicates and babies with delayed screening or not screened for valid reasons but accounted for, to be corrected. Since the removal of the separable metabolic screening card, hospitals are faxing WE-TRAC users delayed hearing screening results to the

WSLH. This is making our user much more responsible for updating their records accurately and in a timely fashion.

Notes - 2007

Hearing screening data are reported on the newborn blood-spot card that is sent from the birth hospital to the Wisconsin State Lab of Hygiene (WSLH). The data are electronically messaged daily to the Wisconsin Early Hearing Detection and Intervention Tracking Referral and Coordination (WE-TRAC) system. Unlike the data reported in previous years from WSLH records, the 2007 data are generated directly from the WE-TRAC system. This method has helped resolve accuracy issues involving duplicate records and delayed records that occurred in the past. The data adhere to the CDC reporting standards for EHDI statistics; i.e., the screened number excludes newborns who were missed in one or both ears, refused screening, or died before screening was possible.

a. Last Year's Accomplishments

1. Outreach/Public Education--Enabling Services--Pregnant women, mothers, and infants

Wisconsin Sound Beginnings has created and continues to evaluate and improve "Just in Time" packets. The packets are designed to assist the provider and family of a child who is deaf or hard of hearing and provide information about appropriate next steps and community resources. The packet includes a letter, resource list, a DVD related to hearing loss, and the EHDI Care Map. The EHDI Care Map is a guideline for parents and providers. It includes a checklist of recommended appointments, resources and referrals for children who refer or do not pass their newborn hearing screening test. The "Just in Time" packet also includes a copy of the confirmation of hearing loss report.

A survey was conducted of OB nurse managers and clinical educators to determine the utilization of WSB materials. After the survey results were compiled, staff performed specific outreach to increase the use of brochures, DVDs, and posters within hospitals and out of hospital birth settings.

2. WSB/Congenital Disorders Program--Population-Based Services--Pregnant women, mothers, and infants

Although hearing screening is voluntary, in 2009 WI screened 95.7% of occurrent births and identified 88 babies with congenital hearing loss. 70 of those kids were enrolled in the state early intervention program. However, Wisconsin continues to address lost to follow-up issues through coordination of follow-up activities with the WSLH as well as through direct outreach to providers. Delayed or missing hearing screening results are submitted through the Wisconsin web-based data collection and tracking system (WE-TRAC) via faxes from birth hospitals. WSLH collects risk factors for late onset hearing loss on newborn screening cards. A notification letter for physicians who care for children with risk factors of hearing loss was developed and implemented. The messaging service that enables data transfer from WSLH to WE-TRAC was upgraded to PHIN MS.

3. Support Services for Parents--Enabling Services--Pregnant women, mothers, and infants

The 9th Annual Statewide Parent Conference was planned through coordinated efforts of WSB, Department of Public Instruction, and families of kids with hearing loss. The conference focuses on education of family members and social networking of the children and their siblings, with a preconference for the professionals who serve them.

4. Birth-3 Technical Assistance Network--Infrastructure Building Services--CYSHCN

Babies identified as deaf or hard of hearing were electronically referred to Birth-3 via WE-TRAC. Reporting requirements that will identify the numbers of children with hearing loss referred to early intervention services were outlined.

5. EHDI Workgroup--Infrastructure Building Services--CYSHCN

The EHDI QI Consortium is a multi-disciplinary advisory group that guides the efforts of the WSB Program. The QI Consortium met once and defined next steps for the state.

6. Reduce Lost to Follow-up--Infrastructure Building Services--CYSHCN

Quality improvement focused learning sessions centered on reduction of lost to follow-up were conducted on a regional and statewide level. The design and content development of a web-based QI toolkit was initiated and will be made available to the Learning Collaborative participants as a resource. The web based toolkit will be a comprehensive source of information related to early hearing detection and intervention.

	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Outreach/Public Education		X		
2. WSB/Congenital Disorders Program			X	
3. Support Services for Parents	X			
4. Birth to 3 Technical Assistance Network				X
5. EHDI Workgroup				X
6. Reduce Lost to Follow-up				X

b. Current Activities

1. Outreach/Public Education--Enabling Services--Pregnant women, mothers, and infants

"Just in time" packets providers are sent upon diagnosis of a hearing loss. Materials survey results prompted the development of an EHDI materials sheet that was disseminated to the same target group.

2. WSB/Congenital Disorders Program--Population-Based Services--Pregnant women, mothers, and infants

WSB continues to coordinate follow-up with the WSLH and improve data quality. Risk factors are collected on the newborn screening card and WSB notifies physicians of infants at risk for late onset progressive hearing loss.

3. Support Services for Parents--Enabling Services--Pregnant women, mothers, and infants

The Statewide Parent Conference and professional preconference will occur. Parent Follow-through position was hired to provide GBYS Follow-through support.

4. Birth-3 Technical Assistance Network--Infrastructure Building Services--CYSHCN

Audiologists make an electronic referral to Birth-3 information system. Birth-3 enrollment reports will be generated.

5. EHDI Workgroup--Infrastructure Building Services--CYSHCN

The EHDI Quality Improvement Consortium will continue to meet.

6. Reduce Lost to Follow-up--Infrastructure Building Services--CYSHCN

The learning collaborative was completed. The creation of the WI EHDI Quality Improvement Toolkit continues. EHDI QI Consortium members will spread improvement strategies. The GBYS Follow-through Program and WE-TRAC system development will continue.

c. Plan for the Coming Year

1. Outreach/Public Education--Enabling Services--Pregnant women, mothers, and infants

"Just in time" packets for early intervention providers will continue to be sent upon diagnosis of a hearing loss. Materials survey results indicated a severe underutilization and prompted the development and dissemination of an EHDI materials sheet. A second survey will be sent and results compiled to determine whether outreach efforts increased material utilization.

2. WSB/Congenital Disorders Program--Population-Based Services--Pregnant women, mothers, and infants

WSB will continue to coordinate follow-up with the WSLH and improve data quality. WSLH will continue to collect risk factors on the newborn screening card so physicians may be notified of at-risk infants. Hearing screening results will be added to the WSLH blood screen report that is sent to physicians. Risk factors will be visible in WE-TRAC.

3. Support Services for Parents--Enabling Services--Pregnant women, mothers, and infants

The Statewide Parent Conference and professional pre-conference will be planned. Parent follow-through position will contact families of babies that do not pass the hearing screen.

4. Birth-3 Technical Assistance Network--Infrastructure Building Services--CYSHCN

Babies identified with hearing loss will continue connected to Birth-3 via WE-TRAC, the tracking and surveillance system for newborns and hearing screening results. Birth-3 reports will be generated to determine enrollment.

5. EHDI Workgroup--Infrastructure Building Services--CYSHCN

The EHDI Quality Improvement Consortium will continue to meet.

6. Reduce Lost to Follow-up--Infrastructure Building Services--CYSHCN

The web based WI EHDI Quality Improvement Toolkit will be completed. EHDI QI Consortium members will spread improvement strategies to additional community teams. The GBYS Follow-through Program and WE-TRAC system development will continue.

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

Tracking Performance Measures

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	2	2	2.8	2.7	2.6
Annual Indicator	2.9	3.8	2.4	2.8	2.8
Numerator	38100	48000	31000	36000	36000
Denominator	1300000	1273000	1293000	1292000	1292000
Data Source				WI DHS/ OHI 2010.	WI DHS/ OHI 2010.

Check this box if you cannot report the numerator because

1. There are fewer than 5 events over the last year, and
2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.

Is the Data Provisional or Final?

	2010	2011	2012	Final 2013	Provisional 2014

Annual Performance Objective 2.5 2.5 2.5 2.4 2.4

Notes - 2009

Data issue: Data for 2009 will not be available from the Office of Health Informatics until 2011.

Notes - 2008

Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Family Health Survey, 2009. Madison, Wisconsin: 2009. Numerator: Weighted data. Denominator: Weighted data.

Data issues: 1) Estimated numbers have been rounded to the nearest 1,000. The annual Wisconsin Family Health Survey is a random digit dial telephone survey that collects and reports information about health status, problems, insurance coverage, and use of health care services among Wisconsin residents. The survey has questions about health-related limitations and chronic conditions for persons greater than age seventeen.

Notes - 2007

Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Family Health Survey, 2007. Madison, Wisconsin: 2009. Numerator: Weighted data. Denominator: Weighted data.

Data issues: 1) Estimated numbers have been rounded to the nearest 1,000. The annual Wisconsin Family Health Survey is a random digit dial telephone survey that collects and reports information about health status, problems, insurance coverage, and use of health care services among Wisconsin residents. The survey has questions about health-related limitations and chronic conditions for persons greater than age seventeen.

a. Last Year's Accomplishments

1. Governor's BadgerCare Plus Initiative--Enabling Services--Pregnant women, mothers, infants and children, including CYSHCN

Since implementation of BadgerCare Plus in February 2008 that combined WI Medicaid and SCHIP programs to cover children in the State, the number of children covered has increased as of March 2010 to a total of 402,275 children under age 19 who are eligible for BadgerCare Plus. Of these children, 12,145 are eligible for the benchmark plan at family incomes above 200% FPL. Only 2.8% of Wisconsin children are without health insurance coverage according to the Family Health Survey data. Community partners outreached to families about the program's benefits and provided direct, confidential application assistance. In some cases, children were able to receive immediate, express enrollment in BadgerCare Plus through these community partners.

2. Support the "Covering Kids" Program--Enabling Services--Pregnant women, mothers, infants and children, including CYSHCN

The "Covering Kids and Families" Program in Wisconsin (CKF-WI) is housed at the UW-Madison School of Human Ecology, working in partnership with UW-Extension and other partners throughout the state. It is a coalition of more than 65 organizations committed to reducing the number of uninsured children and families and dedicated to reducing health disparities and improving overall health in Wisconsin by cultivating a network of informed individuals and organizations and thereby enhancing capacity to maximize participation in public health insurance programs. CKF-WI is making sure those who are eligible for BadgerCare Plus know about and can easily enroll in the programs for which they qualify by being an expert resource on access, coverage, and outreach related to public health insurance, a leader in impacting public health policy, and by recognizing that access to coverage does not necessarily mean access to quality care. In 2009, CFK-WI was awarded Bader funds to expand the Milwaukee CHILD (Connecting Health Insurance to Lunch Data) Project for two years.

Table 4a National Performance Measures Summary Sheet Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Governor's BadgerCare Plus Initiative		X		
2. "Covering Kids" Program		X		

b. Current Activities

1. Governor's BadgerCare Plus Initiative--Enabling Services--Pregnant women, mothers, infants and children, including CYSHCN

The Title V MCH/CYSHCN Program continues to provide assistance to Governor Doyle's expansion to the Wisconsin BadgerCare Program that is to provide an opportunity for health insurance for all children in the state and improve access to health care coverage.

2. Support the "Covering Kids" Program--Enabling Services--Pregnant women, mothers, infants and children, including CYSHCN

In cooperation with UW-Extension, the Title V MCH/CYSHCN Program continues to provide support for state and local coalitions that are funded through 2010 by promoting their school outreach strategies tool kit. These activities will assist children and their families and build access to funding mechanisms through BadgerCare Plus for affordable, comprehensive health care coverage. Covering Kids will continue to influence expanded BadgerCare Plus as health care reform is implemented.

c. Plan for the Coming Year

1. Governor's BadgerCare Plus Initiative--Enabling Services--Pregnant women, mothers, infants and children, including CYSHCN

The Title V MCH/CYSHCN Program will continue to provide assistance to Governor Doyle's expansion to the Wisconsin BadgerCare Plus Program that provides health insurance for all children in the state by working with partners throughout the state. Virtually all children in Wisconsin have access to coverage by health insurance in the state.

2. Support the "Covering Kids" Program--Enabling Services--Pregnant women, mothers, infants and children, including CYSHCN

With passage of health care insurance reform, CFK-WI is in the midst of strategic planning to move from health coverage to health access, health outcomes, and/or health disparities. This will be a slightly new realm but also an opportunity to continue to support school based outreach as well as targets toward other areas of need.

3. Wisconsin's Office of Health Care Reform--Enabling Services--Pregnant women, mothers, infants and children, including CYSHCN

In April 2010, Governor Jim Doyle signed Executive Order #312, creating the Office of Health Care Reform. The Office will oversee implementation of national health care reform in Wisconsin and will be co-chaired by DHS Secretary Karen Timberlake and Wisconsin Insurance Commissioner Sean Dilweg. The MCH program will continue to work through 2011 with assuring connectedness to key provisions of the health care reform implementation that impact MCH populations.

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

Tracking Performance Measures

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		12.1	29	28	29.9
Annual Indicator	13.3	29.3	29.2	29.9	30.5
Numerator	6893	15137	15078	16707	18385
Denominator	51825	51667	51636	55875	60280
Data Source				CDC PedNSS 2009.	CDC PedNSS 2010.

Check this box if you cannot report the numerator because

1. There are fewer than 5 events over the last year, and
2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.

Is the Data Provisional or Final?

	2010	2011	2012	2013	2014
Annual Performance Objective	29.8	29.7	29.6	29.5	29.4

Notes - 2009

Source: 2009 Pediatric Nutrition Surveillance System (PedNSS), Centers for Disease Control and Prevention.

Notes - 2008

Source: 2008 Pediatric Nutrition Surveillance System (PedNSS), Centers for Disease Control and Prevention.

Notes - 2007

Source: 2007 Pediatric Nutrition Surveillance System (PedNSS), Centers for Disease Control and Prevention.

a. Last Year's Accomplishments

1. Increased Knowledge of Healthy Behaviors--Enabling Services--Children over the age of 2, including CYSHCN and their families

Through performance based contracting, 10 LHDs created environments that promote breastfeeding, healthy eating, physical activity and a healthy weight in all sectors. The activities are linked to Healthiest Wisconsin 2010 and the Nutrition and Physical Activity State Plan to prevent obesity and related chronic diseases.

2. Community Campaigns--Population-Based Services--Children over the age of 2, including CYSHCN and their families

Through the performance-based contracting system, LHDs promoted nutrition and physical activity in their community. These include a Fun Walk/Run, Safe Routes to School, Turn off TV Week, and Healthy Community Award. The Healthy Community Award was presented to 12 community-based youth-serving organizations in one county. 506 children participated in TV Turn Off week in one county. 100 people participated in a Fun Run/Walk in one rural county. Another LHD sponsored a safe walking awareness campaign for students reaching 256 families, 48 school faculty and 21 PTA members.

3. Needs Assessments and Plans--Infrastructure Building Services--Children over the age of 2, including CYSHCN and their families

Through performance-based contracting, LHDs improved the nutrition and physical activity environment and strengthened their infrastructure. Strategies included: walkability/bikeability surveys, childcare environment assessments, Safe Routes to School, school wellness, assessment of breastfeeding services, worksite wellness, farmers markets, Got Dirt? Garden Initiative and childcare curriculum. Several of the LHDs reported writing and submitting grants for other funding to support their activities.

4. Nutrition and Physical Activity Coalitions--Population-Based Services--Children over the age of 2, including CYSHCN and their families

Partnerships are vital to preventing obesity. There are 38 local coalitions focused on nutrition, physical activity & obesity prevention. These coalitions have continued to foster collaborations between multiple organizations in their community to address childhood obesity through education, environmental, systems and policy change strategies.

Table 4a National Performance Measures Summary Sheet Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Increased Knowledge of Healthy Behaviors		X		
2. Community Campaigns			X	
3. Needs Assessments and Plan				X
4. Nutrition and Physical Activity Coalitions				X

b. Current Activities

1. Increased Knowledge of Healthy Behaviors--Enabling Services--Children over the age of 2, including CYSHCN and their families

Through the performance-based contracting system, 17 LHDs are creating environments that promote healthy eating, physical activity and healthy weight in all sectors. These activities will be linked to the Healthiest Wisconsin 2010 and the Wisconsin Nutrition and Physical Activity State Plan to prevent obesity and related chronic diseases.

2. Community Campaigns, Environment and Policy Change--Population-Based Services--Children over the age of 2, including CYSHCN and their families

LHDs are promoting nutrition and physical activity in their community. These include: campaigns such as Safe Routes to School, TV Turn Off Week, Walk Around the World Month, healthy menus, Community Awards and media campaigns.

3. Needs Assessments and Plans--Infrastructure Building Services--Children over the age of 2, including CYSHCN and their families

LHDs are improving the nutrition and physical activity environment and building the infrastructure through coalition assessment, worksite assessment, and sustainability planning.

4. Nutrition and Physical Activity Coalitions - Collaboration and Partnerships--Infrastructure Building Services--Children over the age of 2, including CYSHCN and their families

Partnerships are vital to preventing obesity. There are ~46 local coalitions who will focus on obesity, improving nutrition and increasing physical activity.

c. Plan for the Coming Year

1. Increased Knowledge of Healthy Behaviors--Enabling Services--Children over the age of 2, including CYSHCN and their families

LHDs and local coalitions will be encouraged to focus efforts related to obesity prevention through increased breastfeeding, increased fruit and vegetable consumption, increased physical activity, decreased television time, decreased sugar-sweetened beverage consumption and decreased consumption of high energy dense foods. These activities will be linked to the Healthiest Wisconsin 2020 and the WI Nutrition and Physical Activity State Plan to prevent obesity and related chronic diseases. The HW 2020 implementation plan will be developed and the Nutrition and Physical Activity State Plan will be revised.

2. Community Campaigns, Environment and Policy Change--Population-Based Services--Children over the age of 2, including CYSHCN and their families

Community-wide campaigns (such as Safe Routes to School, TV Turn Off Week) may be planned as part of the work of LHDs, coalitions, and community-based organizations to implement the WI Nutrition and Physical Activity State Plan. Campaigns are implemented in conjunction with other strategies (such as policy change, environmental change or education) to increase the impact of the campaign. Collaborate with CDC on a national media campaign in Wisconsin.

3. Needs Assessments and Plans--Infrastructure Building Services--Children over the age of 2, including CYSHCN and their families

The Wisconsin Partnership for Activity and Nutrition (WI PAN) and the Nutrition, Physical Activity and Obesity Program will disseminate resources to LHDs, coalitions, and community-based organizations to implement evidence-based strategies to prevent overweight and obesity, work with schools to apply for the Governor's School Health Award, implement a childcare intervention, and promote the Worksite Kit and Safe Routes to School. The Program and WI PAN will promote the use of the State Plan as a "blueprint" for activities to prevent overweight among children and their families.

4. Nutrition and Physical Activity Coalitions--Collaboration and Partnerships--Infrastructure Building Services--Children over the age of 2, including CYSHCN and their families

State and community partnerships are vital to preventing and managing childhood overweight. There are ~46 local coalitions who will focus on preventing overweight, improving nutrition and increasing physical activity. The coalitions focus on a variety of issues related to childhood overweight including family meals, being active as a family, access to healthy food as well as food security and hunger. An annual survey will be conducted to capture capacity to implement interventions, identify training and resource needs and highlight successes. Key partners include: the WIC Program, DPI programs, the Child and Adult Care Feeding Program, Dept. of Transportation, Dept. of Agriculture, UW-Extension, Minority Health Program, LHDs, and community coalitions.

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

Tracking Performance Measures

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		14.5	14	13.5	13.5
Annual Indicator	14.0	14.9	14.9	14.9	15.1
Numerator	9812	10715	10843	10843	10395
Denominator	70012	72114	72560	72560	68841
Data Source				WI DHS/BHIP 2009.	WI PRAMS.

Check this box if you cannot report the numerator because

1. There are fewer than 5 events over the last year, and
2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.

Is the Data Provisional or Final?

	2010	2011	2012	Provisional 2013	Final 2014
Annual Performance Objective	13.5	13	13	13	13

Notes - 2009

Data issue: These data are from Wisconsin PRAMS and from the 2007-2008 weighted data set that is representative of Wisconsin resident mothers who had a live birth. The survey asks if moms smoked cigarettes in the past 2 years. If the moms answered yes, she's asked the quantity of cigarettes she smoked during the last 3 months of her pregnancy. The numerator represents those mothers who said they smoked during the last three months of pregnancy, and the denominator represents Wisconsin resident mothers.

Notes - 2008

Data issue: 2008 data will not be available from the Bureau of Health Information and Policy until 2010. Furthermore, the Bureau of Health Information and Policy most likely will not have data for this indicator until 2010 after the revised birth certificate is implemented with a new on-line system (projected to be in place by 2009). Wisconsin was awarded the Pregnancy Risk Assessment Monitoring System (PRAMS) in April, 2006. We do not expect to have data from PRAMS until late 2009.

Notes - 2007

Data issue: 2007 data will not be available from the Bureau of Health Information and Policy until 2009. Furthermore, the Bureau of Health Information and Policy most likely will not have data for this indicator until 2010 after the revised birth certificate is implemented with a new on-line system (projected to be in place by 2009). Wisconsin was awarded the Pregnancy Risk Assessment Monitoring System (PRAMS) in April, 2006. We do not expect to have data from PRAMS until late 2008 or early 2009.

a. Last Year's Accomplishments

1. Title V Funded Perinatal Services--Enabling Services--Pregnant women, mothers and infants

The Title V Program funded 41 LHDs totaling 65 objectives addressing a variety of perinatal-related issues.

As reported in 2009 in SPHERE 31.2% of women receiving prenatal services through Medicaid and MCH programs smoked during pregnancy. 77% of the women who reported smoking during pregnancy also reported decreased smoking by the end of pregnancy. In 2008, birth certificate data indicated 14.1% of Wisconsin women smoked during pregnancy, a decrease of .8% from 2007. Additionally, Wisconsin PRAMS data for 2007-08 reports that 54% women who said "yes" they smoked in the past 2 years also indicated that they smoked in the last 3 months of pregnancy.

2. First Breath--Enabling Services--Pregnant women, mothers and infants

The Title V Program continued its First Breath Prenatal Smoking Cessation Program partnership with the Wisconsin Women's Health Foundation (WWHF). First Breath is a program that helps pregnant women in Wisconsin quit smoking by integrating cessation strategies into existing prenatal services including those provided by public health and private healthcare. In 2009 1,386 women enrolled in the First Breath Program. Between 2006 and 2009 there was a 71% increase in African American participants in the First Breath Program; a result of concentrated expansion and continued support and technical assistance to sites in Southeastern Wisconsin. A prenatal quit rate of 36% exceeded the program goal of 25%. 76% of the program's participants were Medicaid recipients in 2009.

3. Prenatal Care Coordination--Enabling Services--Pregnant women, mothers and infants

The Medicaid PNCC and MCH--funded prenatal care coordination programs provided services to approximately 12,000 eligible women. Assistance with smoking cessation is an expected service of PNCC. The WWHF has provided education and training for PNCC providers to implement the strength-based First Breath program.

4. Preconception Services--Enabling Services--Pregnant women, mothers and infants

The Infant Death Center of Wisconsin (IDCW) collaborated with the ABC's for Healthy Families social marketing project in Milwaukee to disseminate preconception materials with messages on tobacco use surrounding pregnancy. Additionally the IDCW worked with the Healthy Native Babies Consortium on bringing preconception messages to native women, including tobacco use. The WAPC preconception committee worked on additional materials for providers and consumers addressing the preconception health of both women and men. These materials include information on smoking cessation.

National Performance Measures Summary Sheet Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Title V Funded Perinatal Services		X		
2. First Breath		X		
3. Prenatal Care Coordination		X		
4. Preconception Services		X		

b. Current Activities

1. Title V Funded Perinatal Services--Enabling Services--Pregnant women, mothers and infants

The Title V program is funding 40 LHDs totaling 48 objectives addressing a variety of perinatal-related issues.

2. First Breath--Enabling Services--Pregnant women, mothers and infants

For CY 2010, 106 First Breath sites are participating in the program and 416 women have been enrolled. First Breath participants continue to be predominately of non-Hispanic white race, low income and low education level.

3. Prenatal Care Coordination--Enabling Services--Pregnant women, mothers and infants

Medicaid PNCC and MCH-funded Perinatal Care Coordination continue to receive training and technical assistance from the WWHF First Breath staff to support the strength based program to women during pregnancy and postpartum. Great Beginnings Start before Birth curriculum is being offered in July.

4. Preconception Services--Enabling Services--Pregnant women, mothers and infants

The WAPC preconception committee introduced an algorithm for preconception care outlining the steps for providers to take in providing preconception care for women. Additionally a fact sheet on the preconception health for men was developed for consumers.

c. Plan for the Coming Year

1. Title V Funded Perinatal Services--Enabling Services--Pregnant women, mothers and infants

Due to the complex nature of smoking during pregnancy, this topic will continue to be supported by the Title V Program. The provision of Title V funds and appropriate resources will be allocated in accordance with the Needs Assessment priorities.

2. First Breath--Enabling Services--Pregnant women, mothers and infants

The Title V Program will continue as a partner to accomplish the goals of the First Breath program. Future program focus will be on the following needs: invigorate and motivate participating clinicians; compete with other health care needs for limited clinician time; address clinical challenges (i.e. the risk for post-delivery relapse, unsupportive significant others, willingness to cut down but not quit, untruthful self-report, and failure to implement the agreed-to quit plan); and identify sustainable funding. First Breath will also work to increase enrollment within existing sites, continue expansion efforts in Southeastern Wisconsin and increase enrollment at First Breath Tribal Clinics.

3. Prenatal Care Coordination--Enabling Services--Pregnant women, mothers and infants

Through Medicaid PNCC and MCH-funded programs for women during the perinatal period the WWHF First Breath program will be provided. In collaboration with WWHF, DPH will encourage all Medicaid contracted HMO's to provide smoking cessation programs such as First Breath to all pregnant and postpartum women as part of the pay for performance quality improvement initiative.

4. Preconception Services--Enabling Services--Pregnant women, mothers and infants

In collaboration with statewide partners the MCH program will pilot preconception/interconception services through family planning/reproductive health sites; PNCC provider sites and health plans. Smoking cessation will be included in the specific services addressed.

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

Tracking Performance Measures

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	9	9.2	9	8.7	8.6
Annual Indicator	11.0	8.4	7.7	6.7	6.7
Numerator	45	34	31	27	27
Denominator	409101	404777	402172	401148	401148
Data Source				WI DHS/ OHI 2009.	WI DHS/OHI 2009.

Check this box if you cannot report the numerator because

1. There are fewer than 5 events over the last year, and
2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.

Is the Data Provisional or Final?

	Final			Provisional	
	2010	2011	2012	2013	2014
Annual Performance Objective	8.5	8.5	8.5	8.3	6.7

Notes - 2009

Data issue: Data for 2009 will not be available from the Office of Health Informatics until 2011.

Notes - 2008

Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Bureau of Health Information. Wisconsin Interactive Statistics on Health (WISH), <http://dhs.wisconsin.gov/wish>, Mortality Module, accessed 04/10/2010.

Notes - 2007

Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Bureau of Health Information. Wisconsin Interactive Statistics on Health (WISH), <http://dhs.wisconsin.gov/wish>, Mortality Module, accessed 04/10/2009.

a. Last Year's Accomplishments

1. Anticipatory Guidance, Risk Assessment, and Referrals--Direct Health Care Services--Adolescents

MCH and Injury and Violence Prevention (IVP) staff and LHDs worked with community and professional groups to promote prevention, assessments, referrals and intervention. A template objective for the performance-based contracting system has been offered with 2 of WI's largest health departments choosing it for 2009.

2. Training and Presentations--Population-Based Services--Adolescents

Members of the Suicide Prevention Initiative (SPI) and other community partners met to plan activities for improving WI infrastructure around suicide prevention. The MCH and Injury and Violence Prevention Program (IVPP) were leaders in the development of implementation activities. Trainings occurred on the data and use of the Burden of Suicide Report.

3. Suicide Prevention Initiative (SPI)--Infrastructure Building Services--Adolescents

Members of SPI worked with the Garrett Lee Smith grantees to build infrastructure within their communities as well as promote the development of other community coalitions and groups and support those who already had programs and activities in place.

4. Data--Infrastructure Building Services--Adolescents

The WI Violent Death Reporting System (WVDRS) collected, analyzed and disseminated data on suicides, including specific information for the 15-19 year old population by state, county, sex, incident location, and circumstances.

National Performance Measures Summary Sheet Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Anticipatory Guidance, Risk Assessment and Referrals	X			
2. Training and Presentations to Raise Awareness and Reduce Stigma			X	
3. Suicide Prevention Initiative (SPI)				X
4. Data				X

b. Current Activities

1. Anticipatory Guidance, Risk Assessment, and Referrals--Direct Health Care Services--Adolescents

MCH & IVP staff continue to work with community & professional groups to promote prevention, assessments, referrals & intervention. Four agencies chose the suicide prevention template objective for MCH contracting.

2. Training and Presentations--Population-Based Services--Adolescents

Technical assistance continues on data and use of Burden of Suicide Report. SPI continues to support, train & do presentations for variety of audiences.

3. Suicide Prevention Initiative (SPI)--Infrastructure Building Services--Adolescents

SPI continues work with Garrett Lee Smith grantees, LHDs, and other partners to build infrastructure in their communities, promote development of other community coalitions, groups, and support those who already have programs and activities. Also focusing on carrying out improvements to enhance WI's overall infrastructure.

4. Data--Infrastructure Building Services--Adolescents

WVDRS continues to collect, analyze & disseminate data on suicides, including specific information for 15-19 yr old population as in the past. The suicide rate has declined since 2003. While the WI rate is still higher than the U.S. rate, the difference has narrowed over the past 5 years (2003-2007). In 2003, the WI rate was 11.45/100,000, the national rate was 7.27/100,000. In 2007 (latest year available for both sources), the WI rate was 7.75/100,000, the national rate was 6.91/100,000.

c. Plan for the Coming Year

1. Anticipatory Guidance, Risk Assessment, and Referrals--Direct Health Care Services--Adolescents

MCH and IVP staff work will continue with community and professional groups to promote prevention, assessments, referrals and intervention. Template objectives will continue to support the work of LHDs in addressing suicide prevention as well as other violence.

2. Training and Presentations--Population-Based Services--Adolescents

WVDRS data will continue to be used to help guide local communities in planning efforts and outcomes of their work. SPI will continue to support and provide presentations and trainings to audiences.

3. Suicide Prevention Initiative (SPI)--Infrastructure Building Services--Adolescents

The SPI will continue to move forward with strengthening WI's overall infrastructure related to suicide prevention. A steering committee will prioritize and implement steps for improvement including a state-wide branding campaign assuring communities are using consistent messaging and spreading the word about preventability of suicide. Both MCH and IVP staff will continue to participate on the SPI.

4. Data--Infrastructure Building Services--Adolescents

WVDRS will continue to collect, analyze and disseminate data on suicides, including for 15-19 yr old population as in the past. Additional data will be available through the Child Death Review System National Data Base as the Keeping Kids Alive Initiative is implemented.

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

Tracking Performance Measures

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	81	81.5	82	82.5	76
Annual Indicator	80.6	74.8	75.8	76.7	76.7
Numerator	712	667	623	670	670
Denominator	883	892	822	873	873
Data Source				WI DHS/ OHI 2010.	WI DHS/OHI 2010.

Check this box if you cannot report the numerator because

1. There are fewer than 5 events over the last year, and
2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.

Is the Data Provisional or Final?

	2010	2011	2012	2013	2014
Annual Performance Objective	76	77	77.5	78	78.5

Notes - 2009

Data issue: Data for 2009 will not be available from the Office of Health Informatics until 2011.

Notes - 2008

Source: Wisconsin Department of Health and Family Services, Division of Public Health, Office of Health Informatics.

Data issue: In Wisconsin, hospitals self-designate level of care. Wisconsin does not have a regulatory function to standardize these self-designations. 95% confidence intervals are: 79.6%, 73.9%. Froedtert Hospital (one of the top 10 birthing centers in Wisconsin for number of deliveries) is not included in the above estimate as a facility for high-risk deliveries and neonates. However, infants delivered at Froedtert do have access to such resources, because of a cooperative effort with the Children's Hospital of Wisconsin and the proximity of the two facilities. The Froedtert Birth Center is actually located within Children's Hospital. If Froedtert Hospital were included in the data for 2008 as a facility for high-risk deliveries and neonates, Wisconsin's indicator would be 86.0% instead of 76.7%.

Notes - 2007

Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy.

Data issue: In Wisconsin, hospitals self-designate level of care. Wisconsin does not have a regulatory function to standardize these self-designations. 95% confidence intervals are: 78.7%, 72.9%.

a. Last Year's Accomplishments

1. WAPC Efforts on Regionalization of Perinatal Care--Infrastructure Building Services--Pregnant women, mothers, infants

Hospitals in Wisconsin self designate level of perinatal care. Wisconsin does not have regulatory function over the designations. The Wisconsin Association for Perinatal Care (WAPC) has developed the Levels of Care Self-Assessment Initiative. Through the self-assessment, hospitals are given the opportunity to self-identify what level of perinatal service they provide, based on criteria that were adapted from the AAP levels of care--I, IIA, IIB, IIIA, IIIB, and IIIC. Level I provides well newborn care for infants and stabilizing care for infants of 35-37 weeks gestation and beyond; Level IIA provides care for preterm or ill infants requiring stabilization efforts and are either expected to recover rapidly or are awaiting transfer to another facility; Level IIB provides care at Level IIA plus mechanical ventilation for brief durations or continuous positive airway pressure; Level IIIA provides comprehensive care for infants born >28 weeks and weighing >1000gms and are able to provide life support and mechanical ventilation in addition to minor surgical procedures; Level IIIB provides comprehensive care for the extremely low birth weight infant (less than or equal to 28 weeks, 1000gms) with advanced respiratory support, full range of pediatric subspecialists, advanced imaging and surgical abilities; Level IIIC provides comprehensive care for premature infants at Level IIIB in addition to being able to provide ECMO and complex surgeries. The complete evaluation assessment process and tool can be located on the WAPC website (www.perinatalweb.org). Twenty one birthing hospitals have taken the self-assessment: 10 have identified Level I; 2 have identified Level IIA; 2 have identified Level IIB; 1 has identified Level IIIA; 6 have identified Level IIIB and there are no Level IIIC hospitals identified. The Levels IIIA and IIIB hospitals are primarily located in the southeastern part of Wisconsin. Four of five public health regions have a Level IIIA or Level IIIB facility.

National Performance Measures Summary Sheet Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. WAPC Efforts on Regionalization of Perinatal Care				X

b. Current Activities

1. WAPC Efforts on Regionalization of Perinatal Care--Infrastructure Building Services--Pregnant women, mothers, infants

The Wisconsin Association for Perinatal Care is continuing to support the use of the self assessment tool and materials on the levels of perinatal care. The results of the assessments will be posted on the WAPC website.

c. Plan for the Coming Year

1. WAPC Efforts on Regionalization of Perinatal Care--Infrastructure Building Services--Pregnant women, mothers, infants

WAPC will continue to promote the use of the levels of care self-assessment tool and post the results of the assessments on the WAPC website by level of care; alphabetically by name and geographic location. WAPC will continue to promote the use of PeriData.net for quality improvement efforts in birth hospitals.

2. Medicaid Efforts on Prenatal Care Quality Improvement--Enabling Services--Pregnant women, mothers, infants

Medicaid will implement a quality improvement initiative with the health plans that will monitor if women are referred to appropriate level of prenatal care based on their assessment of risk.

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

Tracking Performance Measures

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	85.5	86	86.5	87	84
Annual Indicator	85.0	83.8	82.8	82.2	82.2
Numerator	60309	60610	60257	59217	59217
Denominator	70934	72301	72757	72002	72002
Data Source				WI DHS/ OHI 2010.	WI DHS/ OHI 2010.

Check this box if you cannot report the numerator because

1. There are fewer than 5 events over the last year, and
2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.

Is the Data Provisional or Final?

	2010	2011	2012	2013	2014
Annual Performance Objective	82	82	82.5	82.5	83

Notes - 2009

Data issue: Data for 2009 will not be available from the Office of Health Informatics until 2011.

Notes - 2008

Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Bureau of Health Information. Wisconsin Interactive Statistics on Health (WISH), <http://dfs.wisconsin.gov/wish>, Birth Counts Module, accessed 04/16/2010.

Notes - 2007

Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Bureau of Health Information. Wisconsin Interactive Statistics on Health (WISH), <http://dhs.wisconsin.gov/wish>, Birth Counts Module, accessed 04/16/2009.

a. Last Year's Accomplishments

Impact on National Outcome Measures: NPM #18 relates to National Outcome Measures #1 Infant mortality rate, #2 Disparity between Black and White IMR, #3 Neonatal mortality rate, and #5 Perinatal mortality rate. The overall proportion of women who receive prenatal care in the first trimester was 82% in 2008, compared to 84% in 1998 (Wisconsin Births and Infant Deaths, 2008). The proportion of women receiving first trimester care increased for blacks/African American, American Indians, and Laotians or Hmong.

1. Title V Funded Perinatal Services--Enabling Services--Pregnant women, mothers, infants

The Title V program funded 3,743 women served through objectives addressing prenatal care. As reported in SPHERE and MCH end of year reports, 55% of women initiated prenatal care in the first trimester.

The Title V program supported the 2009 Healthy Babies summit and Association of Obstetric and Neonatal Nurses State Conference focused on a life course perspective.

2. Prenatal Care Coordination (PNCC)--Enabling Services--Pregnant women, mothers, infants

Medicaid PNCC services assist high risk pregnant women with accessing early and continuous prenatal care. The Great Beginnings Start before Birth curriculum was provided in 4 public health regions to enhance PNCC services through LHDs and other agencies. MCH data sheets were promoted through regional PNCC provider group meetings to support the monitoring of outcomes of prenatal services at the local level, including early access to medical care. The Women's Health Now and Beyond Pregnancy project continued to promote identification of a medical home. Medicaid PNCC guidelines began revision including requiring increased collaboration between PNCC providers, health plans and medical providers to improve outreach and early entry into services. PNCC Advanced training was offered in the Northern Region and included discussion of improving contacts with the medical community to increase the number of women accessing early care and services.

3. Federal Healthy Start Projects in Wisconsin--Population-Based Services--Pregnant women, mothers, infants

Title V MCH/CYSHCN staff have continued to serve on advisory committees for the Honoring Our Children Healthy Start project with Great Lakes Inter-Tribal Council (GLITC) and the Milwaukee Healthy Beginnings project with Black Health Coalition. Healthy Start has a strong focus on early entry into prenatal care and projects report on this measure. GLITC staff attended PNCC training in the Northern Region; GLITC hosted a Great Beginnings Start before Birth training in the Northern region and supported additional tribal site staff attendance at other regional trainings. The Milwaukee Healthy Beginnings Project staff attended Great Beginnings Start before Birth training in the Southeast region.

Table 4a National Performance Measures Summary Sheet Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Title V Funded Services		X		
2. Prenatal Care Coordination (PNCC)		X		
3. Federal Healthy Start Projects in Wisconsin			X	

b. Current Activities

1. Title V Funded Perinatal Services--Enabling Services--Pregnant women, mothers, infants

The Title V MCH/CYSHCN Program is funding 18 objectives to LHDs to address prenatal care. Use of MCH data sheets to monitor program outcomes has been added to mid year evaluation requirements.

2. Prenatal Care Coordination (PNCC)--Enabling Services--Pregnant women, mothers, infants

Great Beginnings Start before Birth curriculum is being offered once statewide. Women's Health Now and Beyond Pregnancy project has been expanded to additional sites, through an EIDP objective for LHDs. The Medicaid PNCC guidelines are currently being revised to include an increase in outreach and intensity of services; improved communication between PNCC, medical and health plan providers; and improved data collection. Training on PNCC Advanced was provided statewide. Medicaid has included PNCC services in the Poor Birth Outcome Assessment quality improvement initiative as a service the health plans should assure for women known to be at high risk for a poor birth outcome.

3. Federal Healthy Start Projects in Wisconsin--Population-Based Services--Pregnant women, mothers, infants

Title V MCH/CYSCHN staff continue to serve on advisory committees for the Healthy Start projects.

c. Plan for the Coming Year

1. Title V Funded Perinatal Services--Enabling Services--Pregnant women, mothers, infants

The Title V MCH/CYSHCN Program will fund template objectives to LHDs to address prenatal care.

2. Prenatal Care Coordination (PNCC)--Enabling Services--Pregnant women, mothers, infants

The PNCC program will continue to provide services to Medicaid-eligible women identified as at risk for a poor birth outcome. The revised Medicaid PNCC guidelines will be completed and disseminated to all providers in an update. Technical support will be provided in all regions at PNCC provider group meetings to offer guidance on adopting the revised guidelines. PNCC providers will be encouraged to continue to collaborate with health plans, the medical community, and other community service agencies to increase access the PNCC services throughout the state. The MCH program will work with Family Planning providers on implementing PNCC services through Family Planning sites. Statewide partners will collaborate with MCH to implement interconception services within existing PNCC services. The MCH program will continue regional education to PNCC provider groups and regional Health Officer meetings in collaboration with regional office staff.

3. Federal Healthy Start Projects in Wisconsin--Population-Based Services--Pregnant women, mothers, infants

The Title V MCH/CYSHCN staff will continue to serve on advisory committees for the Healthy Start projects. Technical assistance to tribal sites implementing PNCC services will continue.