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Department of Health Services

2014 DPH Consolidated Contract Addendum

This contract addendum is specific to Chippewa County Department of Public Health & Home Care whose principal business address is 711 North Bridge Street Room 121, Chippewa Falls WI, 54729. The contact for the GRANTEES Contract Administrator is:

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Section 6.D Funding Controls

Payments through June 30, 2014 are limited to 6/12th of the contract with the balance paid after July 1, 2014 based on reported costs up to the contract level. This applies only to the following Profile IDs:

Profile IDs Subject to 6/12 th Funding Controls			
Profile ID	Name	Profile ID	Name
103010	Regional Radon Information Centers	157720	Childhood Lead
151734	Oral Health Supplement	159320	MCH
151735	Oral Health Mouth Rinse	159321	Reproductive Health
152002	Reproductive Health SLOH	159327	Family Planning
152020	Family Health-Women's	181012	Tobacco Prevention & Control Program
157000	WWWP		

Payments through September 30, 2014 are limited to 9/12th of the contract with the balance paid after October 1, 2014 based on reported costs up to the contract level. This applies only to Profile ID 154710.

Section 34.A Special Provisions

1. Contract Period

The contract period for Profile 159220 is limited to January 1, 2014 through August 31, 2014. No expenses incurred after August 31, 2014 will be reimbursed. The contract period for all other Profile IDs is January 1, 2014 through December 31, 2014.

2. Final Report Dates

The due date of the final fiscal report for Profile 154710 shall be sixty (60) days after the Grant Agreement Period ending date. Expenses incurred during the Grant Agreement period on Profile 154710, but reported later than sixty (60) days after the period ending date, will not be recognized, allowed or reimbursed under the terms of this Grant Agreement.

Contract Agreement Addendum: Exhibit I

Program Quality Criteria

Generally high program quality criteria for the delivery of quality and cost-effective administration of health care programs have been, and will continue to be, required in each public health program to be operated under the terms of this contract.

This Exhibit contains only applicable quality criteria for this contract.

Contract Agreement Addendum: Exhibit I

Contract #: 24145

Agency: Chippewa County Department of Public Health & Home Care

Contract Year: 2014

Program: Preventive Health and Health Services Block Grant Program Quality Criteria

- 1) Assessment and surveillance of public health to identify community needs and to support systematic, competent program planning and sound policy development with activities focused at both the individual and community levels.
 - A) Involvement of key policymakers and the general public in the development of comprehensive public health plans.
 - B) Development and implementation of a plan to address issues related to access to high priority public health services for every member of the community.
 - C) Identification of the scientific basis (evidence base) for the intervention.
- 2) Delivery of public health services to citizens by qualified health professionals in a manner that is family centered, culturally competent, and consistent with the best practices; and delivery of public health programs for communities for the improvement of health status.
 - A) There are no separate sub-criterion to this Quality Criteria Category.
- 3) Record keeping for individual focused services that assures documentation and tracking of client health care needs, response to known health care problems on a timely basis, and confidentiality of client information.
 - A) There are no separate sub-criterion to this Quality Criteria Category.
- 4) Information, education, and outreach programs intended to address known health risks in the general and certain target populations to encourage appropriate decision making by those at risk and to affect policy and environmental changes at the community level.
 - A) Provision of public information and education, and/or outreach activities focused on high-risk populations that increase awareness of disease risks, environmental health risks, and appropriate preventive activities.
 - B) Provision of public information and education and/or outreach activities should utilize strategies that have a scientific basis (best-practices) for delivery methods to assure maximum impact on the selected population.
 - C) All materials produced with PHHS Block Grant funds must include the following statement: "This publication was made possible by the PHHS Block Grant from the Centers for Disease Control and Prevention."
- 5) Coordination with related programs to assure that identified public health needs are addressed in a comprehensive, cost-effective manner across programs and throughout the community.
 - A) There are no separate sub-criterion to this Quality Criteria Category.
- 6) A referral network sufficient to assure the accessibility and timely provision of services to address identified public health care needs.
 - A) There are no separate sub-criterion to this Quality Criteria Category.
- 7) Provision of guidance to staff through program and policy manuals and other means sufficient to assure quality health care and cost-effective program administration.
 - A) Provision of written policy and program information about the current guidelines, standards, and recommendations for community and/or clinical preventive care.

Contract Agreement Addendum: Exhibit I

Contract #: 24145

Agency: Chippewa County Department of Public Health & Home Care

Contract Year: 2014

- 8) Financial management practices sufficient to assure accurate eligibility determination, appropriate use of state and federal funds, prompt and accurate billing and payment for services provided and purchased, accurate expenditure reporting, and, when required, pursuit of third-party insurance and Medical Assistance Program coverage of services provided.
 - A) Program-specific data collection, analysis, and reporting to assure program outcome goals are met or to identify program management problems that need to be addressed.
- 9) Data collection, analysis, and reporting to assure program outcome goals are met or to identify program management problems that need to be addressed.
 - A) There are no separate sub-criterion to this Quality Criteria Category.

Contract Agreement Addendum: Exhibit I

Contract #: 24145

Agency: Chippewa County Department of Public Health & Home Care

Contract Year: 2014

Program: Wisconsin Well Woman Program Quality Criteria

- 1) Assessment and surveillance of public health to identify community needs and to support systematic, competent program planning and sound policy development with activities focused at both the individual and community levels.
 - A) There are no separate sub-criterion to this Quality Criteria Category.
- 2) Delivery of public health services to citizens by qualified health professionals in a manner that is family centered, culturally competent, and consistent with the best practices; and delivery of public health programs for communities for the improvement of health status.
 - A) The following information applies only to breast cancer screening: 1) Each coordinating agency must ensure it focuses its breast cancer screening outreach efforts on women ages 50-64. Seventy-five percent of women receiving mammograms should be between the ages of 50 and 64. 2) Each coordinating agency must document attempts to contact annually 100% of the women enrolled in the program, where rescreening is clinically indicated, to arrange mammography rescreening examinations, and must assure that at least 50% of these women are rescreened for breast cancer. 3) Each coordinating agency must follow the program standards for median days between abnormal mammography results and final diagnosis for women enrolled in the program. The median days between an abnormal mammography result and final diagnosis shall be less than 60 days, with not more than 25% over 60 days. 4) Each coordinating agency must document attempts to follow-up 100% of the women reported to have abnormal or suspicious breast cancer screening findings to assure they understand the need for further evaluation and to assist and refer them for appropriate diagnosis and treatment.
 - B) The following information applies only to cervical cancer screening: 1) Each coordinating agency must follow the program standards for median days between abnormal Pap smear results and final diagnosis for women enrolled in the program. The median days between an abnormal Pap smear result and final diagnosis shall be less than 60 days, with no more than 25% over 60 days. 2) Each coordinating agency must document attempts to follow-up 100% of the women reported to have abnormal or suspicious cervical cancer screening findings to assure they understand the need for further evaluation and to assist and refer them for appropriate diagnosis and treatment.
- 3) Record keeping for individual focused services that assures documentation and tracking of client health care needs, response to known health care problems on a timely basis, and confidentiality of client information.
 - A) Each coordinating agency must maintain a paper system or a computerized tracking database of women from its county enrolled in the program. At a minimum, the database should include annual eligibility determination, results of screening services provided, documentation of follow-up in situations of abnormal screening results, and recommended rescreening dates.
- 4) Information, education, and outreach programs intended to address known health risks in the general and certain target populations to encourage appropriate decision making by those at risk and to affect policy and environmental changes at the community level.
 - A) Each coordinating agency must document contacts made to recruit new WWWP clients with special emphasis on women 50-64 years of age. The agency must provide information and education about covered services and rescreening at appropriate intervals.

Contract Agreement Addendum: Exhibit I

Contract #: 24145

Agency: Chippewa County Department of Public Health & Home Care

Contract Year: 2014

- 5) Coordination with related programs to assure that identified public health needs are addressed in a comprehensive, cost-effective manner across programs and throughout the community.
 - A) There are no separate sub-criterion to this Quality Criteria Category.
- 6) A referral network sufficient to assure the accessibility and timely provision of services to address identified public health care needs.
 - A) Each coordinating agency is responsible for recruiting new providers to the WWWP as needed.
 - B) Women diagnosed with breast and/or cervical cancer will be referred to Well Woman Medicaid as appropriate.
 - C) Each coordinating agency must document contacts with each of its WWWP providers as needed, but at least quarterly, to access program status, identify needs, and share information.
- 7) Provision of guidance to staff through program and policy manuals and other means sufficient to assure quality health care and cost-effective program administration.
 - A) There are no separate sub-criterion to this Quality Criteria Category.
- 8) Financial management practices sufficient to assure accurate eligibility determination, appropriate use of state and federal funds, prompt and accurate billing and payment for services provided and purchased, accurate expenditure reporting, and, when required, pursuit of third-party insurance and Medical Assistance Program coverage of services provided.
 - A) Each coordinating agency must ensure accurate eligibility determination whether completed by the local coordinating agency or the provider.
 - B) Each coordinating agency must document attempts to ensure that billing problems between the providers and the fiscal agent are resolved.
 - C) Each coordinating agency is responsible for educating clients on program-covered services and client responsibility for non-covered services.
 - D) Each coordinating agency is responsible for educating providers on the WWWP and billing practices.
- 9) Data collection, analysis, and reporting to assure program outcome goals are met or to identify program management problems that need to be addressed.
 - A) There are no separate sub-criterion to this Quality Criteria Category.

Contract Agreement Addendum: Exhibit II

Program Objectives

(A) Contract Funds, Program/Objective Values, and Other Contract Details

(B) Objective Details

Contract Agreement Addendum: Exhibit II(A)

Contract #: 24145

Agency: Chippewa County Department of Public Health & Home Care

Contract Year: 2014

Contract Source of Funds		
Source	Program	Amount
Chippewa County	Childhood Lead - Consolidated	\$7,696
Chippewa County	Immunization - Consolidated IAP	\$15,228
Chippewa County	Maternal Child Health - Consolidated	\$25,333
Chippewa County	Maternal Child Health - Statewides, Performance	\$143,420
Chippewa County	Oral Health - Fluoride Supplement	\$2,040
Chippewa County	Prevention - Consolidated	\$2,945
Chippewa County	WIC USDA	\$239,540
Chippewa County	Well Woman - WWWP GPR ss.255.06(2) LPHD	\$23,724
Contract Amount		\$459,926

Contract Match Requirements	
Program	Amount
Childhood Lead	\$0
Immunization	\$0
MCH	\$19,000
MCH - CYSHCN Program	\$107,565
Oral Health	\$0
Prevention	\$0
WIC	\$0
Well Woman	\$0

Contract Agreement Addendum: Exhibit II(A)

Contract #: 24145

Agency: Chippewa County Department of Public Health & Home Care

Contract Year: 2014

Program Sub-Contracts		
Program	Sub-Contractee	Sub-Contract Amount
Childhood Lead	None Reported	\$0
Immunization	None Reported	\$0
MCH	None Reported	\$0
MCH - CYSHCN Program	None Reported	\$0
Oral Health	None Reported	\$0
Prevention	None Reported	\$0
WIC	None Reported	\$0
Well Woman	None Reported	\$0

Contract Agreement Addendum: Exhibit II(A)

Contract #: 24145

Agency: Chippewa County Department of Public Health & Home Care

Contract Year: 2014

Childhood Lead

Program Total Value \$7,696

- | | | |
|---|---|---------|
| 1 | Template Objective 4 | \$6,000 |
| | <p>Throughout the 2014 contract period, residents from the jurisdiction of the Chippewa County Department of Public Health Health Department will receive lead poisoning prevention and intervention services that are provided according to federal and state guidelines.</p> | |
| 2 | Template Objective 3 | \$800 |
| | <p>By December 31, 2014, one environmental lead hazard investigations will be completed on the primary residences and pertinent secondary properties of children with venous blood lead levels greater than or equal to 5 micrograms per deciliter who reside in Chippewa County.</p> | |
| 3 | Template Objective 2 | \$896 |
| | <p>By December 31, 2014, six pre-1950 housing units or childcare sites located in Chippewa County where children less than 6 years of age without an elevated blood lead level and/or pregnant women reside or attend day care will be assessed using the Wisconsin Childhood Lead Poisoning Prevention Program Standard for Home-/Childcare Site-based Intervention to Address Lead Hazards.</p> | |

Immunization

Program Total Value \$15,228

- | | | |
|---|--|----------|
| 1 | LHD Template Objective | \$15,228 |
| | <p>By December 31, 2014, 76% children residing in Chippewa County Department of Public Health's jurisdiction who turn 24 months of age during the contract year will complete 4 DTaP, 3 Polio, 1 MMR, 3 Hib, 3 Hepatitis B, 1 Varicella and 4 Pneumococcal Conjugate (PCV) vaccination by their second birthday.</p> | |

MCH

Program Total Value \$25,333

- | | | |
|---|--|----------|
| 1 | By December 31, 2014, The Keeping Kids Alive Initiative will be implemented by the Chippewa County Department of Public Health in collaboration with community partners. | \$12,668 |
| 2 | Template Objective 1 | \$12,665 |
| | <p>By December 31, 2014, continued planning and initiation of implementation activities for the Wisconsin Healthiest Families Initiative will be undertaken by the Chippewa County Department of Public Health in collaboration with community partners focusing on infant and early childhood mental health. (Step 2 & Step 3).</p> | |

Contract Agreement Addendum: Exhibit II(A)

Contract #: 24145

Agency: Chippewa County Department of Public Health & Home Care

Contract Year: 2014

MCH - CYSHCN Program

Program Total Value \$143,420

- | | | |
|---|--|----------|
| 1 | By December 31, 2014, 250 families with children and youth with special health care needs (CYSHCN), providers, and the general public will receive brief contact services that support optimal health and well-being of CYSHCN from the Western Regional Center for CYSHCN. | \$12,500 |
| 2 | By December 31, 2014, 225 children and youth with special health care needs (CYSHCN) and their families will receive consultation, referral and follow-up, and/or care coordination from the Western Regional Center for CYSHCN and any subcontracted agencies. | \$61,500 |
| 3 | By December 31, 2014, the role of parents as partners in decision making will be strengthened and supported by the Western Regional Center for Children and Youth with Special Health Care Needs. | \$10,000 |
| 4 | By December 31, 2013, local infrastructure building that supports and promotes Medical Home will be implemented by the Western Regional Center for CYSHCN in partnership with the Wisconsin Medical Home Hub Statewide Initiative (WiSMHI). | \$40,000 |
| 5 | By December 31, 2014, a regional outreach and partnership plan will be developed and implemented which supports a coordinated system of services for CYSHCN and their families and increases regional-awareness and utilization of the Western Regional Center. | \$8,000 |
| 6 | By December 31, 2014, the transition of youth from childhood to adult life will be supported and promoted with an emphasis on health related services by the Western Regional Center for Children and Youth with Special Health Care Needs in partnership with the Youth Health Transition Hub Statewide Initiative. | \$11,420 |

Oral Health

Program Total Value \$2,040

- | | | |
|---|---|---------|
| 1 | Template Objective 1 | \$2,040 |
| | School-Based Fluoride Supplement Program: By December 31, 2014, (insert number) children ages 6 months through 16 years from non-fluoridated communities will participate in a dietary fluoride supplement program administered by (insert name) Health Department. | |

Prevention

Program Total Value \$2,945

- | | | |
|---|--|---------|
| 1 | Template Objective 10 - Community Health Improvement Process and Plan | \$2,945 |
| | By August 31, 2014 Chippewa County Department of Public Health will complete a community health assessment with measurable objectives. | |

WIC

Program Total Value \$239,540

- | | | |
|---|--|-----------|
| 1 | Template Objective 1 | \$239,540 |
| | During the contract budget period of January 1, 2014 through December 30, 2014, the Chippewa County WIC Project will maintain an average monthly participation that is at least 97% of the assigned case load. | |

Well Woman

Program Total Value \$23,724

- | | | |
|---|--|----------|
| 1 | Template Objective 1: | \$23,724 |
| | By December 31, 2014, 46 Chippewa County residents ages 35-64 years will be screened through the Wisconsin Well Woman Program. | |

		\$459,926
Total of Contract Objective Values		
Total of Contract Statement Of Work Values		\$0

Contract Agreement Addendum: Exhibit II(B)

Contract #: 24145

Agency: Chippewa County Department of Public Health & Home Care

Contract Year: 2014

Program: Childhood Lead Consolidated

Objective #: 1 of 3

Objective Value: \$6,000

Objective: Primary Details

Objective Statement

Template Objective 4

Throughout the 2014 contract period, residents from the jurisdiction of the Chippewa County Department of Public Health Health Department will receive lead poisoning prevention and intervention services that are provided according to federal and state guidelines.

Deliverable Due Date: 01/31/2015

Contract Deliverable (Evidence)

A report to document the extent to which assurance of each of the three follow-up components of this objective was provided, specifically: 1) the number of children with a capillary blood lead level greater than or equal to 5 micrograms per deciliter and the number who received a venous confirmation test; 2) the number of families with children with a venous blood lead level greater than or equal to 5 micrograms per deciliter and the number who received a home visit to provide information on lead poisoning prevention and treatment, and 3) the number of children with a venous blood lead level greater than or equal to 5 micrograms per deciliter and the number of environmental lead hazard investigations conducted on their primary residence and/or secondary properties, including accompanying work orders and property clearance. For evaluation purposes, those children whose families are non-responsive to outreach or moved from the jurisdiction before appropriate follow-up services could be provided can be removed from this cohort.

Programs Providing Funds for this Objective

Childhood Lead Consolidated: \$6,000

Agency Funds for this Objective:

Data Source for Measurement

An agency-generated report.

Baseline for Measurement

Context

There is no designated value range for this objective; it is automatically accepted if the entire Childhood Lead Poisoning Prevention Program (CLPPP) allocation is \$6000 or less. If the allocation is greater than \$6000 and the agency wants to select this objective, negotiation for the value of this objective is required. This assurance objective is intended to assure that the local health department is providing a comprehensive childhood lead poisoning prevention program. For this objective, a home visit will be conducted for all children with one or more venous blood lead levels greater than or equal to 5 micrograms per deciliter. For this objective, an environmental lead hazard investigation will be conducted for all children with one or more venous blood lead levels greater than or equal to 5 micrograms per deciliter. This environmental lead hazard investigation includes a risk assessment of the property, issuance of work orders to address the identified lead hazards, and a clearance report indicating that the hazards have been controlled. The intent is to provide early environmental intervention in response to a lead poisoned child to prevent more severe lead poisoning. The environmental lead hazard investigation can include a child's primary residence and pertinent secondary properties. The procedure for the investigation is outlined in Chapter 9 of the WCLPPP Handbook for Local Health Departments (<http://www.dhs.wisconsin.gov/lead/doc/WCLPPPHandbook.pdf>, 2002), and is conducted at lower blood lead levels than required by state statute (Wis Stat 254). Also see new reference: *Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention* (CDC Advisory Committee on Childhood Lead Poisoning Prevention, January 4, 2012, (http://www.cdc.gov/nceh/lead/ACCLPP/Final_Document_030712.pdf).

Context Continued

Input Activities

Objective: Risk Profile

Percent of Objective Accomplished

0%	10%	20%	30%	40%	50%	60%	70%	80%	85%	90%	95%	100%
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Contract Agreement Addendum: Exhibit II(B)

Contract #: 24145

Agency: Chippewa County Department of Public Health & Home Care

Contract Year: 2014

Program: Childhood Lead Consolidated

Objective #: 1 of 3

Objective Value: \$6,000

Corresponding Percentage Recoupment

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Corresponding Potential Recoupment Amounts

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Definition of Percent Accomplished

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Conditions of Eligibility for an Incentive

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Contract Agreement Addendum: Exhibit II(B)

Contract #: 24145

Agency: Chippewa County Department of Public Health & Home Care

Contract Year: 2014

Program: Childhood Lead Consolidated

Objective #: 2 of 3

Objective Value: \$800

Objective: Primary Details

Objective Statement

Template Objective 3

By December 31, 2014, one environmental lead hazard investigations will be completed on the primary residences and pertinent secondary properties of children with venous blood lead levels greater than or equal to 5 micrograms per deciliter who reside in Chippewa County.

Deliverable Due Date: 01/31/2015

Contract Deliverable (Evidence)

A report to document: 1) the number of children with a blood lead level greater than or equal to [10 or 5 (choose one)] micrograms per deciliter; and 2) the number of associated environmental lead hazard investigations that were completed.

Programs Providing Funds for this Objective

Childhood Lead Consolidated: \$800

Agency Funds for this Objective:

Data Source for Measurement

An agency-generated report.

Baseline for Measurement

Context

Acceptable value for this objective is up to \$800 per environmental lead hazard investigation. The most important factor in managing childhood lead poisoning is reducing the child's exposure to lead. CDC recommends that environmental investigations be conducted in housing where a child with a venous blood lead level greater than or equal to 5 micrograms per deciliter lives, where the child spends a significant amount of time, secondary residences, and other areas where the child (or other children) may be exposed to lead hazards (e.g., in buildings with more than one housing unit, conduct inspection not only in the elevated blood lead child's residence, but also in adjacent units where children could be at risk). When notified that a child has a blood lead level greater than or equal to [10 or 5 (choose one)] micrograms per deciliter, the public health agency will conduct an environmental lead hazard investigation. This environmental lead hazard investigation includes a risk assessment of the property, issuance of work orders to address the identified lead hazards, and a clearance report indicating that the hazards have been controlled. The intent is to provide early environmental intervention in response to a lead poisoned child to prevent more severe lead poisoning. The environmental lead hazard investigation can include a child's primary residence and pertinent secondary properties. The procedure for the investigation is outlined in Chapter 9 of the WCLPPP Handbook for Local Health Departments (<http://www.dhs.wisconsin.gov/lead/doc/WCLPPPHandbook.pdf>, 2002), and is conducted at lower blood lead levels than required by state statute (Wis Stat 254). Also see new reference: *Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention* (CDC Advisory Committee on Childhood Lead Poisoning Prevention, January 4, 2012, http://www.cdc.gov/nceh/lead/ACCLPP/Final_Document_030712.pdf).

Context Continued

Input Activities

Objective: Risk Profile

Percent of Objective Accomplished

0%	10%	20%	30%	40%	50%	60%	70%	80%	85%	90%	95%	100%
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Corresponding Percentage Recoupment

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Corresponding Potential Recoupment Amounts

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Definition of Percent Accomplished

Contract Agreement Addendum: Exhibit II(B)

Contract #: 24145

Agency: Chippewa County Department of Public Health & Home Care

Contract Year: 2014

Program: Childhood Lead Consolidated

Objective #: 2 of 3

Objective Value: \$800

Conditions of Eligibility for an Incentive

Contract Agreement Addendum: Exhibit II(B)

Contract #: 24145

Agency: Chippewa County Department of Public Health & Home Care

Contract Year: 2014

Program: Childhood Lead Consolidated

Objective #: 3 of 3

Objective Value: \$896

Objective: Primary Details

Objective Statement

Template Objective 2

By December 31, 2014, six pre-1950 housing units or childcare sites located in Chippewa County where children less than 6 years of age without an elevated blood lead level and/or pregnant women reside or attend day care will be assessed using the Wisconsin Childhood Lead Poisoning Prevention Program Standard for Home-/Childcare Site-based Intervention to Address Lead Hazards.

Deliverable Due Date: 01/31/2015

Contract Deliverable (Evidence)

For each property assessed, the "Standards for Home Visitation to Address Lead Hazards Documentation" form may be completed. This form is found in the WCLPPP Standard for Home/Childcare Site-based Intervention to Address Lead Hazards resource kit. The required deliverables are: 1) property address; 2) year the structure was built; 3) activities conducted, i.e., lead poisoning education, visual assessment/intervention guidance, sampling via dust wipes or Wisconsin-recognized lead paint test kits (3M LeadCheck or ESCA Tech D-Lead), and demonstration of cleaning techniques; 4) results of dust wipe samples or lead paint test kits; and 5) date information was provided to the property owner regarding the presence of lead in the property.

Programs Providing Funds for this Objective

Childhood Lead Consolidated: \$896

Agency Funds for this Objective:

Data Source for Measurement

The "Standards for Home Visitation to Address Lead Hazards Documentation" form contains all the required information for this objective. Completed forms are sufficient as the data source for measurement; an agency-generated report is also acceptable.

Baseline for Measurement

Context

Acceptable value for this objective is up to \$150 per housing unit or childcare site. The protocol to be followed is the WCLPPP Standard for Home/Childcare Site-based Intervention to Address Lead Hazards. The following components must be included: 1) a visit to the home to provide lead poisoning prevention education and identify potential lead hazards; 2) sampling via dust wipe samples or Wisconsin-recognized lead paint test kits (3M LeadCheck or ESCA Tech D-Lead) to document the presence of lead; and 3) notifying the property owner of the results of the home assessment, including results of dust wipe samples or lead paint test kits, and non-abatement measures that can be taken to correct lead hazards.

This objective entails using the standard with one or more target audiences. Target audiences are families whose primary residence or childcare site was built before 1950. For pregnant women residing in pre-1950 housing, the Home/Childcare Site-based Intervention Standard can be incorporated into a perinatal care coordination or newborn visitation program, or into Medicaid Prenatal Care Coordination services. A resource kit is available by calling the WCLPPP at 608/266-5817. Dust-wipe samples can be analyzed at the State Laboratory of Hygiene and billed to the Basic Agreement (fee exempt).

Context Continued

Input Activities

Objective: Risk Profile

Percent of Objective Accomplished

0%	10%	20%	30%	40%	50%	60%	70%	80%	85%	90%	95%	100%
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Corresponding Percentage Recoupment

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Corresponding Potential Recoupment Amounts

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Contract Agreement Addendum: Exhibit II(B)

Contract #: 24145

Agency: Chippewa County Department of Public Health & Home Care

Contract Year: 2014

Program: Childhood Lead Consolidated

Objective #: 3 of 3

Objective Value: \$896

Definition of Percent Accomplished

Conditions of Eligibility for an Incentive

Contract Agreement Addendum: Exhibit II(B)

Contract #: 24145

Agency: Chippewa County Department of Public Health & Home Care

Contract Year: 2014

Program: Immunization

Objective #: 1 of 1

Objective Value: \$15,228

Objective: Primary Details

Objective Statement

LHD Template Objective

By December 31, 2014, 76% children residing in Chippewa County Department of Public Health's jurisdiction who turn 24 months of age during the contract year will complete 4 DTaP, 3 Polio, 1 MMR, 3 Hib, 3 Hepatitis B, 1 Varicella and 4 Pneumococcal Conjugate (PCV) vaccination by their second birthday.

Deliverable Due Date: 01/31/2015

Contract Deliverable (Evidence)

A Wisconsin Immunization Registry (WIR) generated population based standard benchmark report documenting the number of children in (insert health department) jurisdiction who turned 24 months of age in 2014 contract year. Reports should be run with a 45 day buffer to ensure that all updated data has been received by the WIR. If the objective is not met, include a report of the accountability targets and the progress achieved including the activities and interventions conducted; include any barriers that may have been identified.

For your information the cohort of children for this objective is:

Date of Birth 01/01/2012- 12/31/2012

Criteria for the 2014 End of the Year Report:

The date of birth for End of Year Benchmark: 01/01/2012 ; 12/31/2012

Evaluation date: 01/01/2015

Run date: 02/15/2015

Programs Providing Funds for this Objective

Immunization: \$15,228

Agency Funds for this Objective:

Data Source for Measurement

Wisconsin Immunization Registry Records.

Baseline for Measurement

The 2012 end of year population based standard benchmark report will be used to determine the baseline for the 2014 population based objective.

For the baseline the following parameters will be used to run the benchmark report:

Birthdate Range: 01/01/2010 thru 12/31/2010

Evaluation Date: 01/01/2013

Run Date: After: 02/15/2013

Running the report above results in the following information: For a cohort of 797, 601 (75%) met all benchmark criteria, 196 did not. Late-up-to-date: 648 clients (81%) met all benchmark criteria as of the report generated date (10-21-2013); 149 clients did not.

Context

Children will be assessed using the standard benchmark report for having 4 DTaP, 3 Polio, 1 MMR, 3 Hib 3 Hepatitis B, 1 varicella and 4 Pneumococcal Conjugate (PCV) vaccination by 24 months of age. Progress towards reaching 90% will be measured using a WIR Benchmark report. Only children who have moved out of the agency's jurisdiction may be removed from the cohort for analysis. Unless you can prove that a child has moved out of your jurisdiction, you cannot remove them from your cohort.

Contract Agreement Addendum: Exhibit II(B)

Contract #: 24145
Program: Immunization

Agency: Chippewa County Department of Public Health & Home Care
Objective #: 1 of 1

Contract Year: 2014
Objective Value: \$15,228

Context Continued

Input Activities

The Wisconsin Immunization Program recommends the following activities to help ensure success of this objective:

- Contacting parents of infants without immunization histories
- Tracking
- Coordination of immunization services with other LHD programs
- Sharing information with area physicians
- Requesting that information is entered into the WIR.
- Reminder/recall

The Wisconsin Immunization Program requires a minimum of 3 attempts to personally contact a responsible party.

Only children who have moved out of the agency's jurisdiction may be removed from the cohort for analysis. Unless you can prove that a child has moved out of your jurisdiction you cannot remove them from your cohort.

Reminder/recall activity is not listed in a particular order and we suggest you use the method that is the most successful for your community:

- Letter
- Phone call
- Home visit
- Email
- Text message

Additional interventions/activities are in an addendum to the Immunization Program Boundary Statement. These are suggested interventions/activities that LHD's may want to consider in order to achieve this objective.

Objective: Risk Profile

Percent of Objective Accomplished

0%	10%	20%	30%	40%	50%	60%	70%	80%	85%	90%	95%	100%
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Corresponding Percentage Recoupment

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Corresponding Potential Recoupment Amounts

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Definition of Percent Accomplished

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Conditions of Eligibility for an Incentive

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Contract Agreement Addendum: Exhibit II(B)

Contract #: 24145

Agency: Chippewa County Department of Public Health & Home Care

Contract Year: 2014

Program: Maternal and Child Health Block Grant

Objective #: 1 of 2

Objective Value: \$12,668

Objective: Primary Details

Objective Statement

By December 31, 2014, The Keeping Kids Alive Initiative will be implemented by the Chippewa County Department of Public Health in collaboration with community partners.

Deliverable Due Date: 01/31/2015

Contract Deliverable (Evidence)

- 1.A completed baseline assessment of agency core competencies by January 31, 2014, updated throughout the year and completed by marking Final for Contract Year by January 31, 2015.
- 2.Documentation of participation in the MCH/KKA Annual Conference.(Nov. 5&6, 2014 in Wisconsin Dells).
- 3.Documentation of participation in the webinar series: Data-driven Approach to Early Childhood System-building (4 sessions, 90 minutes each).
- 4.A completed Partnership Report for the Focus Area(s) that directly aligns with the objective.
- 5.A completed Planning, Implementation, and Sustainability Report.

Reporting forms are available at: <http://www.dhs.wisconsin.gov/health/mch/EarlyChildhoodSystems>]

Programs Providing Funds for this Objective

Maternal and Child Health Block Grant: \$12,668

Agency Funds for this Objective:

Data Source for Measurement

- 1.SPHERE Report of the MCH Core Competencies.
- 2.MCH Conference Attendee List
- 3.Webinar Evaluation
- 4.SPHERE Partnership Report to include data from the following tab/screen: Partnership Tool. Data entry on this screen includes Partner Representation and Contribution of Partnership.
- 5.KKA Planning, Implementation, and Sustainability Report.
- 6.Data entered in the national data base.

Reporting forms are available at: <http://www.dhs.wisconsin.gov/health/mch/EarlyChildhoodSystems>]

Baseline for Measurement

Include the applicable items that were completed in 2013 for the Baseline for

Measurement:

1. Recruitment for the local CDR Team was conducted during the year.
2. Assistance from the Alliance was sought for this recruitment.
3. On 9-19-2013, the initial CDR team members met for training from the Alliance. The team will again meet in December to finalize review parameters, establish the frequency of meeting dates for 2014, and begin to review a case.

Contract Agreement Addendum: Exhibit II(B)

Contract #: 24145

Agency: Chippewa County Department of Public Health & Home Care

Contract Year: 2014

Program: Maternal and Child Health Block Grant

Objective #: 1 of 2

Objective Value: \$12,668

4. Two staff members of Chippewa County Dept. of Public Health will attend the KKA Summit in November for training that includes data entry from the upcoming reviews.
5. A Public Health Nurse from the Chippewa Co. Dept. of Public Health has been established as the Lead of the CDR team.
6. Prevention strategies will begin in 2014 as determined by initiation of case review.

History: At the end of 2012, three of five public health nurses retired including the nurse who had previously worked on the this effort. A barrier to team development in previous years was getting the local coroner to committ to the team. Our lead law enforcement team member for 2012 was re-assigned and was no longer available. In 2013, a recently hired public health nurse was identified as lead staff and she began intensive recruitment efforts for the team. Working in collaboration with CHAW staff and collaborating with local partners, new team members were identified and recruited. Eventually the coroner agreed to become involved and in September, 2013 a core team was initiated. A new law enforcement partner has been identified for 2013. Extensive work by agency staff in 2013 has finally resulted in a CDR team that we can begin efforts with. In 2014, we will continue to grow/develop/educate our CDR team members and focus on sustainability of this team for the future.

Context

Wisconsin Keeping Kids Alive Initiative Goal: To establish a sustainable, coordinated system to identify causes of all fetal, infant and child deaths, resulting in preventive strategies for community action. See <http://www.chawisconsin.org/kka.htm>

Note: preventive interventions will be implemented via the Healthiest Families Initiative.).

Local infant/child death review teams are part of public health surveillance and are critical to better understanding how and why a child died. We have statistics on how many children die and from what causes, <http://www.dhs.wisconsin.gov/health/injuryprevention>, but often know little about the circumstances leading up to the child's death. These multidisciplinary teams review and acknowledge all child deaths from a prevention standpoint.

In Wisconsin, the Division of Public Health (DPH) works with the Children's Health Alliance of Wisconsin (the Alliance) in an effort to assure all fetal, infant and child deaths have the opportunity to be reviewed with an emphasis on prevention. Current Child Death Review (CDR) teams are expected to follow the Wisconsin Model, known as Keeping Kids Alive in Wisconsin (outlined in the following manual: <http://www.chawisconsin.org/documents/CDRFinal10.13.08.pdf>). Counties will be expected to work with the Alliance and DPH to explore opportunities to review fetal and infant deaths (prior to 2015) to integrate the National Fetal and Infant Mortality Review (NFIMR) recommendations (www.nfimr.org) into their reviews.

The Fetal and Infant Mortality Review (FIMR) is an action-oriented community process that continually assesses, monitors, and works to improve service systems and community resources for women, infants, and families. Through the review of all fetal and infant deaths we can both better understand the maternal and infant health and social risk factors contributing to these deaths and identify potential protective factors. The FIMR process brings private health care providers, public health, and community service providers together with the intention of examining the current systems that support families during pregnancy, infancy, preconception and interconception.

Local Health Departments may choose this objective to:

1. Initiate a new CDR/FIMR Team in their community where one previously did not exist

Contract Agreement Addendum: Exhibit II(B)

Contract #: 24145

Agency: Chippewa County Department of Public Health & Home Care

Contract Year: 2014

Program: Maternal and Child Health Block Grant

Objective #: 1 of 2

Objective Value: \$12,668

(taking into consideration fetal deaths along with infant and child deaths)

2. Assess the fidelity of an existing CDR Team to the Keeping Kids Alive in Wisconsin

Model

3. Assess the ability of the community, with an existing CDR Team, to review fetal deaths

4. Implement and evaluate a plan to address issues brought forth from one of the above assessments

Communities choosing this objective are expected to follow the Keeping Kids Alive model. It is anticipated that most communities can develop and implement a new CDR/FIMR team following this model within two years. Additional time may be negotiated as deemed appropriate.

Local public health departments will each participate in training and technical assistance, identification of new community partners and utilization of the Keeping Kids Alive Model.

The WI Healthiest Families Initiative will be utilized to assess the community's current prevention efforts and move review recommendations to action.

Context Continued

Required Primary Activities: Local public health departments will complete the following activities. Moving to the Wisconsin Healthiest Families objective for prevention activities may be undertaken at any time, as the community sees fit.

Initiation of a New Team

1. Work with staff at the Alliance to receive training on the development and implementation of a death review team and use of the data collection system.
2. Identify and recruit appropriate partners to form a death review team.
3. Implement death reviews in accordance with the Keeping Kids Alive in Wisconsin model, including entering all deaths into the data collection system.
4. Select the Wisconsin Healthiest Families objective to support review recommendations moving to action within your community.

Improvement of a Current Team

1. Utilize the standardized tool created by the Alliance to complete an assessment of the current review teams fidelity to the Keeping Kids Alive Model and ability to incorporate fetal death reviews into the current structure.
2. Implement and evaluate strategies to improve the death review team according to needs identified in the assessment.
3. Select the Wisconsin Healthiest Families objective to support review recommendations moving to action within your community.

Contract Agreement Addendum: Exhibit II(B)

Contract #: 24145

Agency: Chippewa County Department of Public Health & Home Care

Contract Year: 2014

Program: Maternal and Child Health Block Grant

Objective #: 1 of 2

Objective Value: \$12,668

Input Activities

1. Complete an initial agency assessment of MCH Core Competencies and enter in SPHERE by January 31, 2014; review at mid-year; and update in SPHERE by contract reporting deadline. In 2014, we will begin the year with all five PHN positions filled.
2. Participate in education to support the ongoing development of MCH Core Competencies.

Professional staff working with MCH populations will participate in development MCH Competencies through a variety of training opportunities.
3. Identify existing and new community partners, their contributions, and level of collaboration via the Partnership Tool in SPHERE. As partners were dropped or added in 2013, continued efforts for local collaborations will continue in 2014.
4. Participate in training and technical assistance as well as the annual MCH/KKA Conference (Nov. 5&6, 2014 in Wisconsin Dells). At least one staff person will attend required conferences and local partners on the CDR team will also be invited to participate.
5. Utilize the Keeping Kids Alive in Wisconsin model including entering data into the data collection system. Staff will be trained to use the system.
6. Participate in MCH Program evaluation efforts throughout the contract year.
7. Complete the webinar series: Data-driven Approach to Early Childhood System-building (4 sessions, 90 minutes each). Professional and/or other staff will be assigned to complete this requirement.
8. Finalize Initiation of new team and by the end of the grant period begin Improvement Steps. Since development of the CDR team occurred late in the year of 2013, improvement efforts will be focused on in 2014.

Initiation of a New Team

1. Work with staff at the Alliance to receive training on the development and implementation of a death review team and use of the data collection system. Continued training and team development will occur locally and in collaboration with CHAW.
2. Identify and recruit appropriate partners to form a death review team. Current members will be supported with education/training and new recruits sought.
3. Implement death reviews in accordance with the Keeping Kids Alive in Wisconsin model, including entering all deaths into the data collection system. Reviews will be scheduled in 2014 and data will be entered.
4. Identify and support review recommendations moving toward action within our community. Appropriate partners/resources within the community will be sought for collaboration to move toward prevention strategies.

Improvement of a Current Team

1. Utilize the standardized tool created by the Alliance to complete an assessment of the current review team, fidelity to the Keeping Kids Alive Model, and ability to incorporate fetal death reviews into the current structure.
2. Implement and evaluate strategies to improve the death review team according to needs identified in the assessment.
3. Select the Wisconsin Healthiest Families objective to support review recommendations moving to action within your community.

Objective: Risk Profile

Contract Agreement Addendum: Exhibit II(B)

Contract #: 24145

Agency: Chippewa County Department of Public Health & Home Care

Contract Year: 2014

Program: Maternal and Child Health Block Grant

Objective #: 1 of 2

Objective Value: \$12,668

Percent of Objective Accomplished

0%	10%	20%	30%	40%	50%	60%	70%	80%	85%	90%	95%	100%
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Corresponding Percentage Recoupment

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Corresponding Potential Recoupment Amounts

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Definition of Percent Accomplished

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Conditions of Eligibility for an Incentive

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Contract Agreement Addendum: Exhibit II(B)

Contract #: 24145

Agency: Chippewa County Department of Public Health & Home Care

Contract Year: 2014

Program: Maternal and Child Health Block Grant

Objective #: 2 of 2

Objective Value: \$12,665

Objective: Primary Details

Objective Statement

Template Objective 1

By December 31, 2014, continued planning and initiation of implementation activities for the Wisconsin Healthiest Families Initiative will be undertaken by the Chippewa County Department of Public Health in collaboration with community partners focusing on infant and early childhood mental health. (Step 2 & Step 3).

Deliverable Due Date: 01/31/2015

Contract Deliverable (Evidence)

1. A completed 2014 baseline assessment of agency core competencies by January 31, 2014, updated throughout the year and completed by marking " Final for Contract Year" by January 31, 2015.
2. Documentation of participation in the MCH/KKA Annual Conference. (Nov. 5&6, 2014 in Wisconsin Dells).
3. Documentation of participation in the webinar series: Data-driven Approach to Early Childhood System-building (4 sessions, 90 minutes each).
4. Documentation of the number of life course trainings held, audience, and the number of participants.
5. A completed 2014 Partnership Report for the Mental Health Focus Area that directly aligned with the Mental Health objective.
6. An updated assessment report showing the 2013 data used for the Mental Health efforts.
7. An updated Community Logic Model.
8. A completed 2014 Wisconsin Healthiest Families Implementation Report following the instructions found on the Early Childhood Systems website.

Reporting forms are available at: <http://www.dhs.wisconsin.gov/health/mch/EarlyChildhoodSystems.>]

Programs Providing Funds for this Objective

Maternal and Child Health Block Grant: \$12,665

Agency Funds for this Objective:

Data Source for Measurement

SPHERE Report of the MCH Core Competencies; MCH Conference Attendee List; Webinar Evaluation; SPHERE Community Report to include data from the following screens: Community Activity (all appropriate fields), Intervention: Health Teaching; Subintervention: Life Course Framework.

SPHERE Partnership Report to include data from the following tab/screen: Partnership Tool. Data entry on this screen includes Partner Representation and Contribution of Partnership; Community Logic Model; Implementation Report; Project-specific data sources to document results of activities.

Reporting forms are available at: <http://www.dhs.wisconsin.gov/health/mch/EarlyChildhoodSystems.>]

Baseline for Measurement

- Coalition or collaborative details.

COALITION NAME: Chippewa County Infant Mental Health Action Team

ESTABLISHED: April 2012 VISION: The Chippewa County Community will embrace and support the social and emotional development of infants and young children. MISSION: Making little lives better today for a brighter tomorrow. GOAL: The Infant
11/15/2013 10:13 AM DPH Grants and Contracts

Contract Agreement Addendum: Exhibit II(B)

Contract #: 24145

Agency: Chippewa County Department of Public Health & Home Care

Contract Year: 2014

Program: Maternal and Child Health Block Grant

Objective #: 2 of 2

Objective Value: \$12,665

Mental Health Action Team's focus is promoting the social and emotional development of our youngest children by educating professionals and the community at large about factors that affect infant mental health and the development of the infant brain. The team also assists parents in helping their infants develop to their greatest potential.

Health Dept. staff working with the Chippewa Health Improvement Partnership (CHIP), provided leadership to the Infant Mental Health Action Team whose members represent a variety of disciplines which touch the lives of Chippewa County young children and families. The team, aided by WI Alliance for Infant Mental Health, organized a Chippewa Area Infant and Early Childhood Mental Health Summit which was held on September 26, 2013. Parents and members of the community who work with infants, young children and families were invited to attend the day-long Summit which was held at the Lake Wissota Golf Club in Chippewa Falls. Summit attendance exceeded expectations. 95 participants represented a wide variety of Chippewa County professionals including child care providers; Public Health staff; staff from the Western Regional Center for Children and Youth with Special Health Care Needs; mental health clinicians; parent educators; social workers; Head Start staff; Birth to Three staff; child welfare workers; special education staff; family resource and referral staff; representatives from the local medical, law enforcement, and judicial communities. Invited parents were also among the participants. Participants attended presentations about Infant Mental Health, the Importance of Early Relationships, the Adverse Childhood Experiences (ACE) Study, the Pyramid Model, and Prenatal and Postpartum Mental Health Screening and Support. Information on the Life Course Model, Wisconsin Maternal and Child Health Hotlines, existing services/resources was included. Presentations also explored existing services and resources in Chippewa County, as well as future goals and aspirations for Infant Mental Health in the area. Participants reported an increased awareness of how to support healthy social and emotional development in infants and young children, as well as an understanding of the importance of establishing and maintaining loving and caring relationships.

Participants were asked to "Invest in our Community" by joining one of two workgroups which will meet monthly for one year. Each group is charged with increasing awareness of the importance of mental health of all infants, young children, and their families in Chippewa County. One workgroup will target "Hands-On Providers". The other workgroup will target the "Everyday Person" in Chippewa County. The workgroups will continue the work of the Infant Mental Health Task Force by considering questions brought forth from the Summit, and formulating an implementation plan including a public awareness campaign in 2014.

History: In December of 2012, three of five public health nurses retired from our Dept. including one who worked on this initiative. A new public health nurse was assigned to join other staff to complete this objective/initiative. Mental health was identified during the last Community Health Assessment as an area of needed focus for Chippewa County. While the area of focus for the Summit was on infant and early childhood positive mental health promotion, other local and regional partner groups (including CHIP) are simultaneously looking to address the issue of mental health promotion across the lifespan. This "big picture" view lends itself toward continued sustainability.

Context

Note: This work will be accomplished over multiple years with progressive steps negotiated annually. The populations to be served are all infants and children, children and youth with special health care needs, and expectant and parenting families with young children with a special focus on those at risk for poor health outcomes.

All local health departments need to propose reasonable use of their allocated MCH dollars. Those agencies receiving greater allocations of MCH dollars will be expected to provide multiple steps, focus areas, input activities, and/or objectives.

Goal: To assure that all families in Wisconsin have access to a coordinated, integrated and sustainable system of services and supports focused on health promotion and prevention. For more information go to:
<http://www.dhs.wisconsin.gov/health/mch/EarlyChildhoodSystems>.

Focus Areas: The focus areas for the Wisconsin Healthiest Families Initiative includes: family supports, child development, mental

Contract Agreement Addendum: Exhibit II(B)

Contract #: 24145

Agency: Chippewa County Department of Public Health & Home Care

Contract Year: 2014

Program: Maternal and Child Health Block Grant

Objective #: 2 of 2

Objective Value: \$12,665

health, and safety and injury prevention. Go to <http://www.dhs.wisconsin.gov/health/mch/EarlyChildhoodSystems/WHFdefinitions.htm> for definitions. Agencies need to identify separate objectives for each focus area selected.

Framework: Key concepts of the Life Course Framework link to the Wisconsin Healthiest Families Initiative. The focus is on early childhood because it is a critical, sensitive period with life-long impacts on health. The objective promotes a plan for a community system that supports early childhood health and development that can build on protective factors and reduce risk factors for young children and families. Collaborations with community partners are important because the broader community environment strongly affects the capacity to be healthy. The lead for this work may vary from one community to the next and from one focus area to the next. Strengths of community partners should be promoted and supported through strategies identified by the collaborating partners. It is expected that education and/or training and utilization of the Life Course Framework concepts will be provided and implemented on an ongoing basis with community partners.

Outcomes: See sample outcomes at: <http://www.dhs.wisconsin.gov/health/mch/EarlyChildhoodSystems/WHFdefinitions.htm>.

Context Continued

Steps: The Wisconsin Healthiest Families Initiative will be implemented in collaboration with community partners. Sequential steps will be implemented to complete: 1) assessment, 2) plan, 3) implementation, and 4) evaluation and sustainability. These steps will be completed over multiple years. Reporting documents for these steps are located at: <http://www.dhs.wisconsin.gov/health/mch/EarlyChildhoodSystems>.

Step 1: Assessment - Complete a community, population focused assessment that identifies the community program needs or other resources related to family supports, child development, mental health, and/or safety and injury prevention within the agency's jurisdiction. Assessment of multiple focus areas can be reported on one Assessment Findings form.

Step 2: Plan In collaboration with community partners, develop a plan that addresses the strengths and gaps identified in the assessment completed in Step 1. The plan should promote integrated, multi-sector service systems to assure services are easily accessed by expectant families and families with infants and young children, with special focus on those at risk for poor health outcomes. Coalitions/collaboratives will identify strategies and specific activities that map out their process to complete the initiative. The plan will be reported as a Community Logic Model (with one logic model submitted for each focus area) and must reflect the activities of the agency and partners.

Step 3: Implementation The agency and partners will implement strategies and activities identified in the plan completed in Step 2 to strengthen the system of early childhood services. Step 3 will be reported on the Implementation Report with one report submitted for each focus area addressed by the agency and partners.

Step 4: Evaluation and Sustainability Evaluate the impact on the community of the strategies and activities implemented and identify how this system will be sustained long term.

Contract Agreement Addendum: Exhibit II(B)

Contract #: 24145

Agency: Chippewa County Department of Public Health & Home Care

Contract Year: 2014

Program: Maternal and Child Health Block Grant

Objective #: 2 of 2

Objective Value: \$12,665

REQUIRED SUPPORT ACTIVITIES:

Required activities to support assessment, planning, implementation, and evaluation and sustainability steps include the following:

- Complete an initial agency assessment of MCH Core Competencies and enter in SPHERE by January 31, 2014; review at mid-year; and update in SPHERE by contract reporting deadline.
- Participate in education to support the ongoing development of MCH Core Competencies.
- Identify existing and new community partners, their contributions, and level of collaboration via the Partnership Tool in SPHERE.
- Provide and implement education and/or training and utilization of the Life Course Framework on an on-going basis with community partners and enter in SPHERE.
- Participate in MCH Program evaluation efforts throughout the contract year.
- Participate in training and technical assistance as negotiated, as well as the 2014 MCH Conference.
- Complete the webinar series: Data-driven Approach to Early Childhood System-building (4 sessions, 90 minutes each).

Input Activities

Both newly formed Infant Mental Health workgroups will meet monthly for one year beginning in 2013 and continuing into 2014. Each group is charged with increasing awareness of the importance of mental health of all infants, young children, and their families in Chippewa County. One workgroup will focus on raising awareness of Hands-On Providers; the other workgroup will focus on raising awareness of the Everyday Person in Chippewa County. The workgroups will continue the work of the Infant Mental Health Task Force by considering questions raised at the Summit and formulating a plan for moving forward with the implementation strategies that may include but are not limited to an awareness campaign and other collaborative local or regional initiatives to promote infant and early child mental health. The plan will be completed within the first 4-5 months of 2014. It will be shared with community decision-makers such as the CHIP Steering Committee and Board of Health and Human Services. Implementation of strategies included in the plan will begin mid-year in 2014.

Department staff will complete these Required Support Activities:

1. Complete an agency assessment of MCH Core Competencies and enter the updated version into SPHERE by January 31, 2014.
2. Participate in education to support the ongoing development of MCH Core Competencies by attending webinars, conferences, trainings, internet research and/or other means of education offered.
3. Review the current Partnership Tool for existing and new community partners, their contributions and level of collaboration and enter into SPHERE via the Partnership Tool.
4. Provide and implement education and/or training and utilization of the Life Course Framework on an on-going basis with community partners and enter in SPHERE. Local targeted audiences can include but are not limited to Board of Health and Human Services, student nurses participating in clinicals within the Department, and those members involved directly on the CHIP (Chippewa Health Improvement Partnership) Infant Mental Health Team who will input into the community plan.
5. Participate in MCH Program evaluation efforts throughout the contract year.
6. Participate in training and technical assistance as negotiated, as well as sending staff to the 2014 annual MCH/KKA Conference.
7. Complete the webinar series: Data-driven Approach to Early Childhood System-building (4 sessions, 90 minutes each).

Contract Agreement Addendum: Exhibit II(B)

Contract #: 24145

Agency: Chippewa County Department of Public Health & Home Care

Contract Year: 2014

Program: Maternal and Child Health Block Grant

Objective #: 2 of 2

Objective Value: \$12,665

Objective: Risk Profile

Percent of Objective Accomplished

0%	10%	20%	30%	40%	50%	60%	70%	80%	85%	90%	95%	100%
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Corresponding Percentage Recoupment

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Corresponding Potential Recoupment Amounts

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Definition of Percent Accomplished

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Conditions of Eligibility for an Incentive

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Contract Agreement Addendum: Exhibit II(B)

Contract #: 24145

Agency: Chippewa County Department of Public Health & Home Care

Contract Year: 2014

Program: Maternal and Child Health - Children and Youth with Special Health Care Needs Program

Objective #: 1 of 6

Objective Value: \$12,500

Objective: Primary Details

Objective Statement

By December 31, 2014, 250 families with children and youth with special health care needs (CYSHCN), providers, and the general public will receive brief contact services that support optimal health and well-being of CYSHCN from the Western Regional Center for CYSHCN.

Deliverable Due Date: 01/31/2015

Contract Deliverable (Evidence)

An End of Year Summary Report, a SPHERE report and analysis of data collected in SPHERE as defined within the Data Source for Measurement to document: the number of families with children and youth with special health care needs (CYSHCN), providers and the general public who received brief contact services that support the health and wellbeing of CYSHCN from the Western Regional Center for CYSHCN.

Programs Providing Funds for this Objective

Maternal and Child Health - Children and Youth with Special Health Care Needs Program: \$12,500

Agency Funds for this Objective:

Data Source for Measurement

SPHERE

Baseline for Measurement

End of Year Summary Report and SPHERE Brief Contact Summary Report to include the data from the following screens: Brief Contact Summary (all appropriate fields including contacted by, activity method, county, program, services, funding, intervention(s), and information/service requested). Special note regarding data entry for Professional Consultation on the Brief Contact screen: Within the brief contact screen, select Consultation, fill in time spent, and use the Add Note field to list the name of the professional or the name of the organization, i.e., Dr. Paul Johnson or Dean Clinic Pediatrics Department.

Context

Acceptable value range for this objective is \$50 - \$100 for a brief contact for services that support the health and wellbeing of families of CYSHCN, providers, and the general public on behalf of the family, providers in general, and the general public. The MCH and CYSHCN Quality Criteria and Boundary Statement apply. This objective addresses all six CYSHCN National Performance Measures on the individual level. Individual and Household Interventions are set up with an infrastructure that assures timely assistance and interfaces with other broad local, regional and state system of care for children and youth with special health care needs (i.e., Wisconsin Healthiest Families and Keeping Kids Alive Initiatives). This work is a core service of every Regional Center and should align to create sustainable and effective linkages to improve CYSHCN health.

A Brief Contact is any contact with an individual or family that does not consist of an ongoing relationship. This activity is intended to more completely report significant time spent on professional consultation (not just a short phone call). Since SPHERE is intended to individually list clients, not providers, the brief contact data entry screen is the logical place to report this type of activity. The Regional Center for CYSHCN will provide Brief Contact - Professional Consultation on behalf of professional health care providers.

Context Continued

Input Activities

- Provide Brief Contact on behalf of children and youth with special health care needs, their families, providers, and the general public.
- Provide Brief Contact Professional Consultation on behalf of professional providers to coordinate health care delivery, public health, and community-based activities to promote healthy behavior across the life span.

Objective: Risk Profile

Percent of Objective Accomplished

0%	10%	20%	30%	40%	50%	60%	70%	80%	85%	90%	95%	100%
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Corresponding Percentage Recoupment

Contract Agreement Addendum: Exhibit II(B)

Contract #: 24145

Agency: Chippewa County Department of Public Health & Home Care

Contract Year: 2014

Program: Maternal and Child Health - Children and Youth with Special Health Care Needs Program

Objective #: 1 of 6

Objective Value: \$12,500

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Corresponding Potential Recoupment Amounts

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Definition of Percent Accomplished

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Conditions of Eligibility for an Incentive

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Contract Agreement Addendum: Exhibit II(B)

Contract #: 24145

Agency: Chippewa County Department of Public Health & Home Care

Contract Year: 2014

Program: Maternal and Child Health - Children and Youth with Special Health Care Needs Program

Objective #: 2 of 6

Objective Value: \$61,500

Objective: Primary Details

Objective Statement

By December 31, 2014, 225 children and youth with special health care needs (CYSHCN) and their families will receive consultation, referral and follow-up, and/or care coordination from the Western Regional Center for CYSHCN and any subcontracted agencies.

Deliverable Due Date: 01/31/2015

Contract Deliverable (Evidence)

An End of Year Summary Report, a SPHERE report and analysis of data collected in SPHERE as defined within the Data Source for Measurement to document: the number of children and youth with special health care needs and their families who received consultation, referral and follow-up, and/or care coordination from the Regional Center for CYSHCN and any subcontracted agencies.

Programs Providing Funds for this Objective

Maternal and Child Health - Children and Youth with Special Health Care Needs Program: \$61,500

Agency Funds for this Objective:

Data Source for Measurement

Reduction in number of individuals served in this objective related to change in Director/Service Coordinator position in last quarter of 2014. Transition in learning the new job may result in a short term reduction in families served. Planning to continue to offer LHD contracts, but unsure of total number of LHDs who plan to will choose direct services, vs. system interventions for 2014.

Baseline for Measurement

Required data for all interventions provided (consultation, referral and follow-up, and care coordination: End of Year Summary Report and SPHERE Individual/Household Report to include MCH Required Demographic Data, required CYSHCN data elements from the CYSHCN Intake Form and data from the following screens: Intervention: Screening, Subinterventions: Health Care Utilization (all fields) and CYSHCN Transition Assessment (required for ages 14 to 21 years).

Additional data for consultation: Data from the following SPHERE screen: Intervention: Consultation; Subintervention: Health Benefits OR Medical Home

Additional data for referral and follow-up: Data from the following SPHERE screen: Intervention: Referral and Follow-up, Subinterventions: Type/place and outcome.

Additional data for care coordination: Data from the following SPHERE screens: Intervention: Case Management, Subinterventions: CYSHCN Service Coordination/Assessment (all appropriate fields), CYSHCN Care Plan, CYSHCN Ongoing Monitoring; Intervention: Health Teaching, Subintervention: Topic(s) relevant to the services provided under this objective and Results; Intervention: Referral and Follow-up, Subintervention: Type/place and outcome.

In the first 9 months of 2013, WRC staff served 98 CYSHCN Children and families with consultation, referral and follow up services. The LHD's have contracted for the other half of the numbers for this objective.

Context

Acceptable value range for this objective includes: \$100 for consultation services per CYSHCN; \$175-\$225 for referral and follow-up services per CYSHCN; and \$300-\$400 for care coordination services per CYSHCN. The MCH and CYSHCN Quality Criteria and Boundary Statement apply to this objective. This objective addresses all six CYSHCN National Performance Measures on the individual level. This objective enables families to receive consultation, referral, and follow-up, and/or care coordination which in turn will help family's secure needed supports. The services are defined by the Minnesota Public Health Interventions framework. Consultation: seeks information and generates optimal solutions to perceived problems or issues through interactive problem-solving with a community, system, family, or individual, which the best options are selected and acted upon by the entity. Referral and Follow-up: assists individuals, families, groups, organizations, and communities to utilize necessary resources to prevent or resolve problems or concerns and may include developing resources that are needed, but unavailable to the population. The key to successful referral is follow-up; making a referral without evaluating its results is both ineffective and inefficient. Care Coordination/Case Management: optimizes self-care capabilities of individuals and families and the capacity of systems and

Contract Agreement Addendum: Exhibit II(B)

Contract #: 24145 **Agency:** Chippewa County Department of Public Health & Home Care **Contract Year:** 2014
Program: Maternal and Child Health - Children and Youth with Special Health Care Needs Program **Objective #:** 2 of 6 **Objective Value:** \$61,500

communities to coordinate and provide services. Care coordination/case management will be provided as defined and described in the Minnesota Model of Public Health Interventions Manual, including the Basic Steps for Case Management, Individual/Family Practice Level, page 95. CYSHCN care coordination/case management is targeted to those CYSHCN and their families that need/request this comprehensive service.

The required data elements for the Children and Youth with Special Health Care Needs Program are contained in the CYSHCN Intake Form, which has the required data elements highlighted.

Context Continued

Input Activities

- Provide consultation services on behalf of children and youth with special health care needs to promote medical home, Parent to Parent matching, transition and other services.
- Provide referral and follow-up on behalf of children and youth with special health care needs to promote medical home, Parent to Parent matching, transition and other services.
- Provide Health Benefits Assistance as needed: 1) Assist callers in health benefits decisions, problem solving, and access to services from birth through the transition to adulthood. 2) Seek consultation from the Access/Health Benefits Counseling Statewide Initiative for challenging questions, and 3) Refer families with complex health benefits issues to the Access/Health Benefits Counseling Statewide Initiative and follows-up to assure services were received.
- Collaborate with the Access/Health Benefits Counseling CYSHCN Statewide Initiative related to outreach and referrals to include: 1) Completion of the health benefits competency tool annually to identify staff training needs, and 2) Participation in training and technical assistance provided by the Access/Health Benefits Counseling Statewide Initiative to assure that staff maintain competencies in health benefits knowledge and skills.
- Maintain a toll-free phone line, accessible walk-in space, and center-specific website to provide information, consultation, referral, and follow-up services.
- Promote and utilize Wisconsin First Step to include sharing of regional resources.
- Link parents from Wisconsin screening programs (e.g., newborn hearing, congenital disorders, birth defects, and developmental screening) to support services.
- Participate in and share responsibility for monthly Information and Referral calls.
- Optional Activity: Provide case management interventions for children and youth with special health care needs and complete a care coordination assessment, care plan, ongoing monitoring, and evaluation of the activities done within this plan to ensure effectiveness in meeting the child's and family's needs in coordination with the child's medical home.
- + Optional Activity: 1) Administer agreements with Local Public Health Departments (14-17) and/or Delegate Agencies, during the contract period, to provide referral and follow up and care coordination for children and youth with special health care needs and 2) provide subcontracted agencies with ongoing support and technical assistance to build local capacity within the LPHDs to serve CYSHCN with referral and follow-up.

Objective: Risk Profile

Percent of Objective Accomplished

0%	10%	20%	30%	40%	50%	60%	70%	80%	85%	90%	95%	100%
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Corresponding Percentage Recoupment

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Contract Agreement Addendum: Exhibit II(B)

Contract #: 24145

Agency: Chippewa County Department of Public Health & Home Care

Contract Year: 2014

Program: Maternal and Child Health - Children and Youth with Special Health Care Needs Program

Objective #: 2 of 6

Objective Value: \$61,500

Corresponding Potential Recoupment Amounts

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Definition of Percent Accomplished

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Conditions of Eligibility for an Incentive

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Contract Agreement Addendum: Exhibit II(B)

Contract #: 24145

Agency: Chippewa County Department of Public Health & Home Care

Contract Year: 2014

Program: Maternal and Child Health - Children and Youth with Special Health Care Needs Program

Objective #: 3 of 6

Objective Value: \$10,000

Objective: Primary Details

Objective Statement

By December 31, 2014, the role of parents as partners in decision making will be strengthened and supported by the Western Regional Center for Children and Youth with Special Health Care Needs.

Deliverable Due Date: 01/31/2015

Contract Deliverable (Evidence)

An End of Year Summary Report and SPHERE report as defined within the Data Source for Measurement to document:

1) activities implemented by the Western Regional Center for Children and Youth with Special Health Care Needs that strengthen and support the role of parents as partners in decision making; and 2) outcomes that occurred as a result of implemented activities.

Programs Providing Funds for this Objective

Maternal and Child Health - Children and Youth with Special Health Care Needs Program: \$10,000

Agency Funds for this Objective:

Data Source for Measurement

See above

Baseline for Measurement

End of Year Summary Report and SPHERE System Report to include data from the following screens: System Activity (all appropriate fields including the audience focus, and the strategies/outcomes documented in the Results/Outcome field) and either Intervention: Coalition Building, Subintervention: Parent Leadership, Intervention: Community Organizing, Subintervention: Parent Leadership, or Intervention: Collaboration, Subintervention: Parent Leadership.

So far, in 2013, WRC staff have reached 15 CYSHCN families in partnership with Family Voices for the "What's After High School?" training. One more is scheduled for LaCrosse in November.

Context

The MCH and CYSHCN Quality Criteria and Boundary Statement apply to this objective. This is multiyear work focusing on the system changes that impact health outcomes. This objective addresses the CYSHCN National Performance Measure: Families of children with special health care needs will partner in decision making at all levels, and will be satisfied with the services they receive. Family Leadership strategies are intended to encourage more partnering in decision making between parents and providers by increasing opportunities for parents to attend trainings, present their family story, and bring the parent perspective to systems, councils, boards, and committees. Activities to strengthen individual parents as decision makers and facilitate parent leadership opportunities have long been foundational to the regional center infrastructure.

Context Continued

Input Activities

For activities below, provide details based on agency capacity, funding and regional opportunities. This is ongoing, multiyear work, building on outcomes of previous years.

- Collaborate with the Family Health Leadership Hub CYSHCN Statewide Initiative related to outreach, training, and identification of unmet needs, health disparities and barriers to services (e.g., Did You Know, Now Your Know training).
- Respond to quarterly requests from Family Voices to add parents to the Family Action Network.
- Partner with the Parent Matching Program to assure that parents are linked to parent-to-parent and other natural support opportunities.
- Collaborate with other entities to provide training for parents of CYSHCN on information and skill-building related to their children
- Facilitate linkages for parents of CYSHCN to promote parental involvement in decision-making within their local community's

Contract Agreement Addendum: Exhibit II(B)

Contract #: 24145 **Agency:** Chippewa County Department of Public Health & Home Care **Contract Year:** 2014
Program: Maternal and Child Health - Children and Youth with Special Health Care Needs Program **Objective #:** 3 of 6 **Objective Value:** \$10,000

activities/initiatives (e.g., Wisconsin Healthiest Families and Keeping Kids Alive) and/or within other organizations and systems of care to ensure CYSHCN are represented.

Identify a minimum of one successful linkage: assess and document if system and or policy changes occurred or were achieved as a result of this activity.

WRC will conduct a minimum of one training in partnership with the Family Voices HUB, at a new location in the Western Region. We have partnered with The Center for Independent Living and Eau Claire Schools to co-sponsor trainings in past years.

WRC will partner with Parent to Parent to trial a new referral icon on our desktops that automatically sends referrals to P2P. The goal is to make it easier to refer and increase the total number of referrals from our region.

WRC will continue to empower parents of CYSHCN to be partners in decision-making with organizations and systems, both internal and external, including the Wisconsin Healthiest Families Initiative focusing on increasing family support in the community.

WRC will disseminate information on leadership training and advocacy opportunities to parents in the Western Region who participate in our parent List Serve.

WRC will continue to provide parent to parent leadership through our successful HealthWatch coalition which has been meeting in Chippewa County for 13 years and includes

Objective: Risk Profile

Percent of Objective Accomplished

0%	10%	20%	30%	40%	50%	60%	70%	80%	85%	90%	95%	100%
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Corresponding Percentage Recoupment

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Corresponding Potential Recoupment Amounts

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Definition of Percent Accomplished

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Conditions of Eligibility for an Incentive

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Contract Agreement Addendum: Exhibit II(B)

Contract #: 24145

Agency: Chippewa County Department of Public Health & Home Care

Contract Year: 2014

Program: Maternal and Child Health - Children and Youth with Special Health Care Needs Program

Objective #: 4 of 6

Objective Value: \$40,000

Objective: Primary Details

Objective Statement

By December 31, 2013, local infrastructure building that supports and promotes Medical Home will be implemented by the Western Regional Center for CYSHCN in partnership with the Wisconsin Medical Home Hub Statewide Initiative (WiSMHI).

Deliverable Due Date: 01/31/2015

Contract Deliverable (Evidence)

An End of Year Summary Report and SPHERE report as defined within the Data Source for Measurement to document:

1) activities implemented to build the infrastructure that supports and promotes Medical Home; and 2) outcomes that occurred as a result of the implemented activities.

Programs Providing Funds for this Objective

Maternal and Child Health - Children and Youth with Special Health Care Needs Program: \$40,000

Agency Funds for this Objective:

Data Source for Measurement

See above

Baseline for Measurement

End of Year Summary Report and SPHERE System Report to include data from the following screens: System Activity (all appropriate fields including the audience focus, and the strategies/outcomes documented in the Results/Outcome field) and Intervention: Collaboration, Subintervention: Medical Home.

Context

The MCH and CYSHCN Quality Criteria and Boundary Statement apply to this objective. This is multiyear work focusing on the system changes that impact health outcomes. Many children fall through the cracks due to the lack of a Medical Home. The federal Title V Maternal Child Health Bureau (MCHB) has identified six National Performance Measures and the second one states that all children and youth with special health care needs will receive coordinated ongoing comprehensive care within a Medical Home. Wisconsin was selected as a leadership state by MCHB for its work in Medical Home and efforts to further spread the Medical Home approach are underway.

A State Performance Measure to address the need for a Medical Home for all children is in place as a follow-up to the Title V needs assessment. Wisconsin has a Medical Home Toolkit which has numerous resources for implementing this objective:

<http://wimedicalhometoolkit.aap.org/>. The first step in establishing a Medical Home is to identify the children in the practice that have special health care needs. Evidence-based practice and the American Academy of Pediatrics recommend that early and periodic developmental screening be done on all children. The evidence-based tools for screening will be used and promoted (e.g., ASQ, PEDS) consistent with the American Academy of Pediatrics Developmental Surveillance and Screening of Infants and Young Children policy PEDIATRICS Vol. 108 No. 1 July

2001, pp. 192-195 or <http://aappolicy.aappublications.org/cgi/content/abstract/pediatrics;108/1/192>.

Context Continued

Referral to Parent to Parent is consistent with the American Academy of Pediatrics Family-Centered Care and the Pediatrician's Role Policy Statement PEDIATRICS Vol. 112 No. 3 September 2003 or 08/26/2010 11:18 AM Page 12 of 21 DPH Grants and Contracts. Regional Centers for CYSHCN and local public health departments are in a position to facilitate local capacity building to address these outcomes.

Input Activities

For activities below, provide details based on agency capacity, funding and regional opportunities. This is ongoing, multiyear work, building on outcomes of previous years.

Collaborate with the CYSHCN Medical Home Statewide Initiative (WiSMHI) to implement and evaluate regional spread and reach of the statewide medical home plan.

- Outreach to Primary Care Practices throughout the region to increase awareness and promotion of Regional Center, WiSMHI and other CYSHCN Partner programs and resources.

Contract Agreement Addendum: Exhibit II(B)

Contract #: 24145 **Agency:** Chippewa County Department of Public Health & Home Care **Contract Year:** 2014
Program: Maternal and Child Health - Children and Youth with Special Health Care Needs Program **Objective #:** 4 of 6 **Objective Value:** \$40,000

- Conduct a minimum of 2 primary care clinician outreach trainings (to include developmental screening, pediatric mental health screening, or pediatric mental health community resources trainings) following format established by WiSMHI. Materials will be provided by WiSMHI. WiSMHI will do a follow-up visit with practices (final review) in coordination with the Regional Center.
- Coordinate follow-up and technical assistance requests (apart from the above trainings) from local primary care provider practices in coordination with WiSMHI as needed.
- Ensure an updated list of relevant pediatric behavioral health community resources throughout the region exists and aligns with Wisconsin First Step resources; share regional list during behavioral health outreach trainings.
- Promote Parent to Parent of Wisconsin, the Wisconsin Medical Home Toolkit and other medical home outreach opportunities including pediatric mental health screening tools trainings, and/or trainings in pediatric behavioral health community resources.
- Provide information and resources regarding medical home to professionals and families at outreach and training events throughout the region and at statewide events for which the Center has lead responsibility.
- WRC will be continuing to participate in a new initiative started in 2013 to improve Dental care. The "CYSHCN Dental Home Advisory Committee" was formed in partnership with community providers and parents receiving primary dental care through the Marshfield Dental Health Clinics. We meet bi-monthly to assist those providers to improve dental care access and quality dental home resources throughout their service area.

WRC staff will continue our relationship with the Rural Primary Care Residency Program through UW Madison and the Marshfield Clinic to assist residents to better understand the Medical Home Initiative and how to access CYSHCN resources for their patients in Wisconsin.

Objective: Risk Profile

Percent of Objective Accomplished

0%	10%	20%	30%	40%	50%	60%	70%	80%	85%	90%	95%	100%
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Corresponding Percentage Recoupment

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Corresponding Potential Recoupment Amounts

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Definition of Percent Accomplished

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Conditions of Eligibility for an Incentive

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Contract Agreement Addendum: Exhibit II(B)

Contract #: 24145

Agency: Chippewa County Department of Public Health & Home Care

Contract Year: 2014

Program: Maternal and Child Health - Children and Youth with Special Health Care Needs Program

Objective #: 5 of 6

Objective Value: \$8,000

Objective: Primary Details

Objective Statement

By December 31, 2014, a regional outreach and partnership plan will be developed and implemented which supports a coordinated system of services for CYSHCN and their families and increases regional-awareness and utilization of the Western Regional Center.

Deliverable Due Date: 01/31/2015

Contract Deliverable (Evidence)

An End of Year Summary Report and SPHERE report as defined within the Data Source for Measurement to document:

1) the CYSHCN Regional Center outreach and partnership plan; 2) strategies implemented from the plan to support a coordinated system of services and increased awareness and utilization of Regional Center information, resources and services for; 3) outcomes that occurred as a result of the implemented strategies.

Programs Providing Funds for this Objective

Maternal and Child Health - Children and Youth with Special Health Care Needs Program: \$8,000

Agency Funds for this Objective:

Data Source for Measurement

Baseline for Measurement

End of Year Summary Report and SPHERE System Report to include data from the following screens: System Activity (all appropriate fields including the goals and objectives and partners documented in the results/Outcome field) and Intervention: Collaboration, Subintervention CYSHCN Partnership.

The WRC was a key partner in working with Chippewa County DPH and other community providers in planning a very successful Infant Mental Health Summit, Sept. 26,2013. This was the primary focus of the first year of the Healthiest Families Initiative to improve awareness and identify resources to positively impact Infant Mental Health in Chippewa County. Two work groups have been identified and begun to meet now and into next year, to address the issues brought forth in the Summit.

We are hosting the Wisconsin Sound Beginnings Coordinator for the Western Region in the Western Regional CYSHCN Program. Jeannie Gustafson has been working with families throughout the Region to provide DHH services to children, families and providers throughout the Region.

Context

The MCH and CYSHCN Quality Criteria and Boundary Statement apply to this objective. This is multiyear work focusing on the system changes that impact health outcomes. This objective addresses the CYSHCN National Performance Measure: Community-based service systems will be organized so families can use them easily. Regional Centers for CYSHCN hold an enormous amount of expertise through their highly qualified staff, dedication to quality and extensive resources. There is a need to assure that internal and external partners recognize and value that expertise. Regional Centers need to foster relationships with their internal organizational leaders and external CYSHCN partners so that more families can ultimately know about and have access to the supports and services that may improve the quality of their lives.

Context Continued

Input Activities

For activities below, provide details based on agency capacity, funding and regional opportunities. This is ongoing, multiyear work, building on outcomes of previous years.

- Collaborate with other Regional Centers for CYSHCN and statewide hubs to develop and implement outreach activities with the new ACA Navigators to support enrollment for eligible CYSHCN in the health insurance marketplace. Participate in applicable

Contract Agreement Addendum: Exhibit II(B)

Contract #: 24145 **Agency:** Chippewa County Department of Public Health & Home Care **Contract Year:** 2014
Program: Maternal and Child Health - Children and Youth with Special Health Care Needs Program **Objective #:** 5 of 6 **Objective Value:** \$8,000

training. (This specific outreach activity may or may not be included in your 2014 Partnership Reflection and Planning Tool).

- Based on Center's Partnership Reflection and Planning Tool, identify and implement strategies to strengthen one or more of the partnerships you identified such as: establish more linkages with community partner or coalition, identify pressing and or emerging issues, exchange information and resources, gather local input regarding unmet needs, enhance the understanding of the multiple services available in the region, disseminate information to regional stakeholders on key issues, and or build relationships between partners to assure cultural reach.

- Complete a 2014 Partnership Reflection and Planning Tool (similar to the tool introduced at the end of 2012) by the contract reporting deadline, identifying select partners for work related to the National Performance Outcomes, partnership type, frequency of contact, activities and outcomes.

Objective: Risk Profile

Percent of Objective Accomplished

0%	10%	20%	30%	40%	50%	60%	70%	80%	85%	90%	95%	100%
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Corresponding Percentage Recoupment

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Corresponding Potential Recoupment Amounts

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Definition of Percent Accomplished

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Conditions of Eligibility for an Incentive

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Contract Agreement Addendum: Exhibit II(B)

Contract #: 24145

Agency: Chippewa County Department of Public Health & Home Care

Contract Year: 2014

Program: Maternal and Child Health - Children and Youth with Special Health Care Needs Program

Objective #: 6 of 6

Objective Value: \$11,420

Objective: Primary Details

Objective Statement

By December 31, 2014, the transition of youth from childhood to adult life will be supported and promoted with an emphasis on health related services by the Western Regional Center for Children and Youth with Special Health Care Needs in partnership with the Youth Health Transition Hub Statewide Initiative.

Deliverable Due Date: 01/31/2015

Contract Deliverable (Evidence)

An End of Year Summary Report and SPHERE report as defined within the Data Source for Measurement to document:

1) Activities implemented to support and promote youth health transition and 2) Region-wide system improvements in health transition services and coordination of care and 3) outcomes that occurred as a result of the implemented activities.

Programs Providing Funds for this Objective

Maternal and Child Health - Children and Youth with Special Health Care Needs Program: \$11,420

Agency Funds for this Objective:

Data Source for Measurement

SPHERE

Baseline for Measurement

End of Year Summary Report and SPHERE System Report to include data from the following screens: System Activity (all appropriate fields including the strategies documented in the Results/Outcomes, and include the Intervention: Collaboration with the Subintervention Youth Leadership.

Two successful transition trainings in partnership with Family Voices have been planned for 2013 in the Western Region.

Context

The MCH and CYSHCN Quality Criteria and Boundary Statement apply to this objective. This is multiyear work focusing on the system changes that impact health outcomes. This objective addresses the CYSHCN National Performance Measure: All youth with special health care needs will receive the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence. As background information this objective was built on groundwork of the statewide Community of Practice on Transition.

Context Continued

Input Activities

For activities below, provide details based on agency capacity, funding and regional opportunities. This is ongoing, multiyear work, building on outcomes of previous years.

- Facilitate regional participation in the Hub's Statewide Youth Health Transition Learning Community to include participation in technical assistance calls that the Transition Hub Statewide Initiative may host.
- Collaborate with the Transition Hub Statewide Initiative to disseminate and advance best practice information and research; promote resources/tools; assist in planning and facilitating regional training opportunities to promote successful transition of youth with SHCN from pediatrics to adult health care.
- Assist the Hub in effective dissemination of the Youth Health Transition Toolkit.
- Collaborate with the Transition Hub Statewide Initiative to implement and evaluate regional spread and reach of Youth Health Transition.
- Identify and inform the Transition Hub of regional transition needs.
- Collaborate with Family Voices of Wisconsin on Youth Transition training as applicable.

Contract Agreement Addendum: Exhibit II(B)

Contract #: 24145

Agency: Chippewa County Department of Public Health & Home Care

Contract Year: 2014

Program: Maternal and Child Health - Children and Youth with Special Health Care Needs Program

Objective #: 6 of 6

Objective Value: \$11,420

Optional Activity: Facilitate or host professional education opportunities in youth health transition among partners including grand rounds and/or clinic team presentations and conference presentations.

Objective: Risk Profile

Percent of Objective Accomplished

0%	10%	20%	30%	40%	50%	60%	70%	80%	85%	90%	95%	100%
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Corresponding Percentage Recoupment

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Corresponding Potential Recoupment Amounts

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Definition of Percent Accomplished

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Conditions of Eligibility for an Incentive

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Contract Agreement Addendum: Exhibit II(B)

Contract #: 24145
Program: Oral Health

Agency: Chippewa County Department of Public Health & Home Care
Objective #: 1 of 1

Contract Year: 2014
Objective Value: \$2,040

Objective: Primary Details

Objective Statement

Template Objective 1

School-Based Fluoride Supplement Program: By December 31, 2014, (insert number) children ages 6 months through 16 years from non-fluoridated communities will participate in a dietary fluoride supplement program administered by (insert name) Health Department.

Deliverable Due Date: 01/31/2015

Contract Deliverable (Evidence)

A report to document, by age and community, the number of children who participated in a dietary fluoride supplement program administered by (insert name) Health Department.

Programs Providing Funds for this Objective

Oral Health: \$2,040

Agency Funds for this Objective:

Data Source for Measurement

SPHERE Community Report to include the data from the following screens: Community Activity (all appropriate fields) and Fluoride Supplement (no detail screen).

Baseline for Measurement

Context

The target population for this program is children from age 6 months to 16 years. The children targeted must not have access to fluoridated water or have natural fluoride levels at or above certain concentration levels for specific age groups. Water sources must be tested to determine the fluoride content prior to determining the dosage for dietary fluoride supplements. In other words, this program is targeted to children in non-fluoridated communities or rural areas with low natural fluoride in the water.

Context Continued

Input Activities

Objective: Risk Profile

Percent of Objective Accomplished

0%	10%	20%	30%	40%	50%	60%	70%	80%	85%	90%	95%	100%
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Corresponding Percentage Recoupment

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Corresponding Potential Recoupment Amounts

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Definition of Percent Accomplished

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Conditions of Eligibility for an Incentive

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Contract Agreement Addendum: Exhibit II(B)

Contract #: 24145

Agency: Chippewa County Department of Public Health & Home Care

Contract Year: 2014

Program: Preventive Health and Health Services
Block Grant

Objective #: 1 of 1

Objective Value: \$2,945

Objective: Primary Details

Objective Statement

Template Objective 10 - Community Health Improvement Process and Plan

By August 31, 2014 Chippewa County Department of Public Health will complete a community health assessment with measurable objectives.

Deliverable Due Date: 09/30/2014

Contract Deliverable (Evidence)

A report entered into an electronic data collection tool that describes:

1. Description of strategies implemented and outcomes measured
2. Challenges or barriers to success
3. Actions to address challenges
4. Indicate and describe if Prevention funded activities were used to obtain additional funding, donations or in-kind contributions

Programs Providing Funds for this Objective

Preventive Health and Health Services Block Grant: \$2,945

Agency Funds for this Objective:

Data Source for Measurement

Agency report to be entered into an electronic data collection tool to be provided by the WI Division of Public Health.

Baseline for Measurement

The last community health assessment was completed in 2010.

Context

The community health assessment was last completed in 2010. This department will update the assessment with community partners and explore ranking of activities and objectives.

An updated community health assessment will be presented by the county health officer to the Chippewa County Board of Health and Human Services by August 31, 2014.

Context Continued

Input Activities

CDC strongly encourages Preventive Health and Health Services Block Grant funds be used only on evidence based strategies, best practices or promising practices. Describe the strategies/practices to be used and identify the associated web links as available. Potential links to strategies for this objective include but are not limited to:

<http://dhs.wisconsin.gov/CHIP/>

<http://www.naccho.org/topics/infrastructure/MAPP/index.cfm>

<http://www.walhdab.org/CHIPPIInfrastructure.htm>

www.countyhealthrankings.org/roadmaps

Objective: Risk Profile

Percent of Objective Accomplished

Contract Agreement Addendum: Exhibit II(B)

Contract #: 24145

Agency: Chippewa County Department of Public Health & Home Care

Contract Year: 2014

Program: Preventive Health and Health Services

Objective #: 1 of 1

Objective Value: \$2,945

Block Grant

0%	10%	20%	30%	40%	50%	60%	70%	80%	85%	90%	95%	100%
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Corresponding Percentage Recoupment

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Corresponding Potential Recoupment Amounts

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Definition of Percent Accomplished

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Conditions of Eligibility for an Incentive

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Contract Agreement Addendum: Exhibit II(B)

Contract #: 24145

Agency: Chippewa County Department of Public Health & Home Care

Contract Year: 2014

Program: Women Infants Children Supplemental Nutrition

Objective #: 1 of 1

Objective Value: \$239,540

Objective: Primary Details

Objective Statement

Template Objective 1

During the contract budget period of January 1, 2014 through December 30, 2014, the Chippewa County WIC Project will maintain an average monthly participation that is at least 97% of the assigned case load.

Deliverable Due Date: 01/31/2015

Contract Deliverable (Evidence)

The State WIC Office will be responsible for providing this deliverable. Monthly participation, 3-month average participation, and/or 12-month average participation per the monthly participation report will be maintained and monitored by the State WIC Office.

Programs Providing Funds for this Objective

Women, Infants, and Children (WIC) Supplemental Nutrition:

Agency Funds for this Objective:

Data Source for Measurement

WIC Participation Reports. Baseline for Measurement:

Current caseload is 1246 participants.

Programs Providing Funds for this Objective

Women Infants Children Supplemental Nutrition: \$239,540

Agency Funds for this Objective:

Data Source for Measurement

Rosie

Baseline for Measurement

Context

WIC participation means the number of "total participating" on the monthly participation report maintained and monitored by the State WIC Program Office. It is defined as the number of WIC participants, who receive WIC food instruments for one calendar month,

including the number of exclusively breastfed infants.

Context Continued

Input Activities

Policies and procedures as outlined in the Wisconsin WIC Operations Manual.

Objective: Risk Profile

Percent of Objective Accomplished

0%	10%	20%	30%	40%	50%	60%	70%	80%	85%	90%	95%	100%
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Contract Agreement Addendum: Exhibit II(B)

Contract #: 24145

Agency: Chippewa County Department of Public Health & Home Care

Contract Year: 2014

Program: Women Infants Children Supplemental Nutrition

Objective #: 1 of 1

Objective Value: \$239,540

Corresponding Percentage Recoupment

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Corresponding Potential Recoupment Amounts

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Definition of Percent Accomplished

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Conditions of Eligibility for an Incentive

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Contract Agreement Addendum: Exhibit II(B)

Contract #: 24145

Agency: Chippewa County Department of Public Health & Home Care

Contract Year: 2014

Program: Wisconsin Well Woman

Objective #: 1 of 1

Objective Value: \$23,724

Objective: Primary Details

Objective Statement

Template Objective 1:

By December 31, 2014, 46 Chippewa County residents ages 35-64 years will be screened through the Wisconsin Well Woman Program.

Deliverable Due Date: 01/31/2015

Contract Deliverable (Evidence)

An agency generated report to document an unduplicated count of Chippewa County residents ages 35-64 years who received screening services through the Wisconsin Well Woman Program.

Programs Providing Funds for this Objective

Wisconsin Well Woman: \$23,724

Agency Funds for this Objective:

Data Source for Measurement

Agency records.

Baseline for Measurement

As of 10-24-13, the Program Database (reference 10-24-13 email from Courtney Newman) indicates 31 women enrolled.

Context

Screening services supported by the Wisconsin Well Woman Program include breast cancer and cervical cancer. Refer to the program boundary statement and program updates for exceptions for women ages 35-44.

The Wisconsin Well Woman Program also provides staged assessment for Multiple Sclerosis for high risk women.

Context Continued

Input Activities

Women who meet program guidelines and are currently enrolled will be recalled for re-enrollment. Women who meet program guidelines and are referred by physicians, clinics, public health and other community agencies will be enrolled using the Forward

Health partnership website. All enrollees will be offered appointment assistance. Women needing follow-up services for abnormal results will be contacted by the program public health nurse or coordinator to assure follow through. Follow-up will be done with women who are diagnosed with breast or cervical cancer while enrolled in the WWWP to assure enrollment, through Forward Health, into the Well Woman Treatment Program if clients meet the criteria. Enrolled women will also receive a staged assessment for Multiple Sclerosis for high risk women as applicable.

Objective: Risk Profile

Percent of Objective Accomplished

0%	10%	20%	30%	40%	50%	60%	70%	80%	85%	90%	95%	100%
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Corresponding Percentage Recoupment

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Corresponding Potential Recoupment Amounts

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Definition of Percent Accomplished

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Conditions of Eligibility for an Incentive

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