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**2014 DPH Consolidated Contract Addendum**

This contract addendum is specific to Marathon County Health Dept whose principal business address is 1000 Lake View Drive, Suite 100, Wausau WI, 54403-6797. 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 6/12<sup>th</sup> 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 <sup>th</sup> 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 9/12<sup>th</sup> 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 #: 24180

Agency: Marathon County Health Department

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 #: 24180

Agency: Marathon County Health Department

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 #: 24180

Agency: Marathon County Health Department

Contract Year: 2014

### Program: Radon Indoor Radon RICs 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) Contractee must assess surveillance data (including their own data) for prevalence of homes with elevated indoor radon exposures in their regions. The Division of Public Health (DPH) radon zip-code map and database are at [www.lowradon.org](http://www.lowradon.org).
- 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) Cultural competence and other qualifications of persons delivering radon services must be the same as those of employees of local health agencies, such as environmental sanitarians and public health nurses.
- 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) Contractee must maintain a database of measurements carried out by the public with agency assistance and, to the extent possible, follow cases of elevated exposures to promote appropriate interventions and outcomes. However, the ability to follow-up may be limited in some instances, since indoor radon is not regulated in Wisconsin and because detectors and mitigation services are available from the private sector.
- 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) Contractee must serve as a resource for information in their region, and provide referrals when requested for technical information they can't provide. This enables residents to understand the lung cancer risk from radon, test their homes for radon, interpret test results and follow-up testing, and obtain effective radon mitigation services where appropriate.
- 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) Contractee must coordinate outreach with other public health programs in their agency, adjusting services so as to fit into appropriate priorities among groups with other health needs.
  - B) Contractee must participate in radon outreach training by their regional Radon Information Center, and coordinate outreach for the Radon Action Month media blitz in January with them.
- 6) A referral network sufficient to assure the accessibility and timely provision of services to address identified public health care needs.
  - A) Contractee must use the referral network consisting of their Regional Radon Information Center, nationally certified radon mitigation contractors, and Web sites for fast access to DPH and EPA radon information and literature. The DPH Web site is [www.lowradon.org](http://www.lowradon.org).
- 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.

## Contract Agreement Addendum: Exhibit I

Contract #: 24180

Agency: Marathon County Health Department

Contract Year: 2014

- A) Contractee must provide guidance on radon testing and mitigation following US EPA policies as recommended in EPA's booklets: Citizen's Guide to Radon, Consumer's Guide to Radon Reduction, and Home Buyers and Seller's Guide to Radon, which are readable and downloadable through the US EPA radon web site and the DPH radon web site.
  - B) Contractee must meet criteria of cost-effective program administration in state and local statutes, ordinances and administrative rules.
- 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) Considerations of eligibility determination, pursuit of third-party insurance and Medical Assistance coverage do not apply to radon outreach funded by DPH.
- 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) Contractee must review results of radon measurements they have facilitated. To the extent funded and practicable, Contractee must follow cases where elevated screening tests are reported, to ensure appropriate follow-up testing is done, and to ensure that every opportunity for radon mitigation by sub-slab depressurization is given. However, because indoor radon is not regulated in Wisconsin and because detectors and mitigation services are available from the private sector, the ability to follow-up may be limited in some instances.
  - B) Contractee's report to the radon program in DPH must be sent by email, so it can be included in the DPH report to US EPA, which requires electronic reporting.

## Contract Agreement Addendum: Exhibit I

Contract #: 24180

Agency: Marathon County Health Department

Contract Year: 2014

### Program: Radon Outreach 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) Contractee must assess surveillance data (including their own data) for prevalence of homes with elevated indoor radon exposures in their regions. The Division of Public Health (DPH) radon zip-code map and database are at [www.lowradon.org](http://www.lowradon.org).
- 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) Cultural competence and other qualifications of persons delivering radon services must be the same as those of employees of local health agencies, such as environmental sanitarians and public health nurses.
- 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) Contractee must maintain a database of measurements carried out by the public with agency assistance and, to the extent possible, follow cases of elevated exposures to promote appropriate interventions and outcomes. However, the ability to follow-up may be limited in some instances, since indoor radon is not regulated in Wisconsin and because detectors and mitigation services are available from the private sector.
- 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) Contractee must serve as a resource for information in their region, and provide referrals when requested for technical information they can't provide. This enables residents to understand the lung cancer risk from radon, test their homes for radon, interpret test results and follow-up testing, and obtain effective radon mitigation services where appropriate.
- 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) Contractee must coordinate outreach with other public health programs in their agency, adjusting services so as to fit into appropriate priorities among groups with other health needs.
  - B) Contractee must participate in radon outreach training by their regional Radon Information Center, and coordinate outreach for the Radon Action Month media blitz in January with them.
- 6) A referral network sufficient to assure the accessibility and timely provision of services to address identified public health care needs.
  - A) Contractee must use the referral network consisting of their Regional Radon Information Center, nationally certified radon mitigation contractors, and Web sites for fast access to DPH and EPA radon information and literature. The DPH Web site is [www.lowradon.org](http://www.lowradon.org).
- 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.

## Contract Agreement Addendum: Exhibit I

Contract #: 24180

Agency: Marathon County Health Department

Contract Year: 2014

- A) Contractee must provide guidance on radon testing and mitigation following US EPA policies as recommended in EPA's booklets: Citizen's Guide to Radon, Consumer's Guide to Radon Reduction, and Home Buyers and Seller's Guide to Radon, which are readable and downloadable through the US EPA radon web site and the DPH radon web site.
  - B) Contractee must meet criteria of cost-effective program administration in state and local statutes, ordinances and administrative rules.
- 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) Considerations of eligibility determination, pursuit of third-party insurance and Medical Assistance coverage do not apply to radon outreach funded by DPH.
- 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) Contractee must review results of radon measurements they have facilitated. To the extent funded and practicable, Contractee must follow cases where elevated screening tests are reported, to ensure appropriate follow-up testing is done, and to ensure that every opportunity for radon mitigation by sub-slab depressurization is given. However, because indoor radon is not regulated in Wisconsin and because detectors and mitigation services are available from the private sector, the ability to follow-up may be limited in some instances.
  - B) Contractee's report to the radon program in DPH must be sent by email, so it can be included in the DPH report to US EPA, which requires electronic reporting.

## Contract Agreement Addendum: Exhibit I

Contract #: 24180

Agency: Marathon County Health Department

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 #: 24180

Agency: Marathon County Health Department

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 #:** 24180

**Agency:** Marathon County Health Department

**Contract Year:** 2014

<b>Program Sub-Contracts</b>		
<b>Program</b>	<b>Sub-Contractee</b>	<b>Sub-Contract Amount</b>
Childhood Lead	None Reported	\$0
Immunization	None Reported	\$0
MCH	None Reported	\$0
MCH - CYSHCN Program	None Reported	\$0
Prevention	None Reported	\$0
Radon Outreach	None Reported	\$0
Radon-RICs	None Reported	\$0
Well Woman	None Reported	\$0

## Contract Agreement Addendum: Exhibit II(A)

Contract #: 24180

Agency: Marathon County Health Department

Contract Year: 2014

### Childhood Lead

**Program Total Value \$13,381**

- |   |   |          |
|---|---|----------|
| 1 | Template Objective 1  | \$1,381  |
|   | By December 31, 2014, 250 children at risk for lead poisoning who reside in Marathon County will receive an age-appropriate blood lead test.  |          |
| 2 | Template Objective 3  | \$12,000 |
|   | By December 31, 2014, 15 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 Marathon County. |          |

### Immunization

**Program Total Value \$32,142**

- |   |   |          |
|---|---|----------|
| 1 | By December 31, 2014, 79% children residing in Marathon County 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. | \$32,142 |
|---|---|----------|

### MCH

**Program Total Value \$44,933**

- |   |   |          |
|---|---|----------|
| 1 | By December 31, 2014, implementation activities for the Wisconsin Healthiest Families Initiative will be undertaken by the Marathon County Health Department in collaboration with community partners focusing on family supports, child development, mental health and safety/injury prevention. (Remaining in Step 3) | \$44,933 |
|---|---|----------|

### MCH - CYSHCN Program

**Program Total Value \$125,399**

- |   |   |          |
|---|---|----------|
| 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 Northern Regional Center for CYSHCN.  | \$25,000 |
| 2 | By December 31, 2014, 75 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 Northern Regional Center for CYSHCN and any subcontracted agencies.   | \$16,875 |
| 3 | By December 31, 2014, the role of parents as partners in decision making will be strengthened and supported by the Northern Regional Center for Children and Youth with Special Health Care Needs.  | \$14,500 |
| 4 | By December 31, 2014, local infrastructure building that supports and promotes Medical Home will be implemented by the Northern Regional Center for CYSHCN in partnership with the Wisconsin Medical Home Hub Statewide Initiative (WiSMHI).  | \$26,000 |
| 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 Northern Regional Center.   | \$22,900 |
| 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 Northern Regional Center for Children and Youth with Special Health Care Needs in partnership with the Youth Health Transition Hub Statewide Initiative. | \$20,124 |

### Prevention

**Program Total Value \$4,733**

- |   |   |         |
|---|---|---------|
| 1 | Template Objective 2 - Healthy Weight in Adults   | \$4,733 |
|   | By August 31, 2014, Marathon County Health Department will implement one (1) evidence based strategy to promote healthy weight in adults. |         |

### Radon Outreach

**Program Total Value \$13,350**

- |   |   |          |
|---|---|----------|
| 1 | This objective is for calendar year 2014. | \$13,350 |
|---|---|----------|

**Contract Agreement Addendum: Exhibit II(A)**

**Contract #:** 24180

**Agency:** Marathon County Health Department

**Contract Year:** 2014

**Radon-RICs**

**Program Total Value \$2,766**

1 This objective is for calendar year 2014. \$2,766

**Well Woman**

**Program Total Value \$38,097**

1 Template Objective 1: \$38,097

By September 30, 2014, eighty eight (88) Marathon County residents ages 35-64 years will be screened through the Wisconsin Well Woman Program.

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<b>Total of Contract Objective Values</b>	\$274,801
<b>Total of Contract Statement Of Work Values</b>	\$0

## Contract Agreement Addendum: Exhibit II(B)

**Contract #:** 24180

**Agency:** Marathon County Health Department

**Contract Year:** 2014

**Program:** Childhood Lead Consolidated

**Objective #:** 1 of 2

**Objective Value:** \$1,381

### Objective: Primary Details

**Objective Statement**

Template Objective 1

By December 31, 2014, 250 children at risk for lead poisoning who reside in Marathon County will receive an age-appropriate blood lead test.

**Deliverable Due Date:** 01/31/2015

**Contract Deliverable (Evidence)**

A report to document the number of unduplicated children at risk for lead poisoning residing in (insert name of jurisdiction) who received a blood lead test at the appropriate ages: age 1 and age 2, or, if no prior test was done at age 1 or 2, between the ages 3 to 5.

**Programs Providing Funds for this Objective**

Childhood Lead Consolidated: \$1,381

**Agency Funds for this Objective:**

**Data Source for Measurement**

An agency-generated report; or a SPHERE Individual/Household Report, including information from the Lead-testing screen.

**Baseline for Measurement**

Between 1/1/2012 and 6/1/2012, there were 331 first time blood lead draws in children under 3 years of age. As of 10/16/2013, there were XXX first time blood lead draws in children under 3 years of age.

**Context**

Acceptable value for this objective is up to \$18 per blood lead test. Children at highest risk for lead poisoning are those eligible or enrolled in the Medicaid or WIC Program, those living or spending time in pre-1950 housing or pre-1978 housing that is undergoing renovation, or those with a sibling with lead poisoning. Age appropriate blood lead tests are done at around 12 months and around 24 months, or at least once between the ages of 3 to 5 years if the child has no previous test documented. Local health departments should seek third party reimbursement for testing Medicaid-enrolled children by billing Medicaid fee-for-service or the appropriate managed care organization. See new reference: CDC Advisory Committee on Childhood Lead Poisoning Prevention (ACCLPP) ; ;Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention; ([http://www.cdc.gov/nceh/lead/ACCLPP/Final\\_Document\\_030712.pdf](http://www.cdc.gov/nceh/lead/ACCLPP/Final_Document_030712.pdf), CDC, January 4, 2012) and the WCLPPP Handbook for Local Health Departments (<http://www.dhs.wisconsin.gov/lead/doc/WCLPPPHandbook.pdf>, 2002).

**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 #: 24180

Agency: Marathon County Health Department

Contract Year: 2014

Program: Childhood Lead Consolidated

Objective #: 2 of 2

Objective Value: \$12,000

### Objective: Primary Details

#### Objective Statement

Template Objective 3

By December 31, 2014, 15 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 Marathon 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 5 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: \$12,000

#### Agency Funds for this Objective:

#### Data Source for Measurement

An agency-generated report.

#### Baseline for Measurement

In 2012, 15 properties received a LHI where a child resided having a blood lead level of <10 ug/dl and 7 properties received a LHI where a child resided having a blood lead level of equal to or greater than 10 ug/dl. As of October 16, 2013, 17 properties have received a LHI where a child resides having <10 ug/dl and 4 properties received a LHI where a child resided having a blood lead level of equal to or greater than 10 ug/dl.

#### 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 10 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 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 Wisconsin Childhood Lead Poisoning Prevention Program Handbook (2002), and is conducted at lower blood lead levels than required by state statute (Wis Stat 254).

#### Context Continued

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 5 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](http://www.cdc.gov/nceh/lead/ACCLPP/Final_Document_030712.pdf)).

## Contract Agreement Addendum: Exhibit II(B)

**Contract #:** 24180

**Agency:** Marathon County Health Department

**Contract Year:** 2014

**Program:** Childhood Lead Consolidated

**Objective #:** 2 of 2

**Objective Value:** \$12,000

### 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 #:** 24180  
**Program:** Immunization

**Agency:** Marathon County Health Department  
**Objective #:** 1 of 1

**Contract Year:** 2014  
**Objective Value:** \$32,142

### Objective: Primary Details

#### Objective Statement

By December 31, 2014, 79% children residing in Marathon County 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: \$32,142

#### Agency Funds for this Objective:

#### Data Source for Measurement

Wisconsin Immunization Registry Records.

#### Baseline for Measurement

The 2012 end of year WIR Benchmark report was run for the baseline for measurement. For the selected benchmarks: DTaP (4), HepB (3), Hib (3), MMR (1), Polio (3), Pneumo (4), Varicella (1) children are 79% up to date.

The 2012 end of year population based standard benchmark report will be used to determine the baseline for the 2014 population based objective. There is no percentage increase for 2014; health departments need to meet or exceed the baseline percentage.

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

#### 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 #: 24180  
Program: Immunization

Agency: Marathon County Health Department  
Objective #: 1 of 1

Contract Year: 2014  
Objective Value: \$32,142

## 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 #: 24180

Agency: Marathon County Health Department

Contract Year: 2014

Program: Maternal and Child Health Block Grant

Objective #: 1 of 1

Objective Value: \$44,933

### Objective: Primary Details

#### Objective Statement

By December 31, 2014, implementation activities for the Wisconsin Healthiest Families Initiative will be undertaken by the Marathon County Health Department in collaboration with community partners focusing on family supports, child development, mental health and safety/injury prevention. (Remaining in Step 3)

**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 LPHD 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 Partnership Report for the Focus Area(s) that directly aligns with the objective.
6. A completed Wisconsin Healthiest Families Implementation Report following the instructions found on the Early Childhood Systems website.

#### Programs Providing Funds for this Objective

Maternal and Child Health Block Grant: \$44,933

#### Agency Funds for this Objective:

#### Data Source for Measurement

1. SPHERE Report of the MCH Core Competencies.
2. MCH/KKA Conference Attendee List
3. Webinar Evaluation
4. SPHERE Community Report to include data from the following screens: Community Activity (all appropriate fields), Intervention: Health Teaching; Subintervention: Life Course Framework.
5. 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.
6. WHF Implementation Report (Note: One Implementation Report submitted for each focus area.) Project-specific data sources to document results of activities.
7. Reporting forms are available at: <http://www.dhs.wisconsin.gov/health/mch/EarlyChildhoodSystems>.

#### Baseline for Measurement

- Marathon County Early Years Coalition has been in existence since 2012.
- Their vision is "that every child is supported in their early years for a journey of lifelong success". Health Department is Lead and Participating Member of the Coalition. The full Coalition has 7 Action Teams (Parents as First Teachers, Developmental Screening, High Quality Child Care, Healthy Babies, Early Reading Pilot Project, Advocacy and Awareness, and Planning) each meeting at least 4 or more times during the year.
- Assessment conducted in 2011 with findings reported out at the end of the year based on a coalition capacity building model. The assessment details are contained in the partner inventory tool.

- Coalition established mission and vision statements with objectives in spring of 2012

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DPH Grants and Contracts

## Contract Agreement Addendum: Exhibit II(B)

**Contract #:** 24180

**Agency:** Marathon County Health Department

**Contract Year:** 2014

**Program:** Maternal and Child Health Block Grant

**Objective #:** 1 of 1

**Objective Value:** \$44,933

- In 2012 planning activities included development of a tearless Logic Model where partners answer a series of questions via survey focusing on the changes in the community and inputs, outcomes. The responses are categorized in the Logic Model based on coalition input.

- The 2013 progress is directing the work for the 2014 work plan. We are in the second year of implementation.

### 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 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.

## Contract Agreement Addendum: Exhibit II(B)

**Contract #:** 24180

**Agency:** Marathon County Health Department

**Contract Year:** 2014

**Program:** Maternal and Child Health Block Grant

**Objective #:** 1 of 1

**Objective Value:** \$44,933

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

**Input Activities**

Strategies and activities:

1. Continue to provide training on the Life Course Framework for health department so that health department employees continue to link life course principles to all programs and initiatives.
2. Continue coalition development (infrastructure building for sustainability) for Marathon County Early Years Coalition
3. Facilitate implementation and evaluation of 2014 work plans for 7 action teams within the Marathon County Early Years Coalition, ensuring links to the four focus areas
4. Partner with March of Dimes to air Pregnancy Time lapse public service announcement to fulfill part of Healthy Babies Action Team goals (details for funding acknowledgement to be forthcoming)

REQUIRED SUPPORT ACTIVITIES that support assessment, planning, implementation, and evaluation and sustainability steps include the following:

5. 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.
6. Participate in education to support the ongoing development of MCH Core Competencies.
7. Identify existing and new community partners, their contributions, and level of collaboration via the Partnership Tool in SPHERE.
8. 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.
9. Participate in MCH Program evaluation efforts throughout the contract year.
10. Participate in training and technical assistance, as well as the 2014 MCH/KKA Conference.
11. Complete the webinar series: Data-driven Approach to Early Childhood System-building (4 sessions, 90 minutes each).

**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 #:** 24180

**Agency:** Marathon County Health Department

**Contract Year:** 2014

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

**Objective #:** 1 of 6

**Objective Value:** \$25,000

### 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 Northern 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 Regional Center for CYSHCN.

#### Programs Providing Funds for this Objective

Maternal and Child Health - Children and Youth with Special Health Care Needs Program: \$25,000

#### Agency Funds for this Objective:

#### Data Source 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.

#### Baseline for Measurement

The Northern Regional Center consistently documents 200-250 brief contacts annually on behalf of families, providers and the general public. In 2012 257 brief contacts were made and additional contacts with youth parents and providers through trainings, outreach and other systems capacity objectives totaled 796. In the first 3 quarters of 2013 175 brief contacts have been documented thus far.

#### 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

**Contract Agreement Addendum: Exhibit II(B)**

**Contract #:** 24180

**Agency:** Marathon County Health Department

**Contract Year:** 2014

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

**Objective #:** 1 of 6

**Objective Value:** \$25,000

**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 #:** 24180

**Agency:** Marathon County Health Department

**Contract Year:** 2014

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

**Objective #:** 2 of 6

**Objective Value:** \$16,875

### Objective: Primary Details

#### Objective Statement

By December 31, 2014, 75 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 Northern 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: \$16,875

#### Agency Funds for this Objective:

#### Data Source 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.

#### Baseline for Measurement

In 2012 the Northern Regional Center provided direct service interventions of Referral and Follow Up or Consultation to 78 children or youth. In 2013 62 children and youth have received direct service interventions. The Northern Regional Center direct service interventions have consistently run from 70-80 each year.

#### 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 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.

## Contract Agreement Addendum: Exhibit II(B)

**Contract #:** 24180

**Agency:** Marathon County Health Department

**Contract Year:** 2014

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

**Objective #:** 2 of 6

**Objective Value:** \$16,875

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 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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**Corresponding Potential Recoupment Amounts**

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**Definition of Percent Accomplished**

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**Contract Agreement Addendum: Exhibit II(B)**

**Contract #:** 24180

**Agency:** Marathon County Health Department

**Contract Year:** 2014

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

**Objective #:** 2 of 6

**Objective Value:** \$16,875

**Conditions of Eligibility for an Incentive**

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## Contract Agreement Addendum: Exhibit II(B)

**Contract #:** 24180

**Agency:** Marathon County Health Department

**Contract Year:** 2014

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

**Objective #:** 3 of 6

**Objective Value:** \$14,500

### 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 Northern 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 Northern 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: \$14,500

#### Agency Funds for this Objective:

#### Data Source 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.

#### Baseline for Measurement

This is ongoing multi-year work, building on outcomes of previous years. The Northern Regional Center plans to continue to collaborate with Parent to Parent of Wisconsin and Family Voices of Wisconsin as well as other partners to assure that the family perspective is heard at all levels.

In 2012 26 referrals were made to Parent to Parent of WI; 47 parents and 37 providers were referred to Family Voices of WI through participation in 3 trainings in the region; parents received many emails throughout the year promoting PALS, YIPPE, Family Voices Advocacy training, conferences such as the Circles of Life, Autism Society of Wisconsin, Children Come First/Wisconsin Family Ties;

#### 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). The Northern Regional Center will conduct a minimum of one Did You Know Now You Know training within the region in partnership with Family Voices of Wisconsin.

- Respond to quarterly requests from Family Voices to add parents to the Family Action Network. The Northern Regional Center submits names of training participants to Family Voices of Wisconsin.

- Partner with the Parent Matching Program to assure that parents are linked to parent-to-parent and other natural support opportunities. The Northern Regional Center offers referrals for Parent to Parent of Wisconsin to all families receiving Consultation

## Contract Agreement Addendum: Exhibit II(B)

**Contract #:** 24180

**Agency:** Marathon County Health Department

**Contract Year:** 2014

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

**Objective #:** 3 of 6

**Objective Value:** \$14,500

or Referral and Follow Up interventions. The Northern Regional Center will partner with Parent to Parent of Wisconsin to explore the need for a support parent training within the northern region.

- 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 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. The Northern Regional Center disseminates information received from other partners to parents in the Northern Region to promote leadership opportunities such as advocacy trainings, conferences and participation on local and state boards.

### 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 #:** 24180

**Agency:** Marathon County Health Department

**Contract Year:** 2014

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

**Objective #:** 4 of 6

**Objective Value:** \$26,000

### Objective: Primary Details

#### Objective Statement

By December 31, 2014, local infrastructure building that supports and promotes Medical Home will be implemented by the Northern 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: \$26,000

#### Agency Funds for this Objective:

#### Data Source 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.

#### Baseline for Measurement

In 2012 the Northern Region participated in 6 Early Identification and Intervention trainings on developmental screening with WiSMHI for primary care providers. In 2013 the Northern Regional Center participated in a pediatric behavioral health training at Red Cliff Community Health Center with WiSMHI and by years end expects to have conducted 3 new and 1 follow up training on developmental screening at primary care clinics throughout the region. In 2013 the Northern Regional Center has taken a leadership role in the Marathon County Early Years Coalition Developmental Screening Action Team to implement strategies to achieve 100% of providers offering developmental screening at well child exams within Marathon County.

#### 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  
11/13/2013 10:21 AM DPH Grants and Contracts

## Contract Agreement Addendum: Exhibit II(B)

**Contract #:** 24180

**Agency:** Marathon County Health Department

**Contract Year:** 2014

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

**Objective #:** 4 of 6

**Objective Value:** \$26,000

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. The Northern Regional Center maintains an email group of primary care providers in the Northern Region to send outreach information on the Medical Home toolkit, trainings and webcasts offered by the Statewide Medical Home Initiative. Emails are sent to providers a minimum of two times a year. Additionally the Northern Regional Center will strengthen relationships with 4 FQHC in the Region - Bridge Community Health Clinic in Wausau, the Family Health Center in Marshfield, the Red Cliff Community Health Center in RedCliff/Bayfield and the Lakes Community Health Center in Ashland.

- 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. The Northern Regional Center will continue to partner with WiSMHI to provide training to primary care providers. The Northern Regional Center will submit documentation of participants and training outcomes of developmental screening trainings conducted by 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. The Northern Regional Center will continue to seek out resources in the region and communicate with Wisconsin First Step and WiSMHI.

- 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.(e.g., 2014 Learning Collaboratives) The Northern Regional Center will promote Parent to Parent and Family Voices at all trainings.

- 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. The Northern Regional Center addresses medical home through the assessments made when providing services to individuals and family by assessing connections to medical care, satisfaction with care and health care coverage.

### 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 #:** 24180

**Agency:** Marathon County Health Department

**Contract Year:** 2014

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

**Objective #:** 5 of 6

**Objective Value:** \$22,900

### 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 Northern 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: \$22,900

#### Agency Funds for this Objective:

#### Data Source 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.

#### Baseline for Measurement

In previous years the Northern Regional Center has tracked partnership and outreach activities by completing an Outreach and Partnership Work Plan and/or the Regional Center Partnership and Reflection Planning Tool. The Northern Regional Center has maintained participation on local, regional and state committees such as early childhood councils; the Wisconsin Early Childhood Collaborating Partners Northern Action Team; transition advisory councils (now CCoTs); and the MCH Advisory Council.

#### 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 training. (This specific outreach activity may or may not be included in your 2014 Partnership Reflection and Planning Tool). The Northern Regional Center will participate in 2 Regional Enrollment Networks that cover the 15 counties in the region to implement outreach activities on ACA with families and providers to support enrollment and maintain health care coverage.

- 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. The Northern Regional Center will strengthen relationships with 4 FQHC's located in Northern Region.

## Contract Agreement Addendum: Exhibit II(B)

**Contract #:** 24180

**Agency:** Marathon County Health Department

**Contract Year:** 2014

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

**Objective #:** 5 of 6

**Objective Value:** \$22,900

- 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 #: 24180

Agency: Marathon County Health Department

Contract Year: 2014

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

Objective #: 6 of 6

Objective Value: \$20,124

### 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 Northern 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: \$20,124

#### Agency Funds for this Objective:

#### Data Source 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.

#### Baseline for Measurement

In 2012 the Northern Regional Center co-sponsored one Family Voices Transition Training; participated in 3 transition resource fairs and provided information to the 8 youth of transition age who received direct service interventions. In 2013 the Northern Regional Center co-sponsored 2 Family Voices Transition Trainings; participated in 5 transition resource fairs; and is a regular participant of 5 County Communities on Transition. The Northern Regional Center has promoted the Wisconsin Health Transition website maintained by the Transition Statewide Hub at all resource fairs occurring in the fall.

#### 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.

Through participation on County Community on Transition (CCoT) regional groups in 4-5 counties within the northern region the Regional Center plans to promote and disseminate the toolkit and resources that are developed by the Statewide Youth Health Transition Initiative. In addition to CCoT participation the Northern Regional Center will participate in a minimum of 4 transition resource fairs sponsored by the local CCoTs or school districts.

- 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

## Contract Agreement Addendum: Exhibit II(B)

**Contract #:** 24180

**Agency:** Marathon County Health Department

**Contract Year:** 2014

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

**Objective #:** 6 of 6

**Objective Value:** \$20,124

Transition.

- Identify and inform the Transition Hub of regional transition needs.

- Collaborate with Family Voices of Wisconsin on Youth Transition training as applicable. The Northern Regional Center will host at least one What's After High School Transition Training in partnership with Family Voices of Wisconsin.

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 #:** 24180

**Agency:** Marathon County Health Department

**Contract Year:** 2014

**Program:** Preventive Health and Health Services  
Block Grant

**Objective #:** 1 of 1

**Objective Value:** \$4,733

### Objective: Primary Details

#### Objective Statement

Template Objective 2 - Healthy Weight in Adults

By August 31, 2014, Marathon County Health Department will implement one (1) evidence based strategy to promote healthy weight in adults.

**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: \$4,733

#### 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

This objective is enhancing current work in Marathon County regarding farmers markets.

#### Context

The strategy chosen is to increase access to local foods by enhancing farmers markets within Marathon County. We will work with current markets accepting EBT to increase awareness of EBT access at markets, support other markets in implementing EBT access, and utilize earned media to encourage residents to choose farmers markets over other food retail.

#### Context Continued

Since 2010, the number of farmers markets have increased from seven to 13 in Marathon County, including a Winter Market set to begin November 16, 2013. By the end of 2013, four of the 13 farmers markets within Marathon County will have the capacity to accept FoodShare. In 2012, the Marathon County Board of Supervisors adopted the vision for Marathon County: to be the healthiest, safest, most prosperous county in the state of Wisconsin. Increasing access to local, fresh produce through farmers markets supports two of these goals.

#### Input Activities

The strategies for this objective relates to the following Healy People 2020 objectives:

NWS-4 (Developmental) Increase the proportion of Americans who have access to a food retail outlet that sells a variety of foods that are encouraged by the Dietary Guidelines for Americans

NWS-14 Increase the contribution of fruits to the diets of the population aged 2 years and older

NWS-15 Increase the variety and contribution of vegetables to the diets of the population aged 2 years and older

"What Works" provides expert opinion that EBT payment at Farmer's markets is an effective strategy

<http://whatworksforhealth.wisc.edu/program.php?t1=21&t2=12&t3=114&id=284>

### Objective: Risk Profile

#### Percent of Objective Accomplished

**Contract Agreement Addendum: Exhibit II(B)**

**Contract #:** 24180

**Agency:** Marathon County Health Department

**Contract Year:** 2014

**Program:** Preventive Health and Health Services  
Block Grant

**Objective #:** 1 of 1

**Objective Value:** \$4,733

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 #:** 24180

**Agency:** Marathon County Health Department

**Contract Year:** 2014

**Program:** Radon Outreach

**Objective #:** 1 of 1

**Objective Value:** \$13,350

### Objective: Primary Details

#### Objective Statement

This objective is for calendar year 2014.

**Deliverable Due Date:** 01/31/2015

#### Contract Deliverable (Evidence)

Six-month reports, emailed by 7/31/14 and 1/31/15 to the Division of Public Health, document the activities and progress toward the negotiated annual target quantities specified in the Context section of this contract. Each report should be emailed as a single file, with all documents, photographs, etc. incorporated in the file, as required for our reports to US EPA.

#### Programs Providing Funds for this Objective

Radon Outreach: \$13,350

#### Agency Funds for this Objective:

#### Data Source for Measurement

Agency records:

Report of DHS bi-annually on the: number of media responses to news releases and other outreach with journal publications and broadcasts: journal and/or broadcast station names; the dates, lengths, and scanned images or the media's website versions of the stories. For Outreach to Professional, Trade and Other Groups needing to know about radon for their work: names of meetings and shows, venues, dates, attendance, and supporting information like announcements and agendas. For Response to Requests for Radon Information and Consulting: A tally of public requests from all channels: telephone, email, walk-in, etc. For Radon Proficiency Certification: Who at the agency is currently certified for radon measurement and mitigation proficiency. For Training and Stocking of Cooperating Local Agencies: A list of local public health agencies in the region and how they are trained and stocked with handouts, detectors and literature as appropriate, with brief information on what they have done. For Statewide and Regional Meetings: meetings RIC staff attended. For Database Development: Summary of measurement results added to the database. Field Site Visits: Number of sites visited.

#### Baseline for Measurement

During 2012: 1) OUTREACH VIA MEDIA: staff will have issued 2 news releases and other outreach to media, stimulating three reports on radon risk, testing and mitigation, in daily and weekly newspapers and broadcast media, radio and television.

2) OUTREACH TO PROFESSIONAL, TRADE AND OTHER GROUPS: During 2012, staff provided outreach to:

- 1-26-2012 Six presentations to 160 eighth-grade science students at Rhinelander Middle School
- 9-21-12 3M Employee Health Fair
- 11-1-12 Greenheck Corporation Health Fair
- 12-17-12 3M Radon presentation, 160 attendees

3) RESPONSE TO REQUESTS FOR RADON INFORMATION: During 2012, staff will have answered 300 requests for radon information and consulting. Requests may include those via 888 LOW RADON and other agency telephone numbers, email, and other forms of communication, and may be logged on 8.5 x 11 inch pads of paper kept near telephones and at the front desk.

Through December 31, 2012, MCHD Staff responded to 472 requests for radon information. In addition, for the year, there were 295 hits to the radon page on our departmental website.

## Contract Agreement Addendum: Exhibit II(B)

**Contract #:** 24180  
**Program:** Radon Outreach

**Agency:** Marathon County Health Department  
**Objective #:** 1 of 1

**Contract Year:** 2014  
**Objective Value:** \$13,350

4) RADON PROFICIENCY CERTIFICATION: During 2012, two staff will have maintained national proficiency certification for radon measurement and mitigation.

Certification Sara J Brown Michelle M. Schwoch \*

Residential Measurement Provider

NEHA NRPP ID 104700RT

Valid through 1/31/2014 NEHA NRPP ID 101537RT

Residential Mitigation Provider

NEHA NHRP ID 104701RMT

Valid through 1/31/2014 NEHA NHRP ID 101538RMT

5) TRAINING AND STOCKING OF COOPERATING LOCAL AGENCIES: During 2012, staff will have recruited or maintained contact with 11 cooperating public health agencies in their region, and assured they have any needed training and stocks of radon detectors and handouts. This was achieved through:

ζ Various emails to NorthCentral Wisconsin RIC counties.

ζ In 2012, a RIC meeting with counties within our RIC was not held as mini-grant funding being eliminated for 2013.

ζ 564 radon test kits provided radon to RIC Counties during 2012

6) STATEWIDE AND REGIONAL MEETINGS: During 2012, staff will have attended one meeting, statewide or regional, with DPH and other RICS. On June 12, 2012, there was a Statewide RIC Conference call.

7) DATABASE DEVELOPMENT: During 2012, staff will have maintained and developed a database of results from radon testing which they facilitated in their region, adding at least 400 test results. As of December 31, 2012, 788 records with radon results were added to the database. Those with results greater than 4 pCi/L are sent a follow up letter giving guidance on the need for a second test and/ mitigation.

8) FIELD SITE VISITS: During 2012, staff shall have visited one field site to consult on challenging and interesting radon measurement or mitigation situations. Site visits are to become better informed on what's occurring in the field while assisting the

## Contract Agreement Addendum: Exhibit II(B)

**Contract #:** 24180  
**Program:** Radon Outreach

**Agency:** Marathon County Health Department  
**Objective #:** 1 of 1

**Contract Year:** 2014  
**Objective Value:** \$13,350

public.

None occurred in 2012. We are fortunate to have several well experience radon contractors which impact this activity. Contractors reported installing 456 radon mitigations systems in the 12-county RIC.

**Context**

These activities shall be completed in 2014: 1) **OUTREACH VIA MEDIA:** Staff will have issued news releases and other public outreach, stimulating reports on radon risk, testing, and mitigation in major journal and broadcast media. Some of the outreach will have been done during January (National Radon Action Month), for synergy with outreach by other LPHAs, WI DPH and US EPA. Media interviewing the RIC will have been encouraged to also contact local businesses and residents for their radon stories; and to include the RIC telephone number and state website address, www.lowradon.org. 2) **OUTREACH TO PROFESSIONAL AND TRADE GROUPS:** Presentations will have been delivered by staff at meetings, shows, or conferences of groups that need to deal with radon as part of their work, such as realtors, home builders, code officials and health professionals. 3) **RESPONSE TO REQUESTS FOR RADON INFORMATION:** Respond to public requests for radon information and consulting. 4) **RADON PROFICIENCY CERTIFICATION:** National proficiency certification for radon measurement and mitigation will have been maintained by at least one staff working on radon, unless they have attended all recent annual RIC meetings, in which case after eight years of an individual being certified they may let their certification lapse. 5) **TRAINING AND STOCKING OF COOPERATING LOCAL AGENCIES:** Staff will traing cooperating local public health agencies in their region as interest arises and help with follow-up for elevated measurement results as needed. 6) **MEETINGS:** Staff will attend statewide conference calls and meetings of RICs and DPH. 7) **DATABASE DEVELOPMENT:** Staff will have add new results of radon measurements that they facilitated to a database. 8) **FIELD SITE VISITS:** Staff will visit sites to consult and become informed about challenging radon mitigations or measurements as funding and schedules permit.

**Context Continued**

**Input Activities**

See Context above.

**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 #: 24180

Agency: Marathon County Health Department

Contract Year: 2014

Program: Radon Indoor Radon RICs

Objective #: 1 of 1

Objective Value: \$2,766

### Objective: Primary Details

#### Objective Statement

This objective is for calendar year 2014.

**Deliverable Due Date:** 01/31/2015

#### Contract Deliverable (Evidence)

Six-month reports, emailed by 7/31/14 and 1/31/15 to the Division of Public Health, document the activities and progress toward the negotiated annual target quantities specified in the Context section of this contract. Each report should be emailed as a single file, with all documents, photographs, etc. incorporated in the file, as required for our reports to US EPA.

#### Programs Providing Funds for this Objective

Radon Indoor Radon RICs: \$2,766

#### Agency Funds for this Objective:

#### Data Source for Measurement

Agency records:

Report of DHS bi-annually on the: number of media responses to news releases and other outreach with journal publications and broadcasts: journal and/or broadcast station names; the dates, lengths, and scanned images or the media's website versions of the stories. For Outreach to Professional, Trade and Other Groups needing to know about radon for their work: names of meetings and shows, venues, dates, attendance, and supporting information like announcements and agendas. For Response to Requests for Radon Information and Consulting: A tally of public requests from all channels: telephone, email, walk-in, etc. For Radon Proficiency Certification: Who at the agency is currently certified for radon measurement and mitigation proficiency. For Training and Stocking of Cooperating Local Agencies: A list of local public health agencies in the region and how they are trained and stocked with handouts, detectors and literature as appropriate, with brief information on what they have done. For Statewide and Regional Meetings: meetings RIC staff attended. For Database Development: Summary of measurement results added to the database. Field Site Visits: Number of sites visited.

#### Baseline for Measurement

During 2012: 1) OUTREACH VIA MEDIA: staff will have issued 2 news releases and other outreach to media, stimulating three reports on radon risk, testing and mitigation, in daily and weekly newspapers and broadcast media, radio and television.

2) OUTREACH TO PROFESSIONAL, TRADE AND OTHER GROUPS: During 2012, staff provided outreach to:

- 1-26-2012 Six presentations to 160 eighth-grade science students at Rhinelander Middle School
- 9-21-12 3M Employee Health Fair
- 11-1-12 Greenheck Corporation Health Fair
- 12-17-12 3M Radon presentation, 160 attendees

3) RESPONSE TO REQUESTS FOR RADON INFORMATION: During 2012, staff will have answered 300 requests for radon information and consulting. Requests may include those via 888 LOW RADON and other agency telephone numbers, email, and other forms of communication, and may be logged on 8.5 x 11 inch pads of paper kept near telephones and at the front desk.

Through December 31, 2012, MCHD Staff responded to 472 requests for radon information. In addition, for the year, there were 295 hits to the radon page on our departmental website.

## Contract Agreement Addendum: Exhibit II(B)

**Contract #:** 24180

**Agency:** Marathon County Health Department

**Contract Year:** 2014

**Program:** Radon Indoor Radon RICs

**Objective #:** 1 of 1

**Objective Value:** \$2,766

4) RADON PROFICIENCY CERTIFICATION: During 2012, two staff will have maintained national proficiency certification for radon measurement and mitigation.

Certification Sara J Brown Michelle M. Schwoch \*

Residential Measurement Provider

NEHA NRPP ID 104700RT

Valid through 1/31/2014 NEHA NRPP ID 101537RT

Residential Mitigation Provider

NEHA NHRP ID 104701RMT

Valid through 1/31/2014 NEHA NHRP ID 101538RMT

5) TRAINING AND STOCKING OF COOPERATING LOCAL AGENCIES: During 2012, staff will have recruited or maintained contact with 11 cooperating public health agencies in their region, and assured they have any needed training and stocks of radon detectors and handouts. This was achieved through:

ζ Various emails to NorthCentral Wisconsin RIC counties.

ζ In 2012, a RIC meeting with counties within our RIC was not held as mini-grant funding being eliminated for 2013.

ζ 564 radon test kits provided radon to RIC Counties during 2012

6) STATEWIDE AND REGIONAL MEETINGS: During 2012, staff will have attended one meeting, statewide or regional, with DPH and other RICS. On June 12, 2012, there was a Statewide RIC Conference call.

7) DATABASE DEVELOPMENT: During 2012, staff will have maintained and developed a database of results from radon testing which they facilitated in their region, adding at least 400 test results. As of December 31, 2012, 788 records with radon results were added to the database. Those with results greater than 4 pCi/L are sent a follow up letter giving guidance on the need for a second test and/ mitigation.

8) FIELD SITE VISITS: During 2012, staff shall have visited one field site to consult on challenging and interesting radon measurement or mitigation situations. Site visits are to become better informed on what's occurring in the field while assisting the

## Contract Agreement Addendum: Exhibit II(B)

**Contract #:** 24180

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public.

None occurred in 2012. We are fortunate to have several well experience radon contractors which impact this activity. Contractors reported installing 456 radon mitigations systems in the 12-county RIC.

**Context**

These activities shall be completed in 2014: 1) **OUTREACH VIA MEDIA:** Staff will have issued news releases and other public outreach, stimulating reports on radon risk, testing, and mitigation in major journal and broadcast media. Some of the outreach will have been done during January (National Radon Action Month), for synergy with outreach by other LPHAs, WI DPH and US EPA. Media interviewing the RIC will have been encouraged to also contact local businesses and residents for their radon stories; and to include the RIC telephone number and state website address, www.lowradon.org. 2) **OUTREACH TO PROFESSIONAL AND TRADE GROUPS:** Presentations will have been delivered by staff at meetings, shows, or conferences of groups that need to deal with radon as part of their work, such as realtors, home builders, code officials and health professionals. 3) **RESPONSE TO REQUESTS FOR RADON INFORMATION:** Respond to public requests for radon information and consulting. 4) **RADON PROFICIENCY CERTIFICATION:** National proficiency certification for radon measurement and mitigation will have been maintained by at least one staff working on radon, unless they have attended all recent annual RIC meetings, in which case after eight years of an individual being certified they may let their certification lapse. 5) **TRAINING AND STOCKING OF COOPERATING LOCAL AGENCIES:** Staff will traing cooperating local public health agencies in their region as interest arises and help with follow-up for elevated measurement results as needed. 6) **MEETINGS:** Staff will attend statewide conference calls and meetings of RICs and DPH. 7) **DATABASE DEVELOPMENT:** Staff will have add new results of radon measurements that they facilitated to a database. 8) **FIELD SITE VISITS:** Staff will visit sites to consult and become informed about challenging radon mitigations or measurements as funding and schedules permit.

**Context Continued**

**Input Activities**

See Context above.

**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 #:** 24180  
**Program:** Wisconsin Well Woman

**Agency:** Marathon County Health Department  
**Objective #:** 1 of 1

**Contract Year:** 2014  
**Objective Value:** \$38,097

### Objective: Primary Details

**Objective Statement**

Template Objective 1:

By September 30, 2014, eighty eight (88) Marathon 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 Marathon 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: \$38,097

**Agency Funds for this Objective:**

**Data Source for Measurement**

Agency records.

**Baseline for Measurement**

We typically enroll well over 200 women each year in this program.

**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**

As instructed, we will continue to use existing methods and systems to enroll participants into the WWWP. We look forward to guidance from State Program Staff on prioritizing which 88 women will receive services in 2014 and how the implementation of the Health Care Exchange System will impact the WWWP.

### 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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