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| **DEPARTMENT OF HEALTH SERVICES** Division of Public Health F-01611 (11/2022) | **STATE OF WISCONSIN**Page 1 of 6 |
| **AGENCY:**      **2023 MATERNAL CHILD HEALTH (MCH) SUPPLEMENT TO GAC**  |
| ***Instructions for the 2023 MCH contracting process:***1. In GAC, local agencies need to select 2023 MCH objectives, assign value, and click the notification button.
2. Local agencies will then complete a GAC Supplement for each objective selected and send to their MCH contract monitor via email.
3. Contract monitors will review the GAC Supplements and notify agencies of approval or recommended edits.
4. When GAC Supplements are finalized and approved, both parties enter negotiation notes in GAC, and contract monitor will sign off in GAC.
5. Negotiations must be completed by November 15, 2022.
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| **Objective** | **Strategy or Strategies** |
| [ ]  Social Connections | [ ]  Assess need for improvement with social connections within community and implement at least one practice change to enhance family, youth and community engagement and social connection for the MCH population. |
| [ ]  Breastfeeding | [ ]  Support workplaces and/or childcare sites to become breastfeeding friendly. |
| [ ]  Enhance local community coordination to improve continuity of care by strengthening consistent implementation of prenatal, maternity care, and postpartum practices that support breastfeeding.   |
| [ ]  Developmental Screening | [ ]  Collaborate to promote awareness, education, and programing for advancing developmental monitoring and screening within your community.  |
| [ ]  Promote education and training of the public health workforce to increase skill and competency in completing an evidence-based developmental screening.  |
| [ ]  Adolescent Well-Being | [ ]  Coordinate and/or facilitate skills-based, gate keeper, risk behavior recognition, and other evidence-based suicide prevention and mental health promotion trainings with local community coalitions and other partners.  |
| [ ]  Collaborate with local schools on the implementation of evidence-based suicide prevention programs and/or collaborate with local schools on development and implementation of evidence-based bullying prevention policies and strategies that promote belonging and safety. |
| [ ]  Promote Zero Suicide principles and practices with health care providers and health care systems. |
| [ ]  Health Equity and Community Engagement | [ ]  Implement one practice change to enhance family, youth, and community engagement and one additional practice change to advance health equity for the MCH population. |
| [ ] Perinatal Mental Health | [ ]  Implement at least 2 practice changes to improve screening and follow-up services for perinatal mood and anxiety disorders. |
| [ ]  Physical Activity and Nutrition | [ ]  Partner with programs such as UW Extension and FoodWise to support health in children ages 6-11 years old. |
| [ ]  Partner with K-5 schools and local partners on school wellness requirements |
| [ ]  Partner with local afterschool/out of school time programs and community organizations to support opportunities for improved physical activity and nutrition in children |
| **Justification for Selecting Objective: Required**  |
| Provide the **rationale and baseline data** for selecting continued work on objective or new objective and strategy.  |       |
| Describe the **coalition or collaborative group(s)** that supports your MCH work. |       |
| **Input Activities** |
| **Agency Activities** |  |
| Describe how your agency will address each of the core activities identified in the GAC objective. (Add more lines as needed) | **Responsible Person** |
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| * Participate in all quarterly Learning Community meetings/calls as applicable, and attend

the virtual 2023 MCH Summit. |  |
| * Report in REDCap
* Maintain a link to the Well Badger Resource Center website and searchable directory at: [www.WellBadger.org](http://www.WellBadger.org)
* Display and provide marketing information and referral resources and services for Well Badger.
* Provide a voice message for the Well Badger MCH/First Step Resource Line:

Call: 1-800-642-7837Text: 608-360-9328Email: help@wellbadger.org |       |

**SOCIAL CONNECTION**

**Strategy 1**: Implement the action plan to support at least one practice change to enhance family, youth, and community engagement and social connection for the MCH population.

Core Activities:

* Assess need for improvement with social connections within community, may be related to environment, safe stable housing, community connections, social support, social isolation, schools and childcare, community development, and neighborhood safety.
* Results from needs assessment, community health assessment or community health improvement plan can be used.
* Outreach, recruit and support sustained partnerships.
* Enhance community engagement to inform, develop and implement social connections activities. Complete the Community Engagement Assessment Tool [Community Engagement Assessment Tool](https://www.dhs.wisconsin.gov/mch/family-youth-community-engagement.htm). Develop an action plan focusing on one indicator from the Community Engagement Assessment Tool. Implement the action plan to support at least one practice change to enhance family, youth, and community engagement.
* Collaborate with community partners to promote consistent messaging throughout the community.

**BREASTFEEDING**

**Strategy 1**: Support **workplaces and/or childcare sites** to become breastfeeding friendly.

Core Activities:

* Collaborate with the Wisconsin Breastfeeding Coalition and utilize available resources.
* Outreach, recruit and support sustained partnerships.
* Assist site to complete an assessment and in making improvements to policies and practices, based on assessment results.
* Assure recognition of breastfeeding friendly status.
* Enhance community engagement to inform breastfeeding strategies and activities. Complete the Community Engagement Assessment Tool. [Community Engagement Assessment Tool](https://www.dhs.wisconsin.gov/mch/family-youth-community-engagement.htm). When possible, include family and community representatives who are engaged with breastfeeding activities in the assessment process. Develop an action plan focusing on one indicator from the Community Engagement Assessment Tool. Implement the action plan to support at least one practice change to enhance family, youth, and community engagement.

(This activity is listed as input activity #2 in the objectives)

* Participate in webinars provided by contracted partner.
* Collaborate with community partners to promote consistent messaging throughout the community.

**Strategy 2**: Enhance local **community** **coordination** to improve continuity of care by strengthening consistent implementation of prenatal, maternity care, and postpartum practices that support breastfeeding.

Core Activities:

* Outreach, recruit and support sustained partnerships with community stakeholder(s) (e.g., parent or family organizations, home visiting agencies, faith-based organizations, hospitals, and clinics).
* Facilitate local connections and improvements to breastfeeding friendly policies and practices.
* Enhance community engagement to inform breastfeeding strategies and activities. Complete the Community Engagement Assessment Tool. [Community Engagement Assessment Tool](https://www.dhs.wisconsin.gov/mch/family-youth-community-engagement.htm). When possible, include family and community representatives who are engaged with breastfeeding activities in the assessment process. Develop an action plan focusing on one indicator from the Community Engagement Assessment Tool. Implement the action plan to support at least one practice change to enhance family, youth, and community engagement. (This activity is listed as input activity 2 in the objectives)
* Participate in webinars provided by contracted partner.
* Collaborate with community partners to promote consistent messaging throughout the community.

**DEVELOPMENTAL SCREENING**

**Strategy 1**: Collaborate to promote awareness, education, and programing for advancing developmental monitoring and screening within your community.

Core Activities:

* Collaborate with statewide technical assistance provider to implement available tools and resources and specifically use and promote the CDC Learn the Signs Act Early Material and or implement the CDC WIC Developmental Milestones Checklist Program to promote developmental monitoring and screening.
* Outreach and recruit community groups (e.g., parent or family organizations, home visiting agencies, churches, businesses).
* Provide trainings/education for community groups to support implementation of developmental monitoring and screening practices, using tools and resources with common messaging.
* Promote other resources such as HealthCheck and Lead Screening and, resources for coordinated referrals and follow-up services.

**Strategy 2:** Promote education and training of the **public health workforce** to increase skill and competency in completing an evidence-based developmental screening.

Core Activities:

* Collaborate with the statewide technical assistance provider and utilize and promote specifically the CDC Learn the Signs Act Early Material.
* Coordinate, organize and host a professional developmental screening training.
* Partner with an expert (i.e., Brookes Professional Development Coordinator) to provide training to event participants on the fundamentals of ASQ-3 developmental screening administration.
* Outreach to promote training with multiple agencies that may benefit (i.e., childcare providers/agency, bordering health departments, home visiting, tribal community health)

**ADOLESCENT WELL-BEING (Note: numbers 2-5 are required regardless of the strategy selected for number 1.)**

1. Implement and evaluate the selected strategy with activity details identified in the 2023 Supplement to GAC Objective

Strategy 1: Coordinate and/or facilitate skills-based, gate keeper, risk behavior recognition, and other evidence-based suicide prevention and mental health promotion trainings with local community coalitions and other partners.

Core Activities:

* Collaborate with statewide technical assistance provider and local mental health or suicide prevention coalitions to promote gatekeeper trainings such as QPR (Question, Persuade and Refer), Youth Mental Health First Aid, ASIST (Applied Suicide Intervention Skills Training), Connect Training, adverse childhood experiences and trauma-informed care education/training.
* Collaborate with law enforcement and community partners on strategies to restrict means such as distribution of firearm locks and access to medication drop boxes.

Strategy 2: Collaborate with local schools on the implementation of evidence-based suicide prevention programs and/or collaborate with local schools on development and implementation of evidence-based bullying prevention policies and strategies that promote belonging and safety.

Core Activities:

* Collaborate with statewide technical assistance provider Wisconsin and/or local suicide coalitions in the planning and implementation of evidence-based suicide prevention programs, such as: [Trevor Lifeguard Workshop](http://www.sprc.org/resources-programs/trevor-lifeguard-workshop); [ACT on FACTS](http://www.sprc.org/resources-programs/making-educators-partners-youth-scuicide-prevention-act-facts); [Signs of Suicide](http://www.sprc.org/resources-programs/sos-signs-suicide); [Hope Squad](https://hopesquad.com/); [Sources of Strength](https://sourcesofstrength.org/).
* Utilize and promote anti-bullying resources from the Wisconsin Department of Public Instruction - Promote peer support resources, such as The Prism Program (LGBTQ+ specific), Youthline, and Iris Place peer support warmline.

Strategy 3: Promote Zero Suicide principles and practices with health care providers/health care systems.

Core Activities:

* Collaborate with statewide technical assistance partner and local suicide coalitions to implement the [Zero Suicide toolkit](http://zerosuicide.sprc.org/toolkit) with health care providers and health care system.
* Coordinate and/or provide training to Emergency Departments (ED) utilizing available resources (e.g., ED focused tools from Zero Suicide, CALM (Counseling on Access to Lethal Means) training and include planning for continuity of care after an ED visit.
1. Encourage area middle and high schools to participate in the Youth Risk Behavior Survey through the Department of Public Instruction and to utilize results in program planning.
2. Complete the [Community Engagement Assessment Tool](https://www.dhs.wisconsin.gov/mch/family-youth-community-engagement.htm) and implement at least one practice change, informed by the results, that increases youth leadership and engagement.
3. Participate on the local CDR team and ensure reporting in the National Case Reporting System, to align with the team's prevention recommendations. \* Note: For those jurisdictions with no CDR team, consult with your contract monitor.
4. Outreach, recruit, and support sustained partnerships around improving adolescent well-being.

**HEALTH EQUITY AND COMMUNITY ENGAGEMENT**

**Strategy 1:** Implement one practice change to enhance family, youth, and community engagement and one additional practice change to advance health equity for the MCH population.

Core Activities:

1. Complete assessments utilizing the following tools:
* Community Engagement Assessment Tool [Community Engagement Assessment Tool](https://www.dhs.wisconsin.gov/mch/family-youth-community-engagement.htm).
* When possible, include family, youth and/or community representatives in the assessment process
* Agencies completing a Community Engagement Assessment Tool for the breastfeeding or nutrition and physical activity objective do not need to complete a second assessment; however, they do need to implement an additional practice change related to the health equity objective, informed by the assessment results.
* Foundational Practices Checklist. [Foundation Practices for Health Equity](https://www.mchnavigator.org/documents/FoundationalPracticesforHealthEquityLearningandActionTool.pdf). If a health equity assessment tool was completed in a previous year, it is not necessary to repeat the assessment.
1. Develop an action plan focusing on one indicator from the Community Engagement Assessment Tool and one of the Foundational Practices.
2. Implement the action plan to support one practice change to enhance family, youth, and community engagement and one additional practice change to advance health equity.
3. Identify the impact or potential impact of the practice changes.
4. Collaborate with the MATCH Group to utilize available training and tools.

**PERINATAL MENTAL HEALTH**

**Strategy 1:** Implement at least 2 practice changes to improve screening and follow-up services for perinatal mood and anxiety disorders.

Core Activities:

1. Identify the scope for the perinatal mental health objective to:
	1. Improve services within a program area that currently provides screening for perinatal mood and anxiety disorders (i.e., PNCC, home visiting).
	2. Implement new services within a program area that engages pregnant and postpartum women but does not currently provide screening (i.e., WIC, well child services).
2. Utilize a Quality Improvement process to test and implement changes in at **least 2 of the 4** areas identified below. *Examples of practice changes are listed below:*
	1. Screening
* Policy and procedures for screening that identify validate, standardized tools and periodicity schedule
* Guidance for initiating the screening process that focuses on building relationships and ongoing conversations
* Guidance for sharing screening results with families
* Reminder system for rescreens
	1. Referral and Follow-up
* Policy and procedures for referral and linkage to services for women who screen positive
* Policy and procedures to assess and respond to suicide risk
* Tracking system for referrals
	1. Support materials and discussion points related to identifying personal supports, scheduling breaks, getting sleep, and other support strategies.
	2. Workforce:
* Education of public health providers utilizing the Perinatal Mental Health Training Modules
* Enrollment of public health and health care providers in The Periscope Project to receive consultation with a perinatal psychiatrist, information on community resources, and education (https://the-periscope-project.org)

**PHYSICAL ACTIVITY AND NUTRITION**

**Strategy 1**: Partner with programs such as **UW Extension and FoodWise** to support health in children ages 6-11 years old.

Core Activities:

* Develop partnership with programs such as UW Ext and FoodWise.
* Collaboratively identify gaps in services within communities.
* Partner with local Extension staff to collaborate on a local project, program or practice change that relates to the objective and DHS Title V PAN Survey Results. [PAN Survey Results](https://www.dhs.wisconsin.gov/publications/p02955.pdf)

Enhance PSE knowledge for the MCH workforce to inform PAN strategies and activities centered in health equity.

* + - Complete the Systems Approaches for Healthy Communities online training if this is the **first** year your agency chooses this objective. Expand capacity building with partners to strengthen PSE collaborations and impact (e.g., community residents, community organizations). This course can be completed with community partners and resident leaders.
		- **If 2023, will be the second year** of this MCH objective complete the Community Engagement Assessment Tool. (When possible, include family and community representatives who are engaged with activities in the assessment process.)
			* Develop an action plan focusing on one indicator from the Community Engagement Assessment Tool.
			* Implement the action plan to support at least one practice change to enhance family, youth, and community engagement.

**Strategy 2**: Partner with **K-5 schools and local partners** on **school wellness** requirements.

Core Activities:

* Outreach, recruit, or leverage existing partnership with at least 1 K-5 school and offer assistance in completing their school wellness assessment. (Alliance for a Healthier Generation, CDC, or Action for Healthy Kids)
* Support K-5 schools in updating their school wellness policy based on the data collected in the assessment.
* Participate in the school wellness committee.
* Partner with the school on implementing new opportunities or support ongoing activities that align with the WI DHS Title V PAN survey results.
* Enhance PSE knowledge for the MCH workforce to inform PAN strategies and activities centered in health equity.
* Complete the Systems Approaches for Healthy Communities online training if this is the **first** year your agency chooses this objective. Expand capacity building with partners to strengthen PSE collaborations and impact (e.g., community residents, community organizations). This course can be completed with community partners and resident leaders.
* **If 2023, will be the second year** of this MCH objective complete the Community Engagement Assessment Tool. (When possible, include family and community representatives who are engaged with activities in the assessment process.)
* Develop an action plan focusing on one indicator from the Community Engagement Assessment Tool.
* Implement the action plan to support at least one practice change to enhance family, youth, and community engagement.

**Strategy 3:** Partner with local **afterschool/out of school time programs and community organizations** to support opportunities for improved physical activity and nutrition in children.

Core Activities:

* Partner with the local afterschool/out of school time programs and youth serving community organizations on implementing new opportunities or support ongoing activities that align with the WI DHS Title V PAN survey results.
* Enhance PSE knowledge for the MCH workforce to inform PAN strategies and activities centered in health equity.
* Complete the Systems Approaches for Healthy Communities online training if this is the **first** year your agency chooses this objective. Expand capacity building with partners to strengthen PSE collaborations and impact (e.g., community residents, community organizations). This course can be completed with community partners and resident leaders.
* **If 2023, will be the second year** of this MCH objective complete the Community Engagement Assessment Tool. (When possible, include family and community representatives who are engaged with activities in the assessment process.)
* Develop an action plan focusing on one indicator from the Community Engagement Assessment Tool.
* Implement the action plan to support at least one practice change to enhance family, youth, and community engagement.