III.C. Five-Year Needs Assessment Summary
(as submitted with the FY 2021 Application/FY 2019 Annual Report)

III.C.2.a. Process Description

The Wisconsin 2020 MCH Needs Assessment began in October 2018 under the leadership of Epidemiologist and Evaluator, Stephanie West, PhD; State Systems Development Initiative Coordinator, Katrina Alber, MPH; and Health Equity Coordinator, Nafla Poff, MPH. An internal Needs Assessment Core Team was formed to provide oversight and guidance to the process, and is composed of Sharon Fleischfresser, MD, MPH, CYSHCN Medical Officer; Jody Brassfield, Family Health Section Chief; Katie Gillespie, DNP, RN, Title V Director and MCH Unit Supervisor; Anne Odusanya, DrPH, MPH, CYSHCN Unit Supervisor; Mariah Geiger, MPH, Adolescent Health Coordinator; Fiona Weeks, MSPH, MCH Epidemiologist; Paige Andrews, MPH, Injury Strategic Planner; and Angela Rohan, PhD, CDC assignee and Senior Maternal and Child Health Epidemiologist. The Core Team convened monthly to make decisions regarding Needs Assessment planning and implementation and assure alignment with the larger DPH activities including the statewide health assessment for public health accreditation. Additional persons contributing to oversight and guidance for the 2020 MCH Needs Assessment include liaisons from the Wisconsin State Health Assessment team; Susan Uttech, Policy Initiatives Executive; Margarita Northrop, Office of Policy and Practice Alignment; Abigail Eskenazi, Lead for Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Needs Assessment; and Thomas Hinds, epidemiologist from the Wisconsin Department of Children and Families.

Needs Assessment activities were guided by adapting the framework from the National Association of County and City Health Officials (NACCHO) Mobilizing for Action through Planning and Partnership (MAPP) guide, aiming to identify and build upon the existing strengths and assets in Wisconsin's communities and identify the largest needs for Title V throughout the state. The process included these major phases, described in detail below: Planning and creation of four MAPP assessments and supplemental assessments; Stakeholder engagement; Data collection to identify MCH population strengths and needs; Assessment of Title V program and staff capacity; Data analysis and synthesis; Selection of Priority Needs and performance measures; and Strategic planning.

MAPP Assessments and Supplemental Assessments: This included an assessment of community health status indicators, providing quantitative information on community health conditions by collecting national, state, and programmatic data to answer the question: "What health conditions currently exist in our community/state?" Across all population domains, Wisconsin performed either slightly better or similar to the rest of the country**.** However, **vast disparities were identified in all domains across race and ethnic minority groups.**

MAPP 2 included an online survey and community conversations. The online survey assessed the strengths and assets that exist in communities around the state, and was promoted throughout the state for one month, collecting 379 responses. 94 additional responses were collected via iPad by sending an epidemiologist and Health Equity Coordinator to MCH/CYSHCN-related conferences around the state. Secondly, 59 community conversations were held with community members around the state; 38 were conducted through local and tribal health agencies, and 21 were facilitated by state staff with other groups.

MAPP 3 included a Public Health Systems Survey emailed to primary stakeholders and their relevant partners. It measured how partners work together and identified strengths and weaknesses of the public health system. Of 369 total responses, 241 respondents identified being primary partners of MCH, and 132 of CYSHCN.

MAPP 4 assessment, or Forces of Change, was an interactive activity conducted at 29 partner and stakeholder meetings between November 2018 and June 2019. The assessment helped identify forces, opportunities, and threats that may affect a community, in an effort to find the best ways to take action.

Supplemental assessments created by state staff include:

1. Child Health Improvement Survey: Sent to primary care providers in Wisconsin, with 98 responses identifying topics influencing overall health of children, and areas providers are interested in working on in the future to improve child health.

2. Staff Capacity Survey: Sent to Title V Program staff, with 24 respondents identifying skill level across priority competencies.

3. Environmental scan of all recent local Community Health Needs Assessments: This ensured representation from all counties and alignment with locally identified needs. 185 assessments were reviewed, including 92 from hospital systems, 82 local health departments, and 11 tribal health agencies.

Stakeholder Engagement: Stakeholders and families had multiple avenues to offer input throughout the Needs Assessment process. This was done by engaging the MCH Advisory Committee, CYSHCN Directors meetings, sending MAPP 3 assessments to primary stakeholders, involving primary care providers through the Child Health Assessment, conducting 29 Forces of Change activities at partner meetings, hosting 21 Community Conversations with PATCH Youth leaders and CYSHCN families, and hosting 38 Community Conversations with families through local and tribal health agencies.

Quantitative and qualitative methods: Quantitative methods used to assess strengths and needs of the MCH/CYSHCN population in Wisconsin include summary statistics, confidence intervals, p-values and significance testing where possible, used to analyze existing state and national data from each of the five population health domains from multiple data sources including CDC Wonder, Vital Statistics, Wisconsin's Interactive Statistics on Health (WISH), Hospital Discharge data, Pregnancy Risk Assessment Monitoring System (PRAMS), American Community Survey (ACS), Wisconsin Sexually Transmitted Diseases (STD) program, Behavioral Risk Factor Surveillance System (BRFSS) survey, Youth Risk Behavior Surveillance System (YRBSS) survey, National Survey of Children's Health and National Immunization Survey for Children (NIS-Child). Data were also stratified by key subpopulations such as age, race/ethnicity, income, education and public/private insurance status. This assessment was derived from the MAPP 1 assessment provided by NACCHO. Additionally, two MCH Title V Summer Interns prepared data placemats (Figure 1) in 2019 for each MCH population domain, designed to share a large amount of relevant quantitative data easily with the general public. These placemats were shared with partners and stakeholders. The interns created data tables for each population domain, including data and stratification of data gathered (Figure 2). These color-coded tables display statistically significant data organized by: higher in the state than the U.S.; lower in the state than in the U.S.; high amount of inequity (across subpopulations, such as seen across race/ethnicity); and no differences found.

Domain tables were used by the core Needs Assessment team for consultation and analysis, and an additional subset of socioeconomic data was pulled from the ACS to incorporate specific social determinants of health, helping to identify upstream areas for improvement.

The MAPP 2 online survey was distributed to Wisconsin residents through avenues including public health conferences, dissemination to community members by Title V partners, and posting to the Wisconsin Title V webpage. The public health systems survey created from the MAPP 3 assessment was distributed to all public health professionals throughout the state. The Child Health Provider Survey was created in conjunction with American Academy of Pediatrics (AAP) and the Quality Improvement Director, Arianna Keil. Survey responses were collected using SurveyGizmo and analyzed by state epidemiologists using techniques such as frequencies, summary statistics, p-values, chi-square and t-tests.

Qualitative data was recorded at each MAPP 2 (Community Conversation) and MAPP 4 (Forces of Change) activity, then transcribed and uploaded into Dedoose, an online program for qualitative coding and analysis. A team of data experts reviewed each activity for initial coding of themes identified. These themes were then reviewed together for a consensus on defined and refined codes for inter-reviewer reliability, and were re-coded a final time for alignment across reviewers. These final qualitative themes were added to the master matrix of themes for later consultation.

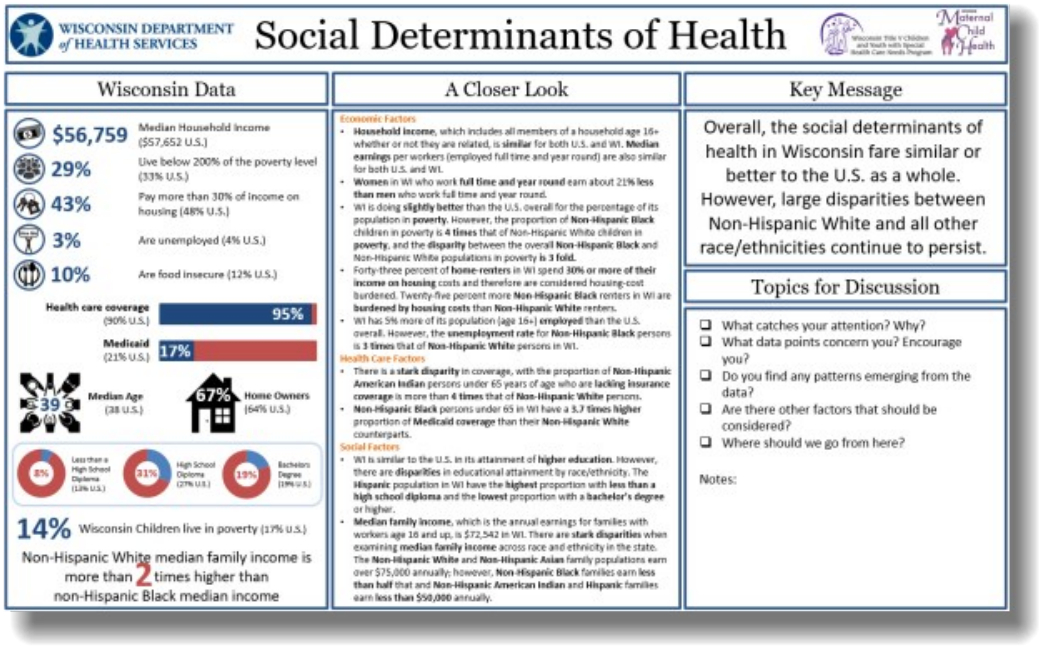
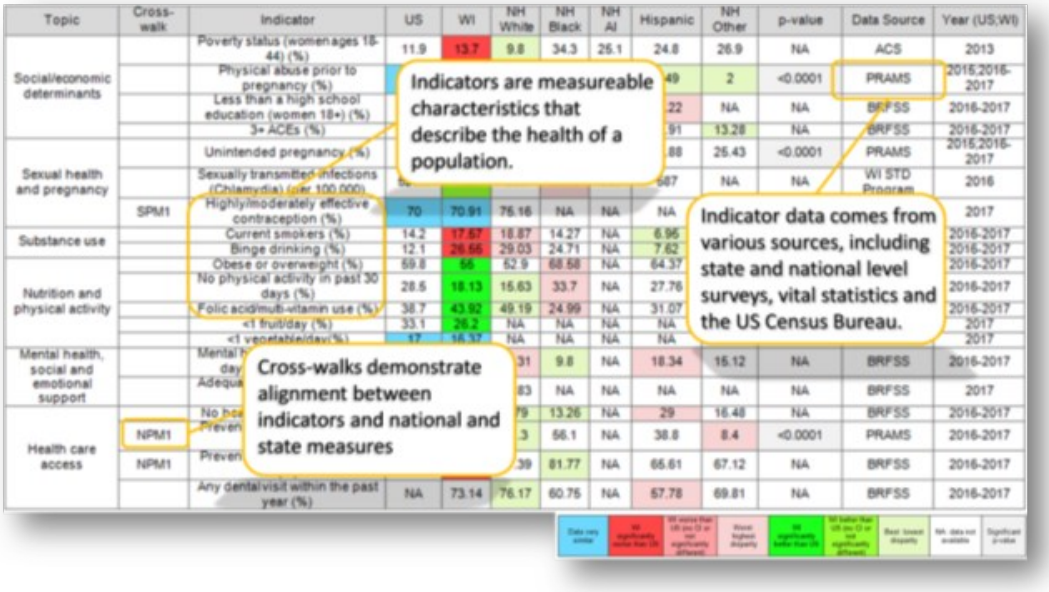


Figure 1: One of several population placemats created by MCH Title V Summer Interns using findings from the 2020 MCH Needs Assessment

Interface between the collection of Needs Assessment data, the finalization of the state's Title V priority needs and the development of the State Action Plan: A subgroup of the core team formed a team to analyze the collected data. They grouped all findings into a master matrix that included 520 themes overall. Then, another subgroup – the matrix team – narrowed the 520 themes to 12 main categories. Next, the entire core team reconvened to form a list of proposed priorities to present to leadership and stakeholders.

Figure 2: Snapshot of the MAPP 1 Database created by MCH Title V Summer Interns



The 12 categories, along with data placemats for each population domain and a summary of findings from each

assessment, were shared at an all-day retreat for Title V Program Leadership. There, the 12 categories became Wisconsin's 7 Priority Needs for 2021-2025. From these 7 Priority Needs, 12 potential performance measures were identified to address in 2021 – 2025. These performance measures were proposed to the DPH Leadership including Wisconsin's State Health Officer Jeanne Ayers, the MCH Advisory Committee, and multiple stakeholder groups around the state for feedback and buy-in.

Once the Priority Needs and performance measures were agreed upon by leadership and stakeholders (October 2019), a performance measure lead and lead epidemiologist were assigned to each NPM/SPM to begin the planning process and to start building the state action plans for 2021. Performance measure leads are responsible for convening planning meetings with subject matter experts and relevant partners to the NPM/SPM topic. The lead epidemiologist is responsible for identifying ESMs associated with each NPM/SPM and ways to measure each proposed strategy included on the action plan.

III.C.2.b. Findings

III.C.2.b.i. MCH Population Health Status

Infant/Perinatal: Overall, Wisconsin is doing better than the nation in regards to preterm and low birth weight rates, perinatal regionalization, Medicaid paid births, and infants being put to sleep on their backs. Strengths and disparities across racial and ethnic groups were identified. White women have the lowest rates of preterm and Medicaid paid births, highest rates of ever breastfed, and sleep-related SUID deaths. Non-Hispanic (NH) Black women have the highest rates of very low birth weight babies and infant well-visits. NH American Indian women have the highest rate of neonatal abstinence syndrome and cesarean delivery at first birth. Hispanic women have the lowest rate of low birth weight babies and infant mortality, and highest rate of infants ever breastfed. Women who identify as NH Other have the highest rate of putting infants to sleep on their backs and lowest rates of neonatal abstinence syndrome. Racial/ethnic disparities are particularly striking in regards to preterm and low birth weight rates, Medicaid paid births, infants being put to sleep on their backs, infants ever breastfed, sleep-related SUID deaths, neonatal abstinence syndrome, and infant mortality.

More than 1 in 4 first births in Wisconsin are Cesarean deliveries, which is slightly higher than the US average (21.9%). NH American Indian women have the highest rate of first-birth Cesareans (32.4%). The percentage of NH Black infants ever breastfed is about half that of NH White infants in Wisconsin. The infant mortality rate in Wisconsin is equivalent to the US infant mortality rate (6 per 1,000 births), however NH Black families experience the loss of a child prior to their first birthday at a rate 2.6 times that of NH White families.

Child: Wisconsin is doing better than the nation overall regarding the proportion of children living in supportive neighborhoods, living in poverty, having good overall and dental health, receiving care within a medical home, developmental screening, systems of care, and receiving care for medical, dental and mental/behavioral health conditions. However, racial/ethnic disparities are particularly striking in regards to adverse childhood experiences, poverty, being physically active for 60 minutes a day, care within a medical home, and living in a safe neighborhood. Strengths across racial and ethnic groups were identified. White children have the lowest rates of adverse childhood experiences and poverty, and the highest rates of physical activity and care within medical home. Hispanic children have the lowest rates of physical activity and secondhand smoke within the home, and the highest rates of being overweight/obese and having excellent or very good health. NH Other children have the lowest rates of excellent or very good health, and highest rate of preventive visits for both medical and dental in past year and living in supportive environments.

For both the US and Wisconsin, about half of all children with a mental or behavioral condition receive treatment. Nearly half of children in the US and Wisconsin receive care within a medical home. In Wisconsin, however, the proportion of NH White children (56%) that receive care within a medical home is more than 3 times higher than their NH Black counterparts (17.9%). Wisconsin is outperforming the US in its proportion of children that receive developmental screening (37% compared to 31%), and similar to the US for up-to-date vaccinations in young children (80% Wisconsin and 81% US).

Only about 12% of children in Wisconsin are reported to have received health care within a well-functioning system, similar to the US percentage. Health care access for children in Wisconsin is similar to or worse than the US and varies by

racial/ethnic group. When it comes to preventive dental care, Wisconsin and the US have a comparable proportion of children receiving a preventive dental visit in the previous year (about 80%). However, in Wisconsin, 17% fewer NH American Indian children receive preventive dental visits than NH White children. Similarly, the proportion of Wisconsin children receiving a preventive medical visit in the past year is equal to the US at 82%. However, NH American Indian children again have the lowest proportion receiving preventive medical visits (30% lower than NH Black children). Nearly 70% of children both in the US and Wisconsin have received both preventive dental and medical visits in the past year. However, in Wisconsin, only 46% of NH American Indian children and 55% of Hispanic children received both preventive dental and medical visits in the past year. When it comes to Wisconsin's oral health, NH American Indian children fare worse when compared to other racial/ethnic groups. They experience a 3-fold higher proportion of children with cavities or tooth decay than NH Black children, who have the lowest proportion of poor oral health among the represented racial/ethnic groups at 7.1%. Wisconsin and the US have a similar percentage of children with special health care needs (17.8% and 18.8% respectively). However, NH Black children are disproportionately affected with a proportion that is higher than the state average and all other racial and ethnic groups by about 10% or more.

Wisconsin is doing worse than the nation in regards to adequate health insurance (69.6% compared to 74.4%), Children in NH White families are families less likely to have adequate health insurance (66.9% NH white, compared to 80.8% NH Black). Wisconsin is also doing worse than the nation in regards to vaccination series (79.4% compared to 80.8%). The subpopulations at greatest risk include adolescents and NH Whites. Wisconsin has approximately the same level of obese/overweight children, and physical inactivity as the nation – 76% are not active at least 20 minutes per day. Those at higher risk include NH American Indian (11.2% physically active for 60 minutes a day) and NH Black children (12.9% physically active for 60 minutes a day).

CYSHCN: Overall, Wisconsin is doing better than the nation in regards to CYSHCN that live in a supportive neighborhood, receive care within a medical home, receive services to make transition to adult care, and have parents that feel like a partner in decision-making. The analysis did not have sufficient data to examine differences by race/ethnicity between the US and Wisconsin.

Analysis of medical home within this population domain included all children, with CYSHCN as one subpopulation. Nearly half of children in the US and Wisconsin receive care within a medical home. In Wisconsin, however, 56% of NH White children receive care within a medical home, which more than 3 times higher than their NH Black counterparts (17.9%). A higher proportion of CYSHCN ages 12-17 received necessary services to make the transition to adult care in Wisconsin (19.1%) than the US (16.7%). Nearly 75% of CYSHCN in Wisconsin receive coordinated services, which is similar to that of the US (72.8%). However, only 59.3% of Hispanic CYSHCN receive coordinated services.

Adolescent: Overall, Wisconsin is doing better than the nation in regards to adolescents living in supportive neighborhoods, having good overall health, using contraception, receiving the HPV vaccine, experiencing depression, seriously considering suicide, smoking cigarettes, using prescription drugs without a prescription, having preventive dental visits, and receiving care within a medical home. Strengths across racial and ethnic groups were identified. White adolescents have the lowest rates of teen births, oral health problems, depression, seriously considering suicide, using prescription drugs without a prescription, and highest rates of receiving care within a medical home, and engaging in daily physical activity. NH Black adolescents have the lowest rates of excessive alcohol use, being bullied at school, and suicide deaths. Hispanic adolescents have the lowest rates of adverse childhood experiences, smoking cigarettes, dating violence, and death. NH Other adolescents have the lowest rates of chlamydia, texting or emailing while driving, riding with driver who had been drinking alcohol, chlamydia, and highest rates of living in a supportive neighborhood, good overall health, receiving a preventive medical visit, and living within a safe neighborhood. Racial/ethnic disparities are particularly striking in regards to overall health, oral health problems, teen births, chlamydia, using prescription drugs without a prescription, being bullied at school, dating violence, and living in a safe neighborhood.

The proportion of Wisconsin adolescents (31.6%) ages 12-17 who have experienced two or more ACEs is slightly higher than the US (27.7%). Wisconsin (53.8%) is doing similarly to the US (56%) among adolescents (ages 12-17) who report

living in a supportive neighborhood. About 9 out of 10 Wisconsin adolescents report being in excellent or very good health in Wisconsin, which is similar to the US overall. Oral health for Wisconsin teens is similar to that of the US as a whole when reporting on the presence of decayed teeth or cavities in the past 12 months (8% and 10%, respectively). Nearly 80% of adolescents in Wisconsin (ages 12-17) report receiving a preventive medical visit in the past year. Greater than 1 in 4 Wisconsin adolescents felt sad or hopeless nearly every day for at least two weeks in the past year, which is slightly lower than the rest of the nation (31.5% US). Similar to the US, 16.4% of Wisconsin teens report having seriously considered suicide. The proportion of Wisconsin youth (16.4%) who report consuming 5+ alcoholic drinks in a row during the past 30 days is similar to the US (17.7%).

In Wisconsin, more teens report being bullied at school than the US (24% and 19%, respectively). Wisconsin's rate (196.7) of adolescent injury-related hospital admissions per 100,000 is nearly double the US (95.5). Significantly more Wisconsin teens report texting or emailing while driving compared to the US (45.7% and 39.2% respectively). 17.4% of Wisconsin teens reported riding with a driver who had been drinking alcohol, which is 3 times higher than the US (5.5%). Wisconsin (10.2%) and the US (9.7%) fare similarly in percent of adolescents who report experiencing dating violence. Wisconsin and the US have a similar rate of adolescent deaths caused by motor vehicle crashes at about 11 deaths per 100,000 youth ages 15-19. Wisconsin (13.7) and the US (13.3) fare similarly in the rate of adolescent suicide per 100,000. The rate of death among Wisconsin youth ages 10-19 is very similar to the US rate at 33.4 per 100,000.

Wisconsin is doing worse than the nation in regards to bullying (22.7% compared to 19.6%). Subpopulations at higher risk of bullying included adolescents ages 12-15 (28.6%); gay, lesbian, or bisexual adolescents (36.9%); and NH whites (24.3%). Wisconsin is doing slightly worse than the nation in regards to adolescents who have not received a well-visit within the past year (19.2% compared to 18.3%). Adolescents living below 200% of the federal poverty level were at higher risk.

Maternal/Women: Overall, Wisconsin is doing better than the nation in regards to women that have a high school education, engage in physical activity, and have adequate emotional support and health care coverage. Strengths and disparities across racial and ethnic groups were also identified. White women have the highest rates of high school graduation, multi-vitamin use prior to pregnancy, post-partum check-ups, first trimester prenatal care, and lowest rates of poverty, chlamydia, poor mental health, and unintended pregnancy. NH Black women have the highest rates of well-visits and lowest rates of binge drinking. NH American Indian women have the lowest rates of being uninsured. Hispanic women have the lowest rates of smoking, alcohol consumption, and hypertension during pregnancy, as well as short inter-pregnancy interval and maternal deaths. Racial/ethnic disparities are particularly striking in regards to physical abuse prior to and during pregnancy, stress during pregnancy, high school graduation, pregnancy intention, substance use, obesity, preventive visits, and maternal deaths. Wisconsin's overall poverty status among women is slightly higher (13.7%) than the US (11.9%). When broken down by race/ethnicity, Wisconsin has 34.3% of NH Black women ages 18-44 that have earned an income below the poverty level within the last 12 months, which is over 3 times that of NH White women (9.8%). Only 2.4% of Wisconsin women have less than a high school education, this is substantially better than the US as a whole (13.1%). However, when examined by race and ethnicity, the differences are striking. Over 22% of Hispanic women in the state have less than a high school education compared to less than 1% of NH White women. Over 8% of Wisconsin women report food insecurity, with NH Black women faring the worst at 15.6%. More women in Wisconsin (17.6%) report having bad mental health for over 2 weeks in the past month than the US (14.3%). In Wisconsin, there is a disparity among racial/ethnic groups with NH white and Hispanic populations having the largest percentage of women reporting bad mental health with around 18% each, while NH Black women report having had bad mental health nearly half that at 9.8%. Nearly 80% of women in Wisconsin report adequate social and emotional support, with almost 84% of white women reporting this.

Wisconsin is doing slightly better than the nation in regards to well-woman care. Young women ages 18-24 are most likely to be without a preventive visit in the past year (40.1%) compared to women 35-44 (26.7%). NH white women were more likely to have a preventive visit (61.3%) compared to Hispanic women (38.8%) and women identified as other race/ethnicity (8.4%). NH Black women that have given birth in the last year in Wisconsin die at nearly 8 times the rate of Hispanic and NH White women (22.5%, 2.9%, and 4.5% respectively).

Cross-Cutting Systems Building: Overall, Wisconsin is doing better than the nation in regards to 4th grade math, educational attainment of mothers, household food insecurity, and adult male incarceration. Racial/ethnic disparities exist across all life course indicators, where NH Black persons fare the poorest.

Five percent (5%) of the Wisconsin population is uninsured (compared to 9% US) and 6% of non-elderly persons (age 0-64) are uninsured (compared to 10% US). However, for the population in Wisconsin under the age of 65, there is a stark disparity in coverage, where the proportion of American Indian persons under 65 years of age who are lacking insurance coverage is more than 4 times that of White persons under 65. The proportion of Wisconsin's population that is covered by Medicaid is less than that of the US. However, Black persons under 65 in Wisconsin have a 3.7 times higher proportion of Medicaid coverage than their White counterparts. Compared to the US, Wisconsin has a lower percentage of its population who have less than a high school diploma, and a higher percentage that have a high school diploma or GED. Wisconsin is similar to the US in its attainment of higher education. However, there are disparities in educational attainment by race/ethnicity. The Hispanic population in Wisconsin have the highest proportion with less than a high school diploma and the lowest proportion with a bachelor's degree or higher.

Wisconsin has 5% more of its population (age 16+) employed than the US overall. However, the unemployment rate for Black persons is 3 times that of White persons in Wisconsin. Household income, which includes all members of a household age 16+ whether or not they are related, is similar for both US and Wisconsin. Median earnings per workers (employed full time and year round) are also similar for both US and Wisconsin. Women in Wisconsin who work full time and year round earn about 21% less than men who work full time and year round. Median family income, which is the annual earnings for families with workers age 16 and up, is $72,542 in Wisconsin. There are stark disparities when examining median family income across race and ethnicity in the state. The White and Asian family populations earn over $75,000 annually; however, Black families earn less than half that and American Indian and Hispanic families earn less than $50,000 annually. Wisconsin is doing slightly better than the US overall for the percentage of its population in poverty. However, the proportion of Black children in poverty is 4 times that of White children in poverty, and the disparity between the overall Black and White populations in poverty is 3 fold. Wisconsin and the US compare similarly for food insecurity overall and among children. Wisconsin's housing units are 67% owner-occupied and 33% renter-occupied. The US overall has slightly fewer owner-occupied units (64%) and a similar percentage of renter-occupied units (36%). Forty-three percent of home-renters in Wisconsin spend 30% or more of their income on housing costs and therefore are considered housing-cost burdened. Twenty-five percent more Black renters in Wisconsin are burdened by housing costs than White renters.

Wisconsin is doing worse than the nation in regards to children that did not have a preventive dental visit within the past year (52.8% compared to 45.7%). Children living below 200% of the federal poverty level were more likely to have inadequate oral health care (63.6%). Wisconsin is doing slightly worse than the nation in regards to not having adequate health insurance (24.7% compared to 23.5%). Subpopulations at higher risk include adolescents ages 12-17 (28.3%), those not on Medicaid (26.7%), and children and youth with special health care needs (29.5%). Wisconsin is doing worse than the nation in regards to prenatal smoking (14.1% compared to 8.7%). Subpopulations at higher risk include women ages 20-24 (23.0%), women on Medicaid (25.0%), and NH American Indian/Alaska Native women (38.0%). Wisconsin is also doing slightly worse in regards to children living in households where someone smokes (25.6% compared to 24.1%). Subpopulations at higher risk include children on Medicaid (41.6%) and children with special health care needs (32.6%).

(a) A summary of the noted strengths and needs in the overall MCH population and in specific MCH sub-population groups: Among the women/maternal population, disparities among different racial and ethnic groups are vast, with white women faring better for preconception and prenatal health, and Hispanic women faring better for maternal health overall. The perinatal/infant population's race and ethnic minority groups are generally experiencing worse health factors and outcomes compared to White persons in Wisconsin, as well as the national average. When health and social factors are examined by race and ethnicity among children in Wisconsin, Black children and Indigenous children generally fare worse than their White and Hispanic counterparts. For adolescents, factors related to safety and injury are worse in Wisconsin than the rest of the nation. There is not enough information within the CYSHCN population to confidently make any statements regarding the overall population, however the Title V Program is working on an oversample, in order to have more information on this

population in the future.

(b) A concise description of the state's successes, challenges and gaps related to major morbidity, mortality, health risks or wellness for each of the five population health domains. At a minimum, the discussion should include the major health issues reflected in the state's priority needs relative to the MCH population as a whole or specific subpopulations when stratified by age, income, geography, frontier/rural/urban status, or other relevant characteristics: The 2020 MCH Needs Assessment revealed great racial disparities across all the population domains, with black women and children of all ages more likely to die, less likely to have access to high quality health services, and less likely to have access to health-promoting resources like adequate income and social support. Data for Native women and children are more limited, but what data are available indicate that they are experiencing some of these same inequities.

White infants have low rates of preterm birth and infant mortality (on par with national averages), but infants born to NH Black mothers have high rates of both of these indicators. Past efforts to improve infant safe sleep efforts have not changed the population rates of infant mortality. Wisconsin mothers of all races are more likely to breastfeed now than they were ten years ago, indicating progress in breastfeeding promotion, but racial disparities and persist, and there is significant room for improvement in breastfeeding rates among NH Black women.

Many Wisconsin children lack adequate health insurance and do not get regular physical exercise. These issues are especially salient for NH Black and Native children. Overall, most Wisconsin children have access to preventive care, but particular communities, including non-white children and rural-dwelling children do not have equal access.

Many Wisconsin CYSCHN have a regular source of care and received coordinated services, but support for transitioning medical care to adulthood was identified as a gap. Hispanic CYSCHN are less likely than others to receive care coordination.

Wisconsin adolescents are more likely than US adolescents on average to live in supportive neighborhoods and to have received the HPV vaccine. However, bullying and suicide were identified as major challenges, especially for LGBTQ+ youth.

While many Wisconsin women have health insurance and recent preventive care, these experiences vary greatly by race and income.

(c) An analysis of current MCH Block Grant efforts in addressing the needs of its MCH population to determine areas of success and areas in which new or enhanced strategies/activities are needed: The Title V Program will continue its comprehensive needs assessment activities on a rolling basis throughout the upcoming block grant cycle to more accurately assess the needs of its MCH population, and update work plans accordingly. The MAPP 1 analyses, Online Community Survey, Community Conversations, and Staff Capacity Survey may occur annually, with the exception of 2020, due to COVID-19 response activities and work delays. The Forces of Change and Policy Change Assessment may occur twice during the five-year block grant cycle, and the Provider Survey may be administered once every 5 years. The Title V Program will continue to regularly engage the MCH Advisory Committee during their 3 annual meetings, as well as groups such as the PATCH Teens, CYSHCN Directors, the Healthy Early Collaborative, and others.

III.C.2.b.ii. Title V Program Capacity

III.C.2.b.ii.a. Organizational Structure

Describe organizational structure and placement of the Governor, state health agency, and the Title V MCH and CYSHCN *Programs in the state government*: The Title V Program is housed within the Family Health Section, which is a part of the Bureau of Community Health Promotion in the Division of Public Health within the Wisconsin Department of Health Services. The Wisconsin Department of Health Services is overseen by the Department of Health Services Secretary, who reports directly to the Governor of Wisconsin.

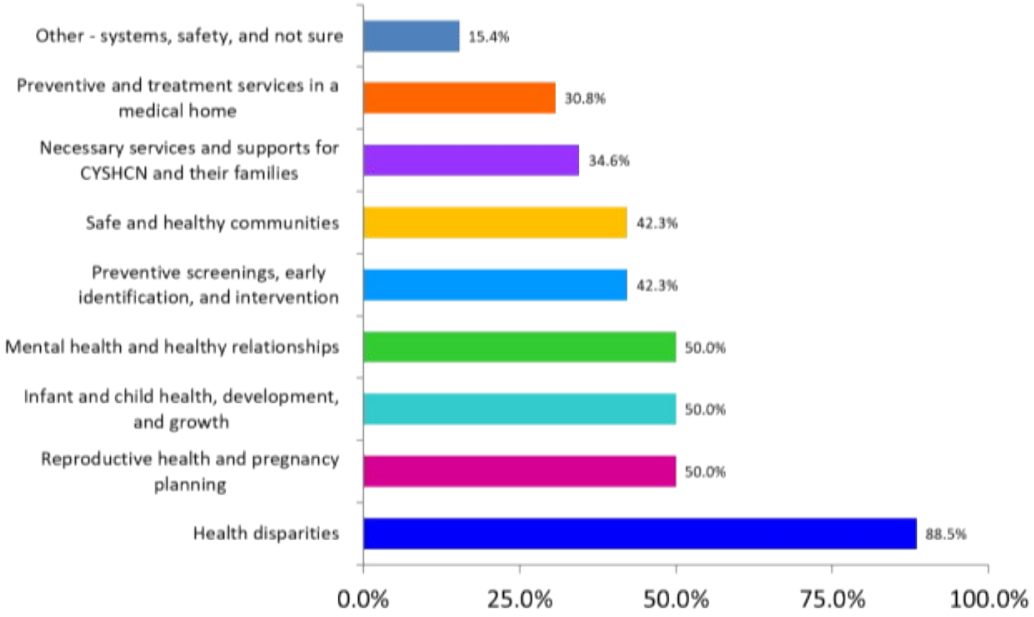
Clarify how the state health agency is "responsible for the administration (or supervision of the administration) of programs

carried out with allotments" under Title V [Section 509(b)]. This description should include all of the programs that are funded by the federal-state MCH Block Grant: The Wisconsin Title V Program reaches an agreement on a scope of work with all contracted agencies, including completion of mid-year reviews, and a required end-of-year report which may include data entry into the REDCap data collection system. Contracted agencies also participate in events such as Learning Community Calls, CYSHCN Network meetings, and participation on steering committees led by several statewide partners.

The Wisconsin Title V Program also provides funding to the following: Newborn Screening Program, the Oral Health Program, Birth Defects Prevention Surveillance, Wisconsin Youth Risk Behavior Surveillance Survey, WellBadger Resource Center, First Breath, Wisconsin Pregnancy Risk Assessment Monitoring System, State Personal Responsibility Education, Rape Prevention and Education, and Title X Family Planning.

III.C.2.b.ii.b. Agency Capacity

Figure 1: Title V Program staff reported priorities related to their current work activities during the 2020 MCH Needs Assessment Staff Capacity Survey.



Description of the state's Title V capacity to provide and assure services within each of the five population health domains: The Wisconsin Title V Program collaborates with programs throughout the state to ensure capacity and assure services within each of the five population health domains. Title V Program staff identified the following priorities related to current staff activities: Health disparities; Reproductive health and pregnancy planning; Infant and child health, development, and growth; Mental health and healthy relationships; Preventive screenings, early identification, and intervention; Safe and healthy communities; Necessary services and supports for CYSHCN and their families; Preventive and treatment services in a medical home; Other, including systems, safety, and not sure (Figure 2).

Title V Program staff also identified top priorities for mothers, children, and families in Wisconsin: Social determinants of health; Mental health; Healthy community; Development and growth; Reproductive health; Children and youth with special health care needs services and supports; Preventive screening; Medical home; and Connectivity and holistic health (Figure 3).

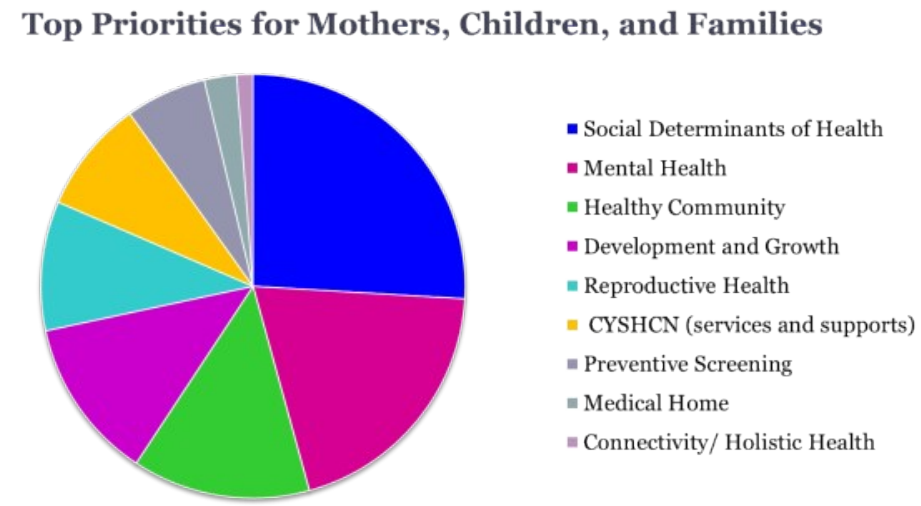


Figure 2: Title V Program staff reported their perceived top priorities for mothers, children, and families in Wisconsin during the 2020 MCH Needs Assessment Staff Capacity Survey.

An expanded discussion on the state's capacity for serving CYSHCN, which includes the Title V program's ability to provide rehabilitation services for blind and disabled individuals under the age of 16 receiving benefits under Title XVI (the Supplemental Security Income Program), to the extent that medical assistance for such services is not provided under Title XIX (Medicaid). If applicable, states may describe their capacity to serve CYSHCN and their families by referencing the National Consensus Standards for Systems of Care for Children and Youth with Special Health Care Needs as a guiding framework (AMCHP, 2014): If a child in Wisconsin is found eligible for the Supplemental Security Income Program, they are automatically eligible for Wisconsin Medicaid. The Disability Determination Bureau, within the Division of Medicaid Services in the Wisconsin DHS, is responsible for making the medical decision for Wisconsin residents applying for the Supplemental Security Income Program. After a child is found eligible for the non-medical requirements (income and resources are not too high for eligibility), the Disability Determination Bureau collects medical evidence to determine if a child is disabled based on the Social Security Administration's definition of disability. The Memorandum of Understanding between the DPH's Title V and Division of Medicaid Services references the coordinated outreach to Social Security applicants under the age of 16 years by providing applicants access to information and referral services provided by the Title V Program's CYSHCN Regional Centers. In addition, the Social Security Administration offices have access to Regional Center brochures and other CYSHCN-specific materials through the DHS publication center to promote client referral to the Regional Centers for additional information about supports and services available. The Social Security Administration agrees to make CYSHCN materials available to child claimants who are determined to be financially ineligible for Supplemental Security Income or to those applying for other Social Security Administration programs. The Wisconsin Title V Program does not provide directly or pay for medical services.

III.C.2.b.ii.c. MCH Workforce Capacity

Number, location and full-time equivalents of state and local staff who work on behalf of the state Title V programs: The Wisconsin Title V Program currently funds 32.75 full-time-equivalents. The majority of these positions are located in Madison, Wisconsin, with a few positions spread throughout the state. All Title V Program staff have been working remotely since March 2020. Due to uncertainty regarding COVID-19 and the future, all Wisconsin Title V Program staff expect to be working remotely until further notice.

Names and qualifications (briefly described) of senior level management employees who serve in lead MCH-related positions and program staff who contribute to the state's planning, evaluation, and data analysis capabilities: Jennifer Ullsvik, Director of the Wisconsin DHS Bureau of Community Health Promotion, serves as Wisconsin's Title V Director. Sharon Fleischfresser, the Wisconsin CYSHCN Medical Director, serves as the Title V CYSHCN Director and co-leads NPMs 11 and 12. Anne Odusanya, CYSHCN Unit Supervisor, co-leads the NPM 11, assists with budget planning, and reviews block grant report sections focused on Medical Home, Youth Health Transition, Developmental Screening, Newborn Screening, and Birth Defects. Ashley Bergeron, Wisconsin DHS Family Health Section Chief and interim MCH Unit Supervisor, assists

with budget planning and Title V Block Grant revisions. Angela Rohan, senior MCH Epidemiologist and CDC Assignee to Wisconsin, provides data and epidemiologic support for SPMs High-Quality Perinatal Care and Representative Participation. She also supports a number of programs that relate to the block grant's priorities, including maternal mortality review and the Wisconsin Perinatal Quality Collaborative. Katrina Alber, SSDI Coordinator, coordinates the planning and submission of the Title V Block Grant, co-coordinates the five-year Needs Assessment, coordinates and facilitates the MCH Advisory Committee, and assists with budget planning.

Number of parent and family members, including CYSHCN and their families, who are on the state's Title V program staff and a brief description of their roles (e.g., paid consultant or volunteer): The Wisconsin Title V Program staff includes 6 paid staff members with lived experience, or family members of CYSHCN, who bring unique perspectives to our programs and partnerships. Lived experience often greatly influences the professional paths we take, and these staff strengthen our programs and provide unique insight to our activities. The Title V Program is also in the process of hiring two Community Partnership Specialists. These will be paid, state-level positions based in communities of highest need, and more information on this work can be found in the Executive Summary, MCH Success Story section of this document.

Additional MCH workforce information, such as the tenure of the state MCH workforce and projected shifts in the MCH and CYSHCN workforce over the five-year reporting period, that aligns workforce capacity with the achievement of Title V program goals: Wisconsin's Title V Program is staffed by those with decades of experience in Title V, and those who have been working on Title V Projects for one year or less. The DHS Family Health Section experienced a large number of vacancies in 2019, which Leadership has been successfully working to fill. The Family Health Section is also working to hire staff for the newly-developed Maternal and Infant Mortality Prevention Unit. Once these positions are filled, the Family Health Section and Title V Program expect to be fully staffed over the next five years.

III.C.2.b.iii. Title V Program Partnerships, Collaboration, and Coordination

As a direct result of the 2020 MCH Needs Assessment, the Representative Participation SPM (SPM 4) was identified. Supporting this work, the Title V Program will also be expanding the pilot project from last year's MCH workforce development project – the Community Engagement Assessment Tool – to include multiple counties and statewide partners and encourage each organization to connect with the families they serve in order to gain valuable insight and feedback on their work at the local level. Technical assistance through associated Title V contract monitors and data collection tools are provided for state-developed projects in REDCap and SurveyGizmo.

The Title V Program also supports the MCH Advisory Committee, a group of community members and partners throughout the state who convene throughout the year to receive programmatic updates and provide feedback for proposed Title V work, programs, and projects. This committee was key to the planning for the Representative Participation and Social Connection SPMs.

The Title V Program also receives input from a variety of other stakeholder groups, including the CYSHCN Network Directors, made up of stakeholders, advocates, and family members of CYSHCN. Needs Assessment findings and proposed 2021-2025 Priority Needs and NPM/SPMs were presented to this group in November 2019, and their input played a key role in determining 2021 State Action Plan strategies, particularly regarding NPM 6, NPM 10, NPM 11, and NPM 12.

Partnerships with other MCHB-Supported Programs: The Family Foundations Home Visiting Program coordinates a number of professional development trainings funded and sponsored by the Maternal and Infant Early Childhood Home Visiting (MIECHV) Program and Milwaukee Child Welfare Partnership. While trainings are centered on on-going professional development for home visitors within local implementing agencies, these educational programs are also available to Title V Program staff and partners. The Milwaukee Child Welfare Partnership works with a variety of partners to provide relevant, high-quality professional development and training opportunities. For example, the Prenatal Care Coordination workforce recently participated in the *Fulfilling the Promise* Conference, an annual event held by the Milwaukee Child Welfare Partnership. This invitation for participation was coordinated and facilitated through the partnership and collaboration between the Title V Program and the Home Visiting Program. The on-going training menu includes an informational online

training toolkit, in person trainings, and most recently, promotion of virtual trainings. There are multiple types of trainings offered including: ASQ-3 screenings, Cultural Humility, Reflective Supervision, Infant/Maternal Mental Health, Motivational Interviewing, Pregnancy – Maternal Health, and Developmental Milestones.

Title V collaboration with the MIECHV Program also strengthens departmental collaboration through addressing endeavors identified in the State Action Plan Performance Measures. Since the MIECHV-funded Family Foundations Home Visiting Program is housed within the Wisconsin Department of Children and Families, the challenges of communication and coordination of services are met through regular communication and collaboration. Participation in relevant programing has been facilitated and coordinated to promote this collaboration. For example, during the Family Foundations Home Visiting all-grantee meetings, there is consistent participation and presentations from Title V Program staff. Most recently, The Title V Program presented a 2021 State Action Plan crosswalk, emphasizing opportunities for collaboration with the MIECHV Program. The presentation emphasized the 2020 MCH Needs Assessment findings which led to common areas of work within the two programs.

The CYSHCN Unit and partners have also presented at all-grantee meetings, as well as the *Fulfilling the Promise* conferences. WellBadger, CYSHCN Regional Centers, WIC, the Medical Home Initiative, and the Newborn Screening Program are only a few of the partner programs which have presented to the Home Visiting Program during these sessions. Additionally, monthly collaborative meetings between the CYSHCN Unit and MIECHV Program staff work to address common endeavors and unify best approaches in providing services to families. These collaborations have continued to synergistically strengthen programming for both the Title V Program and MIECHV Program.

Emerging Issues: On March 12, 2020, Wisconsin's Governor Tony Evers declared a public health emergency to direct all resources needed to respond to and contain a novel strain of the coronavirus (COVID-19). On March 24, 2020, Governor Evers enacted Emergency Order #12, also known as the Safer at Home Order. Response activities related to the COVID-19 pandemic have been underway in Wisconsin since this time, including testing, contact tracing, support, and prevention education. As of July 3, 2020, Wisconsin had 30,317 confirmed cases of COVID-19 of which 796 have resulted in deaths. Many of these cases are disproportionately affecting persons of color, only emphasizing the urgency for more equitable health practices in Wisconsin. Many Wisconsinites restricted their travel and social interactions during the Safer at Home Order, however, new cases of COVID-19 have been increasing since the Order was lifted on May 26, 2020. Former Wisconsin Governor and former U.S. Secretary for Health and Human Services, Tommy G. Thompson, began his term as interim president of the University of Wisconsin Health System on July 1, 2020. As a former U.S. Secretary for Health and Human Services, Governor Thompson's health policy experience will be critical as universities respond to the COVID-19 pandemic. The University of Wisconsin System serves approximately 170,000 students. This new yet promising appointment of such a distinguished leader may help Wisconsin's largest health care system lead the state toward lowering cases and appropriately addressing health care needs of the population. The Title V Program is also collaborating with other groups within the Wisconsin DHS to enhance data collection efforts in order to capture the impact of COVID-19 on MCH populations. This includes information collection regarding home births, immunizations, well-child visits, and a newly-approved pregnancy surveillance program which will soon be implemented. Additionally, Wisconsin PRAMS, which is funded through Title V, added a supplement including economic and healthcare utilization impacts of COVID-19 for 2020 births. A report from the Wisconsin Policy Forum shows 39% of the state's 4,500 child care providers reported to the Wisconsin Department of Children and Families that they had closed down as of May 19, 2020. The Wisconsin Department of Children and Families estimates these closures have affected at least 57,000 children and 12,000 child care employees.

Title V Program staff continue to work remotely until further notice, in order to practice social distancing and limit the spread of COVID-19. Prior to the pandemic, staff had all been issued laptops and Zoom licenses, and the Wisconsin DHS also had policies in place allowing for staff to work from home. The Title V Program worked diligently in the initial weeks of Wisconsin's Safer at Home Order to increase resources listed on their website, and continue to update these resources as new information becomes available. The Title V Program will continue to provide guidance to state agencies and partners, including providing information for webinars related to COVID-19. The WellBadger Resource Center also shifted its focus to be able to provide resources to families specific to COVID-19. The Newborn Screening Program has incorporated telehealth

to continue working with families remotely.

Wisconsin DHS' existing policies did ease the transition for the Title V Program to full remote work, however many program staff members have since been called partially or fully into statewide pandemic response efforts, restricting their ability to work on Title V-related activities. The Title V Program is trying to remain conscious of projects and priorities, while also taking staff burnout into consideration. The transition to a remote work environment has also been difficult for partners of the Title V Program. Furloughs for UW contracted employees at the Wisconsin DHS have caused delays and increased work burdens for non-contracted staff. The Wisconsin DHS has hired over 200 English and bilingual contact tracers to ease the burden of this work on local agencies over the past two months, and has provided resources for local and tribal health agencies to hire additional contact tracers if needed. The Title V Program anticipates the furloughs of health care and hospital staff by health systems, as well as increased reliance on telemedicine and higher payment amounts for such services will have lasting effects on the Title V populations in Wisconsin.

In addition to this unprecedented pandemic, the Black Lives Matter Movement has resurfaced racism as a topic of public health urgency in Wisconsin. Health disparities are by no means a new or emerging issue in Wisconsin, however, this renewed urgency among Wisconsinites to address and eradicate racism presents an opportunity for Wisconsin to advance Title V Program work which addresses racism and the already widening disparities it causes. In June 2020, Governor Evers declared racism a public health crisis. With COVID-19 deepening health disparities by disproportionally affecting persons of color, the infant mortality rate among babies born to Black mothers in Wisconsin being the highest in the nation, and other longstanding health disparities, the Title V Program realizes the urgency of needed action, and has taken steps towards eradicating these unacceptable disparities. The pandemic has not only had biological or medical implications; it has also impacted many people, especially the MCH populations who are already experiencing SDoH such as financial distress, food or housing insecurity, and barriers to psychological or sociological care. The Title V Program is currently exploring how programs will need to change to address these needs – beyond what was addressed in the recent Needs Assessment – as the pandemic has only exacerbated historical trauma.

In 2019, Governor Evers added four full-time state positions dedicated to the prevention of maternal and infant mortality with a focus on communities most burdened by maternal and infant deaths, including Black and Indigenous families. This new program is co-located with the Title V program in the Family Health Section of the Bureau of Community Health Promotion. The Title V Program will support the establishment of this program, including by providing in-kind staff support, by fostering partnerships with MCH partners, and by sharing data and technical expertise. The Bureau of Community Health Promotion has also established a Health Equity work group, which will work to implement recommendations provided by the DHS Health Equity Advisory Team.

III.C.2.c. Identifying Priority Needs and Linking to Performance Measures

Methodologies used to rank the broad set of identified needs and the state's process for selecting its final seven to ten priorities: Please see the Quantitative and Qualitative Methods section of III.C.2.a. Process Description for a detailed description.

Emerging issues or other frequently cited needs that were not included in the final list of priority needs and a rationale for why they were not selected:

> Reproductive Health: While it was agreed that Reproductive Health is a critical subject in the field of public health, the Title V Program believes other groups may be able to advance this work more directly, with support and collaboration from the Title V Program.
>
> Policies, Programs, and Systems: Initial assessments concluded that this category may be more of an overarching theme to keep in mind throughout all action planning, rather than being an independent Priority Need.
>
> Safe Sleep: The 2020 MCH Needs Assessment determined that items such as unsafe neighborhoods and unstable

housing seem to be preventing safe sleep practices. Therefore the Title V Program chose to address the upstream causes of unsafe infant sleep practices through work such as social environments and racial justice.

Bullying: Bullying was originally identified as a potential performance measure, however, due to staff vacancies and staff capacity at the time of the action planning process, it was decided that this NPM, which would be new for Wisconsin, would be addressed as possible in NPM 7.2 work for the time being.

Factors that contributed to changes in the state's priority needs since the previous five-year reporting cycle: The Priority Needs did not change drastically since the 2016 MCH Needs Assessment. Increased responses and participation in assessments related to the 2020 MCH Needs Assessment may have led to a more comprehensive analysis than previous years.

Relationship between the priority need and the selected national and/or state performance measures in driving improvement:

Advance Equity and Racial Justice

- SPM 1 Percent reduction in infant mortality in babies born to non-Hispanic Black mothers
- SPM 4 Percent of performance measures with family, youth, and community engagement embedded into program and policies

Equity is a cross-cutting theme to be kept in mind regardless of the Priority Need a performance measure may be listed under. Due to the public health crisis of racism in Wisconsin and importance placed on equity in 2020 MCH Needs Assessment Findings, advancing equity and racial justice was identified as its own Priority Need. A gap in public input during the 2020 MCH Needs Assessment was that while the Title V Program celebrated comprehensive data collection and increased statewide participation, it could not be ignored that the demographics of those participating in the many 2020 MCH Needs Assessment activities (white females, ages 40-54) are not representative of the diverse population of Wisconsinites served by the Title V Program.

Assure Access to Quality Health Services

- NPM 1 Percent of women, ages 18 through 44, with a preventive medical visit in the past year
- NPM 10 Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year

Main themes identified include access to services, transportation barriers, insurance affordability, insurance access to all, preventive medical care, transitional care, oral health, and resource awareness.

Cultivate Supportive Social Connections and Community Environments

- SPM 3 Percent of strategies on the Wisconsin State Action Plan promoting social connectivity, or connection to community-based resources

Safe and Stable Housing, social connectivity, isolation, belonging, safe spaces, community connectedness, emotional support, and connection to resources/physical structures were main themes identified during the 2020 MCH Needs Assessment. It is apparent that this is a cross-cutting issue throughout the state.

Enhance Identification, Access, and Support for Individuals with Special Health Care Needs and their Families

- NPM 6 Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year
- NPM 11 Percent of children with and without special health care needs, ages 0 through 17, who have a medical home
- NPM 12 Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

Themes rose to the surface of the 2020 MCH Needs Assessment related to the identification, access, and support of CYSHCN and their families.

Foster Positive Mental Health and Associated Factors

- NPM 7.2 Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19

Adolescent suicide and bullying were significant concerns that rose during the 2020 MCH Needs Assessment. Mental health among all populations is also a concern, specifically trauma, other stressors, and alcohol/drug use.

Improve Perinatal Outcomes

- NPM 4 A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months
- SPM 12 A) Percent of women receiving prenatal care within the first trimester B) Percent of women receiving a quality postpartum visit

Infant health concerns including infant mortality, breastfeeding, and birth rate were identified as important themes in the 2020 MCH Needs Assessment.

Promote Optimal Nutrition and Physical Activity

- NPM 8.1 Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Obesity, nutrition, food insecurity, physical activity, and safe places to play were main themes contributing to the identification of this Priority Need. The theme of safe spaces to play also corresponded with the Priority Need **Cultivate Supportive Social Connections and Community Environments**.