National Performance Measures

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

Tracking Performance Measures

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	115	124	112	120	129
Denominator	115	124	112	120	129
Data Source	WI St Lab Hyg 2010.	WI St Lab Hyg 2011.	WI St Lab Hyg 2012	WI St Lab Hyg 2013	WI St Lab Hyg 2014
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	100	100	100	100	100

Notes - 2013
Source: Numerator: NBS program, State Lab of Hygiene, Wisconsin, 2013. The number of infants that were confirmed with a condition through newborn screening and who received appropriate follow-up care.
Denominator: NBS program, State Lab of Hygiene, Wisconsin, 2013. The number of infants screened through NBS and confirmed with a condition.
Wisconsin screens for 44 disorders and for hearing loss at birth. Every newborn with an abnormal NBS result is tracked by the NBS Program to a normal result or appropriate clinical care.

Notes - 2012
Source: Numerator: NBS program, State Lab of Hygiene, Wisconsin, 2013. The number of infants that were confirmed with a condition through newborn screening and who receive appropriate follow-up care.
Denominator: NBS program, State Lab of Hygiene, Wisconsin, 2012. The number of infants screened through NBS and confirmed with a condition.
Wisconsin screens for 44 congenital disorders. Every newborn with an abnormal NBS result is tracked by the NBS Program to a normal result or appropriate clinical care.

Notes - 2011
Source: Numerator: NBS program, State Lab of Hygiene, Wisconsin, 2012. The number of infants that were confirmed with a condition through newborn screening and who receive appropriate follow-up care.
Denominator: NBS program, State Lab of Hygiene, Wisconsin, 2012. The number of infants screened through NBS and confirmed with a condition.
Wisconsin screens for 44 congenital disorders. Every newborn with an abnormal NBS result is tracked by the NBS Program to a normal result or appropriate clinical care.

a. Last Year's Accomplishments
1. Newborn Screening--Population-Based Services--Infants

In 2013, 65,799 infants were screened for 44 different congenital disorders. 129 infants were confirmed with a condition screened for by the NBS Program and 100% were referred for appropriate follow-up care. The NBS Coordinator organized the biannual NBS Advisory Group - Umbrella Committee, Cystic Fibrosis/Molecular, Metabolic, Hemoglobinopathy, Endocrine, Immunodeficiency, Education and Hearing subcommittees. Along with the nation, WI's NBS Program celebrated 50 years of screening babies and hosted an event at the WI State Laboratory of Hygiene (WSLH). The NBS Program, WI Sound Beginnings EHDI, Vital Records, and Birth Defects Surveillance System continue to link newborn screening data with other birth data.

DHS continued to be an active partner with the University of WI Pediatric Cardiology for screening for Critical Congenital Heart Disease (CCHD). DHS has been responsible for collecting data and providing

data analysis services. The project requires DHS participation by the NBS Program, Sound Beginnings EHDI, Birth Defects, and Vital Records.

The NBS Task Force II, appointed by the DHS Secretary, concluded in June 2013 and provided a report to the Secretary with their recommendations. Implementation of the recommendations began. A Secretary's Advisory Committee on Newborn Screening was established following the recommendations. This Committee has been created as a permanent review committee whose purpose is to advise the Secretary on policy issues related to newborn screening, including making recommendations for additions to and deletions from the mandatory panel of newborn screening conditions.

Changes to Section 253.13 (1) Stats., broadened NBS from just blood and urine testing to include the possibility of point of care testing, 253.13 (3) added personal convictions to the exceptions for testing, and 253.13 (4,b) added reporting for the Department for data collection and evaluation.

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

DHS provided necessary diagnostic services, special dietary treatment as prescribed by a physician and follow-up counseling for the patient and his or her family through contracts with specialty clinics and local agencies. Five cystic fibrosis centers, three metabolic clinics, one sickle cell comprehensive care center, one genetics center, and a local health department receive these contracts. The DPH NBS Program Coordinator worked with the contracted agencies to promote and improve the NBS Program through the establishment and evaluation of performance-based objectives. These include the following focus areas: early identification assessment, referral, ongoing clinical services, care coordination with the medical home, links to services, and transitions to adult care. The contract agencies continue to log data into SPHERE to report to DHS. Work with the contract agencies also included the coordination and tracking of special dietary products for congenital disorders patients.

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

The newborn blood and hearing screening staff developed an educational display to promote education and awareness of newborn blood and hearing screening. Newsletters were sent to birth hospital coordinators with regular updates and reminders about newborn screening. NBS brochures, including the "plainclothes" NBS brochure developed for the Amish and Mennonite populations were provided to hospitals and midwives. The WI NBS Program continued to participate in the HRSA "Region 4 Genetics Collaborative" grant with WI representatives in workgroups. The regional collaborative allows states to share expertise in new technologies and best practice models to maximize available newborn screening resources.

Activities	**Pyramid Level of Service**			
Table 4a, National Performance Measures Summary Sheet	**DHC**	**ES**	**PBS**	**IB**
1. Newborn Screening			X	
2. Diagnostic Services	X			
3. Development of Educational Materials		X		

b. Current Activities
1. Newborn Screening--Population-Based Services--Infants

In 2014, all infants born in WI will continue to be screened at birth for a minimum of 44 congenital disorders and for hearing loss. The NBS Advisory Group (Umbrella Committee) and its 7 subcommittees will meet biannually to advise the Department regarding emerging issues and technology in NBS. The Secretary's Advisory Committee on NBS recommended to the Secretary to add CCHD to the mandatory panel of newborn screening conditions. The creation of a nomination process for the addition and deletion of conditions, a nomination form, and a webpage are under final development. Newborn Screening Program-wide Quality Assurance and Quality Improvement initiatives are underway. A Midwife Champion was hired as Outreach Coordinator working with out of hospital births, especially with “Plain Clothes” population.

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

DHS will provide necessary diagnostic services, special dietary treatment and follow-up counseling for the patient and his or her family through contracts with specialty clinics and local agencies. Data will continue to be reported in SPHERE.

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

The NBS Program will continue to promote education and awareness of blood and hearing screening. Newsletters will be sent via constant contact to birth hospitals, midwives, and partners in NBS with regular updates and reminders about newborn screening. NBS brochures will be provided to parents and NBS partners.

c. Plan for the Coming Year

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

In 2015, all infants born in WI will continue to be screened at birth for a minimum of 44 congenital disorders and for hearing loss. WI will continue to support the Critical Congenital Heart Disease (CCHD) screening activities led by the University of Wisconsin Pediatric Cardiology and DHS will continue to be an active partner responsible for collecting data and providing data analysis services. The grant funding for CCHD screening will end in June 2015. The NBS Advisory Group (Umbrella Committee) and its seven subcommittees will meet biannually to advise the Department regarding emerging issues and technology in NBS. The Genetics Systems Integration Hub in collaboration with NBS partners has been chosen for a Genetic Alliance Impact Award to expand the outreach to the "Plain Clothes" population ("Amish Project") in other areas of WI and planning will continue. NBS Program-wide Quality Assurance and Quality Improvement initiatives will continue.

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

DHS will continue documenting in a computer-based tracking system for NBS special dietary treatment services. Tracked services will include the provision of dietary formulas and medical food products to children with conditions screened for NBS by dieticians at contracted specialty centers. Performance based contracts will be reviewed and revised to continue to promote Medical Home implementation strategies such as care coordination and transition planning. Review of NBS data within SPHERE, reporting of data, and development of long term follow-up measures will be planned. The NBS Program, WSLH, Wisconsin Sound Beginnings EHDI, Vital Records, and Birth Defects Surveillance System will continue to link newborn screening data with other birth data.

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

The NBS Advisory Education Subcommittee will continue to educate the public and medical providers about congenital disorders; continue to improve communication with the NBS Program and hospitals through the use of constant contact e-newsletters and the NBS website; will work on updating the educational tool kit for childbirth educators and health care providers with information about newborn screening and newborn screening resources; will use the NBS DVD as an education piece in a variety of settings to educate about Newborn Screening and will provide the "Plain Clothes" NBS brochure and education for the Amish and Mennonite populations. The blood and hearing screening staff will continue to coordinate and integrate outreach and education to hospitals and use the educational display to promote education and awareness of blood and hearing screening.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**66322**					
Reporting Year:	**2013**					
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**		**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received Treatment (3)**	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	65799	99.2	9	7	7	100.0
Congenital Hypothyroidism (Classical)	65799	99.2	273	52	52	100.0
Galactosemia (Classical)	65799	99.2	4	0	0	
Sickle Cell Disease	65799	99.2	16	16	16	100.0
Biotinidase Deficiency	65799	99.2	1	1	1	100.0
Congenital Adrenal Hyperplasia	65799	99.2	312	7	7	100.0
Cystic Fibrosis	65799	99.2	186	17	17	100.0
Fatty Acid Oxidation	65799	99.2	42	9	9	100.0
Organic Acidemia	65799	99.2	70	11	11	100.0
Aminoacidopathies	65799	99.2	70	3	3	100.0
Severe Combined Immune Deficiency	65799	99.2	27	6	6	100.0

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

Tracking Performance Measures

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	71.5	72	72.5	75	75
Annual Indicator	74.4	74.4	74.4	74.4	74.4
Numerator	149937	149937	149937	149937	149937
Denominator	201529	201529	201529	201529	201529
Data Source	2009/10 NCHS CSHCN	2009/10 NCHS CSHCN	2009/10 NS CSHCN	2009/10 NS CSHCN	2009/10 NS CSHCN
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	75	75	75	75	75

Notes - 2013

For 2009-2013, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2012
For 2008-2012, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011
Data issue: 2011 data are not available.
Data source: 2009-10 National Survey of Children with Special Health Care Needs, conducted by the CDC, National Center for Health Statistics, Wisconsin Profile. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.
According to SLAITS documentation, numbers are not comparable for the data years 2005-06 and 2009-10.

a. Last Year's Accomplishments
1. Family Support Services--Enabling Services

In 2013, 2,259 families received individual assistance through the Regional Centers, enhancing parents as decision makers and supporting informal networks of support. The WI First Step Hotline serving CYSHCN provided consultation and referral for an additional 686 families. Both services help connect families to the resources of Parent2Parent (P2P) and Family Voices of Wisconsin (FVW).

P2P completed 96 matches and 4 support parent trainings. 90% of the referred parents reported that the match was successful and 93% of the matches were provided with trained WI support parents and resources. P2P also developed content for the Medical Home Initiative training "Partnering with Your Doctor" providing several trainings including the state families conference, Circles of Life.

FVW served 167 families and youth through their community trainings and 110 providers. These trainings focus on helping connect families to service agencies and resources and to strengthen their self-advocacy skills.

ABC for Health (ABC) provided assistance to 792 CYSHCN and their families to navigate insurance and benefit issues, primarily related to BadgerCare and Medicaid. ABC received more referrals from Regional Centers than any previous year. Many families needed support related to Medical Transportation Services and BadgerCare+ crowd-out rules. Significant work was done to help CYSHCN Collaborating staff and families to navigate ACA enrollment and related BadgerCare changes in WI. The number of private insurance questions and problems were equally high.

The CYSHCN Program coordinates a monthly Information and Referral call and list-serve which facilitates problem sharing and facilitates identification of unmet needs and information gaps.

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

Families received information regarding the ACA, the network's prioritized health policy initiative, through FVW quarterly newsletters, fact sheets and trainings as well as through 67 listserve postings. This information was continuously updated on the FVW website (http://fvofwi.org/wp-content/uploads/2012/01/Factsheet-on-Health-Care-Reform.pdf).

A new page was added to focus on the ACA and issues of importance for CYSHCN. The FVW database includes 1,880 individuals of which 80% are families and there are 900 individuals subscribed to the Family Action Network, a collaborative list-serve between FVW, the Waisman Center, Disability Rights Wisconsin and the Board for People with Developmental Disabilities.

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

Parents served in advisory capacities of local, state, and national councils and committees. Regional Centers and partners were active in several hospital and clinic-based family advisory committees along with many roles on county, community and non-profit planning teams. SE Regional Center's Family Advisory Committee provided feedback to many hospital committees or initiatives in 2013. FVW supported 20 family members to participate in its third "Advocacy for Change" Parent Leadership Institute in March. Parents developed and shared family stories related to waiting lists for long term supports, Medical Transportation reimbursement and prior authorization requests.

Members of the CYSHCN Collaborator's Network also serve on the AMCHP Family and Youth Committee, the Got Transition Advisory Committee and our P2P Director was selected as an AMCHP Family Scholar.

4. Family Partnerships-Culturally Effective--Infrastructure Building

P2P provided a Spanish-subtitled version of a video "Partnering with Your Doctor". P2P collaborated with Alianza, SE Regional Center and WISMHI to provide training for 49 Latino families. 20 Latino families received a scholarship to attend the Circles of Life conference where Spanish translation was provided and contributed to the FVW listening sessions. FVW provides resources in Spanish and supports Latino and African American parent groups in Madison and Milwaukee. GLITC hosted an Honor Circle Retreat for Native American families and service providers. The NE Regional Center collaborated with Casa Alba in Brown Co. to provide a support group for Spanish-speaking families with CYSHCN.

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

b. Current Activities
1. Family Support Services--Enabling Services

CYSHCN Collaborators continue to work to assure families have the skills and intention to be partners in decision making for their children.

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

The CYSHCN Directors prioritize the strengthening of the parent leadership network. FVW leads the effort to assess, broaden and strengthen the way the network identifies parents and connects them to opportunities for growth and leadership. The Network continues to implement strategies strengthening parent roles in decision making.

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

Parents have advisory roles on: CoP ASD and DD, Newborn Screening Program, WI Sound Beginnings, Birth Defects Program, Children' Long Term Supports Council, MCH Advisory Committee, and 2 Children's Hospitals. Parents are staff at all levels of the CYSHCN Program. FVW tracks unmet needs of families and brings them to legislators and state leaders. The CYSHCN Coordinator is an AMCHP family delegate and serves on the Family and Youth Committee. The CYSHCN Medical Director serves on the AMCHP/Packard CYSHCN Standards Workgroup and Got Transition.

4. Family Partnerships-Culturally Effective--Infrastructure Building

FVW is hosting a Transition training for Milwaukee residents, drawing 180 CYSHCN families, through a collaboration with an African American family support group.

c. Plan for the Coming Year
1. Family Support Services--Enabling Services

Families will continue to be matched through P2P of WI program, receive education through FVW, health benefits counseling through ABC for Health, and offered Information & Referral services through the Regional Centers. The WI CYSHCN Network supports family and youth in leadership roles and includes practice groups on parent supports and roles for youth.

The WI Sound Beginnings Program, in collaboration with WIC program sites, will continue to inform families of infants who did not pass the hearing screening of the need for follow-up and resources; 32 WIC projects coordinate hearing screening follow-up with scheduled WIC clinic visits while the remaining 60+ sites provide families who are at risk for lost to follow-up a letter encouraging audiology follow-up.

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

The CYSHCN Program will continue to contract for the services provided by FVW, enhancing the services provided by the Family to Family Health Information Network grant through MCHB. FVW will continue to build and strengthen our parent network and provide: critical parent training, a newsletter, data collection, analysis and dissemination of unmet needs.

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

Families will continue to serve in advisory roles for: MCH Advisory Committee, WI Board for People with Developmental Disabilities, Children's Long Term Care Statewide Committee, Community of Practice on Autism Spectrum Disorders and other Developmental Disabilities, Community of Practice on Transition, and Family Voices of WI listening session at Circles of Life Conference. Parents will continue to be part of the staffing at all levels of the CYSHCN Program. Parents will continue their advisory capacities through the Regional Centers, and be linked to opportunities to serve at a local, regional, or state level. The CYSHCN Collaborators Network will meet annually and quarterly by phone, building the CYSHCN system and assuring parents as partners are coordinated across programs. The Information and Referral group will continue so that staff can inform families regarding the ever-changing health benefits system. FVW will continue to track unmet needs in collaboration with CYSHCN partners so that family needs are articulated on a policy level. The staff at the Regional Centers, Parent to Parent and other partner and collaborating agencies will continue to serve on a range of councils and committees to advance the performance measure of parents as decision makers.

4. Family Partnerships-Culturally Effective--Infrastructure Building

Outreach to underserved populations will be strengthened to reach Latino, African American, and Native American families, including families with children who are deaf or hard of hearing through WI Families for Hands and Voices.

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

Tracking Performance Measures

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective	57	58	59	45	45
Annual Indicator	44.1	44.1	44.1	44.1	44.1
Numerator	88874	88874	88874	88874	88874
Denominator	201529	201529	201529	201529	201529
Data Source	2009/10 NCHS CSHCN	2009/10 NCHS CSHCN	2009/10 NS CSHCN	2009/10 NS CSHCN	2009/10 NS CSHCN
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	45	45	45	45	45

Notes - 2013

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2012

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011

Data issue: 2011 data are not available.
Data source: 2009-10 National Survey of Children with Special Health Care Needs, conducted by the CDC, National Center for Health Statistics, Wisconsin Profile. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

a. Last Year's Accomplishments
1. Medical Home and Community Supports--Infrastructure Building Services--CYSHCN

The CYSHCN Program contracted with Wisconsin Statewide Medical Home Initiative (WiSMHI) (http://wismhi.org/) as the statewide lead for CYSHCN Medical Home activities. WiSMHI leads the Medical Home Collaborators (mental health, Birth-3 (Part C), WAFP, WIAAP, CYSHCN, MCH, others) every other month to promote MH policy development and implementation. This collaboration resulted in DHS payment change to CPT 96110 and approval of the HIPAA/FERPA Joint Release form. A Joint Release of Information and Referral form to WI Birth to 3 Program is posted on the WI Department of Health Services website. A promotional letter to physicians about the form was jointly signed by partners and distributed. The form allows clinicians and Birth to 3 Program professionals to communicate directly with one another and expedite care for children identified with developmental delays. Feedback was solicited to assist with potential updates and revisions to the form. WiSMHI collaborators designed a follow-up survey to assess providers' decision to use the form; distribution planned for 2014. CYSHCN Regional Centers continued partnerships with providers to promote community connections and Information and Referral. Regional Centers engaged in MH system activities and individual activities.

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

WiSMHI conducted 9 clinical site trainings (totaling 128 primary care providers) on screening (ASQ3 and M-CHAT) within the context of a medical home as part of the Early Identification and Referral (EIR) project in collaboration with Regional Center Staff and community partners. WISMHI continues health system recruitment and engagement to promote a system-wide approach to developmental screenings. WiSMHI continues to promote Behavioral Health Integration into pediatric primary care: conducted 6 mental health screening trainings at clinical sites reaching 65 clinicians and care team members. A MH Minute E-Newsletter is distributed by a listserv to over 600, which provides monthly updates to families and clinicians on MH-relevant issues and information on training opportunities. WISMHI contracted with Parent to Parent (P2P) to develop and conduct MH training information for families described at (http://wismhi.org/families).

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

Dissemination of concepts of Medical Home is integrated in Wisconsin Sound Beginnings (WSB) Early Hearing Detection and Intervention (EHDI) and Congenital Disorders (blood spot newborn screenings) Programs. WSB conducts medical home outreach every week to inform medical homes about individual children in their practice who did not pass their newborn hearing screening and have not received follow-up. WSB also conducts medical home outreach to inform primary providers when a child in their practice has been diagnosed with a hearing loss. The EIR included information regarding WSB-EHDI. WISMHI collaborated with Easter Seals National Campaign (Make the First Five Count). Implementing a letter for Wisconsin parents who completed the ASQ online which shares preliminary results, encourages parents to share screening results with the child's Primary Care Provider (PCP), and lists other resources, including the Regional Centers for CYSHCN and First Step.

Activities	**Pyramid Level of Service**			
Table 4a, National Performance Measures Summary Sheet	**DHC**	**ES**	**PBS**	**IB**
1. Medical Home and Community Supports				X
2. Medical Home Education and Training			X	
3. Medical Home Outreach			X	

b. Current Activities
1. Medical Home and Community Supports--Infrastructure Building Services--CYSHCN

WiSMHI serves as lead for the CYSHCN Program Medical Home activities. The Medical Home Collaborators developed and supported the new pediatric mental health community resource trainings. WiSMHI and Project Launch were dedicated to the spread of pediatric behavioral health and developed the momentum for the passing of 2013 WI Act 127, supporting the Children's Psychiatry Consultation

Program (CPCP). A survey is planned to assess primary care clinicians competence for serving children with mental and behavioral health needs.

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

WiSMHI in partnership with ECCS are promoting community awareness events related to children's social and emotional development. WISMHI increased primary care provider trainings on pediatric mental health screening tools. P2P, FVW, Regional Centers and other CYSHCN Collaborator Network agencies continue to integrate MH concepts into their trainings and cross promote resources for CYSHCN.

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

WiSMHI coordinates with programs such as WSB, the Congenital Disorders Program, and Birth Defects. WiSMHI is a partner with the UW-Waisman Center promoting Learn the Signs. Act Early WI-specific materials among primary care providers and families. Brief promotional videos were created of WiSMHI trainings.

c. Plan for the Coming Year
1. Medical Home and Community Supports--Infrastructure Building Services--CYSHCN

WiSMHI serves as lead for the CYSHCN Program Medical Home activities. The Medical Home Collaborators plan to continue work related to MH policy development. It is anticipated that WiSMHI and partners will proceed to support the consultation line for clinicians serving children with mental health needs, since legislation is final. MCH Program is lead in developing an RFP for a year 1 pilot of the CPCP in at least one region of WI. Survey data compiled, analyzed and shared at stakeholder meetings will guide future program needs.

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

WiSMHI will continue its EIR in partnership with the Regional Centers and local Birth-3 Programs to promote screening as part of MH implementation. WiSMHI will continue to provide trainings on pediatric mental health screening tools to primary care providers. P2P, FVW, Regional Centers and other CYSHCN Collaborator Network agencies will continue to integrate MH concepts into their trainings.

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

WiSMHI will coordinate with programs such as WSB, the Congenital Disorders Program, and Birth Defects Surveillance. WiSMHI will continue to collaborate with the UW-Waisman Center to promote Learn the Signs. Act Early. WI specific materials (www.actearly.wisc.edu) among primary care providers, families, and other MCH ECS local agencies to expand Act Early dissemination and coordination in WI.

4. Medical Home Foster Care--Direct Healthcare--CYSHCN

The DHS, Division of Access and Accountability (Medicaid) foster care "Medical Home" program in the southeastern region of the State started January 2014. The program is a joint initiative of the DHS and the Department of Children and Families (DCF) and will be supported as year 2 begins in the select southeastern counties. The WiSMHI team and Regional Center teams will promote and pilot a referral form for physicians to Regional Centers.

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

Tracking Performance Measures

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective	65	66	67	68	66
Annual Indicator	65.1	65.1	65.1	65.1	65.1
Numerator	131195	131195	131195	131195	131195
Denominator	201529	201529	201529	201529	201529
Data Source	2009/10 NCHS CSHCN	2009/10 NCHS CSHCN	2009/10 NSCSHCN	2009/10 NSCHSHCN	2009/10 NSCSHCN
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	66	66	66	66	66

Notes - 2013
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (NSCSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2012
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011
Data issue: 2011 data are not available.
Data source: 2009-10 National Survey of Children with Special Health Care Needs, conducted by the CDC, National Center for Health Statistics, Wisconsin Profile.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

a. Last Year's Accomplishments
1. Health Benefits Services--Enabling Services--CYSHCN

The CYSHCN Regional Centers and Family Voices of Wisconsin continued the "Did You Know, Now You Know" health insurance support training. ABC for Health and FVW created several fact sheets on the Affordable Care Act for families (www.healthwatchwisconsin.org/).

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

The Regional Centers continue assisting families to secure health insurance including SSI and Medicaid coverage through information, referral and follow-up including referral to ABC for Health for complex questions on insurance and other health benefits needs.

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

The 2013-2014 legislative session saw unprecedented activity in support of the expansion of mental health services and supports in Wisconsin. Both the Governor's budget and the recommendations from the Speakers Task Force on Mental Health provided new funding for community-based services/supports with over $34 million dollars allocated. This included funding for: The Office of Children's Mental Health, Child Psychiatry Access Line; loan forgiveness for primary care and psychiatry shortage areas, supported employment, telehealth, peer run respite, law enforcement training, and mobile crisis teams.

Activities	**Pyramid Level of Service**			
Table 4a, National Performance Measures Summary Sheet	**DHC**	**ES**	**PBS**	**IB**
1. Health Benefits Services		X		
2. Access to Health Insurance				X
3. Access to Mental Health Services for CYSHCN				X

b. Current Activities
1. Health Benefits Services--Enabling--CYSHCN

ABC for Health continues as the CYSHCN Statewide Access/Health Benefits Counseling Hub, providing direct technical support in the form of training, consultation and care coordination, with over 100 families served. Work with FVW focused on provision of ACA just-in-time webinars.

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

The Regional Centers continue assisting families to secure health insurance through I&R and follow-up, health benefits counseling as appropriate, and training and technical assistance to the CYSHCN Collaborators Network partners on health access and coverage issues.

The Nourishing Special Needs WIC Network has completed a policy brief with Medicaid to assure medical foods.

3. Children's Long Term Support Medicaid Waiver Participants--Direct Health Care Services--CYSHCN

The Bureau of Long Term Support reports 5242 total Waiver Participants. Of these, 1,485 children received State Funded Non Autism Services of which 40 were Crisis State Match slots (28 DD; 6 PD; 6 SED), and 1,445 were State Match slots (1045 DD; 257; 143 SED). For those children receiving State Funded Autism Services, 933 (735 DD; 198 SED) received Intensive In-Home Autism Services; 1,736 children transitioned to Ongoing Autism Services (1,502 DD; 2 PD; 232 SED). There are 1,072 children receiving services through Locally Matched Waiver slots (658 DD; 119 PD; 295 SED) and 16 children in Pilot Slots (9 DD; 4 PD; 3 SED).

c. Plan for the Coming Year
1. Health Benefits Services--Enabling Services--CYSHCN

Family Voices of Wisconsin, ABC for Health, and the Wisconsin Statewide Medical Home Initiative will implement additional objectives and activities focusing on provider training on ACA, Medicaid transportation survey, and behavioral health screening to better support families to access care and insurance coverage. See (www.healthwatchwisconsin.org/).

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

Under ACA, ABC for Health envisions a competency tool that offers over 200 explicit elements attached to 28 Learning Centers related to public and private insurance, national health reform and advocacy skills. Under the health law, each state had to identify a "benchmark plan" that would serve as a basis for defining the essential health benefits, including defining habilitative benefits. Wisconsin as a default state,

does not cover habilitative services under Medicaid. ABC for Health, FV and others are advocating change in assuring access to habilitative services as part of benchmark plans.

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

Studies suggest that children with disabilities or serious health conditions are vulnerable to mental health problems and lack access to existing services and have unmet needs due to non-existing services. The CYSHCN Program consultant serves on several workgroups that are directly addressing access to mental health services for children. The Children's Committee of the Mental Health Council will address infant and early childhood mental health needs not addressed by current services; facilitate the development of a strategic plan to address infant and early childhood mental health; increase funding for telemental health and child psychiatry access line consultation; eliminate aversive interventions in all child serving agencies; address inequity in use of Children's Long-Term Support waiver for children with SED; identify options to fund psycho-social interventions (respite and crisis respite; parent peer specialist); study mental health provider shortage issues; eliminate charges for child support for kids removed to group home. The WI United for Mental Health Coalition will address children's mental health stigma reduction. The Young Star Child Care Committee will address behavioral health training needs of child care providers. The School Mental Health Coalition will address mental health services conducted in the schools.

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

Tracking Performance Measures

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective	91	92	92	65	65
Annual Indicator	64.6	64.6	64.6	64.6	64.6
Numerator	130187	130187	130187	130187	130187
Denominator	201529	201529	201529	201529	201529
Data Source	SLAITS CSHCN	2009/10 NCHS CSHCN	2009/10 NSCSHCN	2009/10 NSCSHCN	2009/10 NSCSHCN
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	65	65	65	65	65

Notes - 2013

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2012

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011
Data issue: 2011 data are not available.
Data source: 2009-10 National Survey of Children with Special Health Care Needs, conducted by the CDC, National Center for Health Statistics, Wisconsin Profile.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.
According to SLAITS documentation, numbers are not comparable for the data years 2005-06 & 2009-10.

a. Last Year's Accomplishments
1. Access to Individual/Household Services--Enabling Services--CYSHCN

Individuals, families, and providers who contact the 5 CYSHCN Regional Centers and their subcontracted agencies received direct assistance, referrals to other professionals, or other interventions by Center and local staff. In 2013, according to SPHERE, there were 5,295 CYSHCN-funded contacts and services provided, with 2,345 individual/household interventions and 2,950 brief contacts. Brief contacts include consultations that are face-to-face, telephone, or in writing. The Western Regional Center continued to contract with their regional LHDs and have highlighted workshops for families on Mental Health.

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

Family Voices of WI (FVW) developed a set of fact sheets on the Affordability Care Act: The ACA -- A Brief Overview; The ACA -- Key Dates for Health Insurance Coverage -- Enrollment and Penalties; The ACA -- What is a Qualifying Life Event, in addition to Medicaid and Transportation to Medical Appointments. All fact sheets can be found at (http://fvofwi.org/publications/fact-sheets).

ABC for Health, produced a just-in-time series to provide practical tips and explanations that help Wisconsin families enroll in health insurance and challenge inappropriate health coverage denials. The CYSHCN Network's, partnerships at the local, regional and state levels were advanced through co-sponsored events, cross-referral plans, and collaborative efforts with evaluation through a reflective partnership tool to better identify partnership system gaps.

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

The established CYSHCN Collaborators Network and the CYSHCN Program continue to work collaboratively with many partners to assure that CYSHCN are identified early, receive coordinated care, and their families have access to the supports they need. These collaborative partnerships were evaluated through Center reflection and looking at how the Centers can strengthen the partnerships for the coming years. The annual Collaborators meeting focused on the Transition.

The Regional Centers have worked together to support children's healthy development partnering with LHD ECS Initiatives. One effort worked through the Chippewa Health Improvement Partnership to form an Infant Mental Health Action Team.

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

b. Current Activities

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

The Regional Centers continue to collaborate with LHDs to increase referrals. ABC for Health continues to inform families about health reform i.e. "The Consumer's Companion, A February 2014 Guide to Health Care Reform"

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

A Wisconsin navigation guide is disseminated statewide to assist families in understanding how to find services and supports. Region-specific Autism Spectrum Disorders (ASD) resource guides, produced in collaboration with the CAAI ASD State Implementation grant, continue to be disseminated. Multiple news letters are disseminated via listserve (e.g., Medical Home Minute)

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

The Regional Centers and HUBs collaborate with regional nutrition consultants who work with LHDs. The Waisman Center leads the Nutrition Network with the LEND Director, a nutritionist, as lead. Wisconsin received the Act Early State Systems Grant and the Waisman Center will lead expansion efforts to increase alignment and interagency coordination, enhance skills training for early identification and referral of Learn the Signs. Act Early.

The CYSHCN Network offers support and resources to help families navigate ACA implementation and health exchange and to improve coordination of care across the lifespan.

c. Plan for the Coming Year

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

The 5 CYSHCN Regional Centers will continue to provide information and assistance to families and providers. Families will be linked to trainings and parent support opportunities to meet their needs. It is expected that the Western Region will continue to subcontract with their LHDs for information and assistance. Focusing on the evaluation of CYSHCN Regional Center partnerships will help inform needs and gaps for the 5 year needs assessment.

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

The Regional Centers will partner with the CYSHCN Hubs of Expertise through the following: attend trainings and introduce the Center as a resource, assist with provider recruitment, provide community-related resource information to practice sites within their region, coordinate these and other Medical Home activities with partners, and assist with practice site follow-up.

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

In partnership with other funding sources, the CYSHCN Program will plan and implement the following projects: continue to implement the CYSHCN Regional Centers and Hubs of Expertise model, strengthen the Collaborators Network's role to meet, share resources, problem-solve, cross-refer and identify unmet needs. The Nourishing Special Needs Network will continue to improve nutritional services for CYSHCN through a best practice mentoring initiative.

The CYSHCN Program will continue to work to increase visibility, focus more attention on early identification and screening, and broaden the stakeholder group that meets regularly.

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

Tracking Performance Measures

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective	52	54	55	46	46
Annual Indicator	44.4	44.4	44.4	44.4	44.4
Numerator	89478	89478	89478	89478	89478
Denominator	201529	201529	201529	201529	201529
Data Source	2009/2010 SLAITS CSHCN	2009/10 NCHS CSHCN	2009/10 NS CSHCN	2009/10 NS CSHCN	2009/10 NS CSHCN
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	46	46	46	46	46

Notes - 2013

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2012

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011

Data issue: 2011 data are not available. The objective for 2011 was based on previous data NCHS data from 2005-06 which were entered in the previous applications. We cannot change the objectives that were entered in previous years. We cannot change the objective for 2011. We have new data for 2009-2010 which we have entered for 2009 -2011. Our new objectives are based on these new and recent data.

Data source: 2009-10 National Survey of Children with Special Health Care Needs, conducted by the CDC, National Center for Health Statistics, Wisconsin Profile.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

a. Last Year's Accomplishments
1. State Partnership Building--Infrastructure Building--CYSHCN

The Youth Health Transition Initiative, funded by the CYSHCN Program and housed at the UW-Madison, Waisman Center, launched a Statewide Learning Community on Youth Health Transition in November 2013. The Learning Community, linked through a list-serve and quarterly webinars, offers opportunities for transition champions to share best practices. Fields of expertise represented include: pediatrics primary and specialty care, nursing, public health, social work and family leaders.

Through the CYSHCN Program's participation in the State's interagency Community of Practice on Transition, we are increasing our collaboration on resource development and dissemination, training and coordinated planning for several large federal grant initiatives within Long Term Care, Mental Health, Vocational Rehabilitation and Public Instruction, and assuring health care and health care transition planning is incorporated into this work with CYSHCN families.

2. Outreach and Training--Outreach [Population-Based Services] and Training [Infrastructure Building]

The Youth Health Transition Website (www.healthtransitionwi.org/index.htm) was launched in October, 2013 along with a companion Facebook page. In three months, there were 1,245 visits to the site where there are regularly updated resources, family and provider stories and training and grant opportunities.

The Transition Initiative collaborated with Wisconsin LEND to host a webcast of the Baylor Transition Conference at the American Family Children's Hospital in November. Wisconsin's Marshfield Clinic was a presenter and Group Health Cooperative-Madison had a poster session, both highlighting their quality improvement work in youth health and transition practices.

The Transition Health Care Checklist: Preparing for Life as an Adult was fully updated in 2013 (www.waisman.wisc.edu/cedd/pdfs/products/health/THCL.pdf) and is promoted and utilized by all our state partners.

3. Access to Transition Information--Enabling Services

Family Voices, in collaboration with the Regional Centers and other partner organizations, provided 7 "What's After High School Trainings" in each region of the state for 166 families and providers. More than 90% of participants reported they felt better prepared to participate in decision making for their child or for other families and had a better understanding of resources, services and how to navigate them. Their training resources are also available on line at (http://fvofwi.org/resources/materials-from-our-trainings) and (http://fvofwi.org/transition-resources).

In 2013, Regional Centers reported completing 98 transition assessments with 63% completing a written transition plan. Three Regional Centers conducted trainings for families and/or providers in guardianship process. All the Regional Centers participate in county interagency Transition Councils.

4. Access to Transition Services--Infrastructure Building

Three of our Regional Centers are located in or adjacent to our state's largest children's hospitals. Considerable progress was made in 2013 to support transition quality improvement efforts within these systems serving a significant number of the State's CYSHCN families. The SE Regional Center Director chaired the Children's Hospital of Wisconsin Transition Quality Improvement Team. A transition policy has been developed and transition planning tools are being incorporated into their electronic medical record. The Southern Regional Center and the Transition Initiative staff, both based at the Waisman Center are participating in the Transition Quality Improvement Team at American Family Children's Hospital, created in 2013.

Activities Table 4a, National Performance Measures Summary Sheet	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. State Partnership Building				X
2. Outreach and Training--Outreach [Population-Based Services] and Training [Infrastructure Building]			X	X
3. Access to Transition Information		X		
4. Access to Transition Services				X

b. Current Activities
1. State Partnership Building--Infrastructure Building--CYSHCN

In 2014, through a special funding opportunity provided by the CYSHCN Program, the Youth Health Transition Initiative provided Transition Quality Improvement (QI) grants to four health care practices and systems. Children's Hospital of Wisconsin (CHW) and Froedtert Hospital in Milwaukee and UW Hospitals and Clinics (UWHC) and American Family Children's Hospital (AFCH) in Madison will be implementing strategies using the QI tools developed by Got Transition.

Wisconsin has been selected to serve on the "Got Transition" Advisory Committee.

The Youth Health Transition Initiative's Learning Collaborative, formed in 2013, has grown to 141 members on its list-serve. Quarterly webinars are planned, featuring quality improvement efforts in each region of the state.

A QI activity within the state's interagency CoT, has been to develop model Transition Planning case studies for CYSHCN, incorporating health goals, utilizing the Department of Public Instruction's Form 13, required for each 14 year old with an IEP.

2. Outreach and Training--Outreach [Population-Based Services] and Training [Infrastructure Building]

Family Voices is hosting a two-day Transition training in Milwaukee for CYSHCN families in underserved communities. Other key outreach activities and trainings will continue to expand in 2014.

c. Plan for the Coming Year
1. State Partnership Building--Infrastructure Building--CYSHCN

We will convene our second statewide Youth Health Transition Summit in 2015 where we will highlight the work of our Transition QI grantees. The Transition Learning Community work will continue to be supported by our growing Youth Health Transition Initiative (YHTI). The YHTI will continue to disseminate the learning of our QI grantees to spread that work in additional regions of the state.

The CYSHCN Program and YHTI staff will continue collaborative planning with the state Community of Practice on Transition to assure better integration of our work to serve families with youth in transition.

2. Outreach and Training--Outreach [Population-Based Services] and Training [Infrastructure Building]

In 2015 we will continue to build content and utilization of the Youth Health Transition website assuring its resources are extended to a greater array of professionals serving families with youth in transition with growing attention to reaching those adult providers they will be transitioning to.

The YHTI and CYSHCN staff and our Regional Centers and Hubs will continue to provide critical training and technical assistance to our partners and providers and families in every region of the state, assuring health transition is incorporated into planning for CYSHCN.

The YHTI will continue to explore how to incorporate transition planning into other MCH programs including the newly launched Genetics Hub.

CYSHCN staff and contractors will continue to collaborate with B-3 and other Long Term Care Programs and family support organizations to plan and host the annual Circles of Life conference, serving over 400 CYSHCN families each year.

3. Access to Transition Information--Enabling Services

Family Voices will continue to provide their Transition training for families. The five Regional Centers will continue to support families with transition planning while assuring their regional partners are connected to best practice resources in transition.

4. Access to Transition Services--Infrastructure Building

The Regional Centers will continue to provide support to health system initiatives to build transition policies and best practices for all youth.

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

Tracking Performance Measures

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective	83.6	83.7	83.7	87	87
Annual Indicator	83.6	83.6	85.0	81.6	81.6
Numerator	368	368	261	226	226
Denominator	440	440	307	277	277
Data Source	CDC Nat Imm Surv 2010	CDC Nat Imm Surv 2009	CDC Nat Imm Surv 2011	CDC Nat Imm Surv 2012	CDC Nat Imm Surv 2012
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	82.5	82.5	83	83	83.5

Notes - 2013
Data issue: Data are not available for 2013.

Notes - 2012
Data issue: These are 2012 estimates for the 4:3:1:3:3 series, 81.6% (226/277), CDC National Immunization Survey, 2012. The weighted estimate is 78.7 (± 6.3). Estimates are weighted to account for the sampling design.
The indicator for 2012 is lower than the estimate for 2011 because it includes only children who only children who completed the full Haemophilus influenzae b vaccine (Hib) series, whereas in 2011, the estimate included children who received at least three doses of vaccine (depending on the brand of vaccine used, a child may need either three or four doses to complete the series). Therefore, we have revised the objectives accordingly.

Notes - 2011
Source: CDC National Immunization Survey, 2011. The weighted estimate is 83.9% (+_5.9). Estimates are weighted to account for the sampling design.

a. Last Year's Accomplishments
1. Providing, Monitoring and Assuring Immunizations--Population-Based Services--Children, including CYSHCN

Title V staff supported the Immunization Program and LHDs to provide primary prevention activities and monitoring which support compliance with the Immunization Program funding requirements.

According to the latest National Immunization Survey, conducted for the time period Jan. 1-Dec. 31, 2012 and reported in 2013, Wisconsin achieved 78.7% immunization coverage rate among children aged 19-35 months of age for the 4:3:1:3:3 series. This exceeds the national average of 73.2%.

2. Program Coordination--Infrastructure Building--Pregnant women, mothers, infants and children, including CYSHCN.

Coordination occurred with WIC and the Immunization Programs to assure enrollment in the WI Immunization Registry (WIR) and with ROSIE (WIC documentation system). This incorporates the use of State and local data systems to assure lead screening and prevention services for children.

State partnerships continued with Title V MCH/CYSHCN, LHDs, WIC, Medicaid, Tribes and Community Health Centers (CHCs).

3. Updating and Sharing Policy Changes and Clinical Practices--Infrastructure Building--Pregnant women, mothers, infants and children, including CYSHCN

National and International circumstances that result in recommended changes in the immunization schedule continued to be tracked by the Immunization Program in 2013.

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

Provider site visits in 2013 included quality improvement efforts which were promoted and supported by staff in the Immunization Program. Targeted populations included all infants and children including those agencies providing services to CYSHCN.

Activities	**Pyramid Level of Service**			
Table 4a, National Performance Measures Summary Sheet	**DHC**	**ES**	**PBS**	**IB**
1. Providing, Monitoring and Assuring Immunizations			X	
2. Program Coordination				X
3. Updating and Sharing Policy Changes and Clinical Practices				X
4. Quality Improvement of Vaccines for Children Program				X

b. Current Activities

1. Providing, Monitoring and Assuring Immunizations--Population-Based Services--Children, including CYSHCN

The Grants and Contracting (GAC) System is utilized to assure LHDs are providing population level immunization services to all age appropriate children in their jurisdiction, including partnerships with the educational system, child care providers and private providers.

2. Program Coordination--Infrastructure Building--Pregnant women, mothers, infants, children and CYSHCN

The Immunization Program partners with Title V, LHDs, WIC, Medicaid, Tribes, and CHCs. The program incorporates use of state and local data systems to assure lead screening for children.

3. Updating and Sharing Policy Changes and Clinical Practices--Infrastructure Building--Pregnant women, mothers, infants, children, and CYSHCN

National and International circumstances that result in recommended changes in the immunization schedule continue to be tracked with policy sharing occurring as appropriate.

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

QI efforts for providers are maintained through site visits by Immunization staff. The Immunization Program is incorporating a DTap Cocooning Program for postpartum women and families through private providers.

c. Plan for the Coming Year
1. Providing, Monitoring and Assuring Immunizations--Population-Based Services--Children, including CYSHCN

The GAC System will continue to be utilized to assure LHDs are providing population level immunization services to all age appropriate children in their jurisdiction. This includes partnerships with the educational system, child care providers and private providers.

2. Program Coordination--Infrastructure Building--Pregnant women, mothers, infants, children, and CYSHCN

The Immunization Program will continue partnering with Title V, LHDs, WIC, Medicaid, Tribes, and CHCs; incorporating use of state and local data systems to assure lead screening prevention in children in 2015.

3. Updating and Sharing Policy Changes and Clinical Practices--Infrastructure Building--Pregnant women, mothers, infants and children, including CYSHCN

As determined by 2015 national and international standards, policies and recommended changes in protocol and procedures will be updated and shared by the Immunization Program.

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

QI efforts for providers will continue and be enhanced through site visits by Immunization staff. Support, promotion and incorporation of DTap Cocooning for postpartum women and families through private providers prior to discharge will continue in 2015. Cocooning refers to the strategy of protecting infants from pertussis by vaccinating those in close contact with them. Cocooning enhances maternal vaccination to provide maximum protection to the infant. Utilization of immunization services focusing on the adolescent population through local coalitions will continue.

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

Tracking Performance Measures

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective	16.1	16.1	13.9	11	10.3
Annual Indicator	13.9	11.7	10.4	10.2	10.2
Numerator	1608	1345	1187	1131	1131
Denominator	115796	114825	113631	111419	111419
Data Source	WI DHS/OHI 2010	WI DHS/OHI 2012	WI DHS/OHI 2013	WI DHS/OHI 2014	WI DHS/OHI 2014
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	10	9.9	9.5	9	9

Notes - 2013
Data issue: Data will not be available for 2013 from the Office of Health Informatics until late 2014.

Notes - 2012
Data notes: There were 40 births to teens <15 years in 2012. Sources: Numerator: WI Department of Health Services, Division of Public Health, Office of Health Informatics. 2014. Denominator: WI Department of Health Services, Division of Public Health, Office of Health Informatics. Wisconsin Interactive Statistics on Health (WISH) data query system, http://dhs.wisconsin.gov/wish. Population Module, accessed 04/25/14.

Notes - 2011
Data notes: There were 57 births to teens <15 years in 2011. Sources: Numerator: WI Department of Health Services, Division of Public Health, Office of Health Informatics. 2012. Denominator: WI Department of Health Services, Division of Public Health, Office of Health Informatics. WI Interactive Statistics on Health (WISH) data query system, http://dhs.wisconsin.gov/wish. Population Module, accessed 04/25/13.

a. Last Year's Accomplishments
1. Personal Responsibility Education Program (PREP)--Enabling Services--Ages 10-19

The Personal Responsibility Education Program (PREP) provided education to reduce teen birth and STI rates for youth ages 10 to 19 in the cities of Milwaukee, Racine and Beloit. The 6 PREP sites located in these cities provided Making Proud Choices and Street Smart evidence-based curricula programming to over 1,000 youth.

PREP projects also offer services to prepare young people for adulthood. Education on healthy relationships is provided through the Safe Dates curriculum. Financial literacy programming is achieved through 5-hour Got Money? Conferences with breakout sessions on specific financial topics provided by Asset Builders of America. Education and career attainment programming includes activities such as ensuring youth are on track to graduate, assisting with enrollment in GED programs if necessary, and assisting with exposures to various trades, career fairs and college tours.

Additional funding supports stakeholder groups of concerned professionals and citizens in each of the communities to help raise awareness of the instances of teen pregnancy and sexually transmitted infections among youth, and to promote awareness of and access to reproductive health care homes through increased enrollment in the Family Planning Only Service (FPOS) Medicaid benefit. This work began with the Milwaukee Adolescent Pregnancy Prevention Partnership (MAPPP) and is spreading to Beloit and Racine in collaboration with PREP.

PREP and MAPPP were successful in establishing staff capacity for adolescent health and wellness as well as emphasis on life skills in the funded communities. Education and training efforts were conducted through quarterly staff meetings and an annual all staff in-service. In addition fidelity monitoring was fully implemented and quality assurance are solidly in place for the sub-grantee agencies. The yearlong campaign for dual protection as a standard of care was implemented through a standardized referral protocol.

Activities	**Pyramid Level of Service**			
Table 4a, National Performance Measures Summary Sheet	**DHC**	**ES**	**PBS**	**IB**
1. Personal Responsibility Education Program (PREP)		X		

b. Current Activities
1. Personal Responsibility Education Program (PREP)--Enabling Services--Ages 10-19

All six grantees continue to operate at full capacity providing PREP programming. Efforts to reach specific targeted high risk populations are successful through increased partnerships within the communities, including schools.

PREP and MAPPP stakeholders groups continue to meet quarterly. The groups have begun the first of several meetings and webinars designed to increase understanding and promotion of youth's access to

family planning services now that the Affordable Care Act is implemented. The stakeholders groups continue to make progress raising awareness of the issues of teen pregnancy and STI rates in their respective communities. This year's theme for the grantees have related to the following: lifecourse, trauma informed care, adolescent health, social media, reproductive health plans and more.

The Medical College of Wisconsin, on behalf of the PREP Program, was awarded the 2013 Governor's Financial Literacy Award for the work done with PREP youth through the Got Money? Conferences.

c. Plan for the Coming Year
1. Personal Responsibility Education Program (PREP)--Enabling Services--Ages 10-19

The PREP and MAPPP Projects will be engaged in strategic planning and needs assessment related to sustainability and future direction. There will be continued efforts to work with the schools in our PREP communities that received an InSPIRE grant to provide programming to pregnant and parenting teens to delay repeat pregnancies and eliminate barriers to completing their education.

The State's access to the benefit that covers Family Planning Only Services has changed recently with the implementation of the Affordable Care Act. We will focus on work with the PREP partner clinics that have been determined to be "youth friendly" to develop and market their ability to provide confidential services to adolescents.

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

Tracking Performance Measures

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective	51	51	52	52	53
Annual Indicator	50.8	50.8	50.8	50.8	61.0
Numerator	35806	35806	35806	35806	2044
Denominator	70484	70484	70484	70484	3350
Data Source	WI DHS/DPH 2009	WI DHS/DPH 2009	WI DHS/DPH 2009	WI DHS/DPH 2009	WI DHS/DPH 2014
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	61	61	61	61	61

Notes - 2013
Data issue: The indicator for 2013 is from new survey data and was calculated with a different method, and the estimate changed about ten percentage points. The numerator and denominator were weighted for nonresponses. Source: Olson MA, Chaffin JG, Chudy N, Yang A. Healthy Smiles / Healthy Growth: Wisconsin's Third Grade Children, 2013. WI Oral Health Program, WI Department of Health Services. Publication #: P-00589. Our objective is flatlined at 61%; these are survey data and will not change for the next 5 years, until the oral health program does a new survey; therefore, our objectives remain at 61%, the same as the current indicator.

Notes - 2012
Data issue: Numerator and denominator are weighted estimates from the Wisconsin Division of Public Health "Make Your Smile Count, The Oral Health of Wisconsin's Children" survey of third grade children, 2007-08. The unweighted data are: 2,212 and 4,353. The Oral Health Program is finishing data collection for the next round of the third grade survey. Data from the 2012-13 school year will be available next year.

Notes - 2011
Data issue: Numerator and denominator are weighted estimates from the Wisconsin Division of Public Health "Make Your Smile Count, The Oral Health of Wisconsin's Children" survey of third grade children,

2007-08. The unweighted data are: 2,212 and 4,353. If funding is available, the Oral Health Program is scheduled to do the next survey during the 2012-13 school year.

a. Last Year's Accomplishments
1. Wisconsin Seal-A-Smile School-Based Dental Sealant Program--Population-Based Services--Children

The Wisconsin Seal-A-Smile (SAS) statewide school-based dental sealant program provided funding to over 40 programs. The program has experienced significant growth since its inception in 1999. In the 2012-13 school year, SAS programs screened 34,372 children and placed 81,095 dental sealants on 21,150 children. Dental sealants and fluoride varnish are recognized as evidence-based primary prevention interventions to reduce the prevalence and incidence of dental decay. Through a CDC Cooperative Agreement, the Oral Health Program (OHP) has a dedicated Dental Sealant Coordinator. The Coordinator works in collaboration with Children's Health Alliance of Wisconsin (CHAW) to jointly administer and monitor the SAS program. In addition, the Coordinator provides technical assistance to individual grantees. SAS program development and expansion is dedicated to areas of Wisconsin with the highest need. SAS criteria for funding requires that programs provide services in schools where the free and reduced price meal program eligibility is 35% or greater. It is the intent of the SAS program to provide programming in all schools with a free and reduced meal program eligibility rate of 50% and higher. In the 2012-13 school year, SAS programs provided services in 624 schools, 402 (64%) of which had a free and reduced meal program eligibility rate of 50% or higher.

2. Wisconsin Oral Health Program (OHP) Infrastructure Support--Infrastructure Building--Children including CYSHCN

In 2013, the OHP was the recipient of a second round of CDC Cooperative Agreement funding. The award is designed to increase capacity and build infrastructure to assure Wisconsin has an adequate oral health workforce to successfully address statewide needs. The previous award allowed for the creation of a Dental Sealant Coordinator to enhance and expand the program and the current award continues to support that position. The OHP has a highly trained Dental Sealant Coordinator and is positioned to meet the growing needs of our state.

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

Technical assistance was provided to the over 40 statewide grantees in collaboration with CHAW's Associate Director. The OHP Dental Sealant Coordinator provides ongoing project specific technical assistance as well as outreach to potential expansion grantees. The MCH funded State Dental Director assists in monitoring grantee contracts, review of grantee proposals and provides technical support as needed.

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

In the 2012-13 school year, the Wisconsin Division of Public Health OHP conducted its third Make Your Smile Count Survey, now called Healthy Smiles/Healthy Growth, oral health assessment of third grade students. The total sample of children evaluated was 2,832. The survey data revealed that 61.0% of Wisconsin third grade students had dental sealants on at least one permanent tooth, far exceeding the Healthy People 2020 objective of 28% for sealants. It is the intention of the OHP to continue to exceed national objectives related to dental sealants, monitor progress and evaluate the program.

Activities **Table 4a, National Performance Measures Summary Sheet**	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Wisconsin Seal-A-Smile School-Based Dental Sealant Program			X	
2. Wisconsin Oral Health Program Infrastructure Support				X
3. Technical Assistance		X		
4. Oral Health Surveillance			X	

b. Current Activities
1. WI Seal-A-Smile Sealant Program--Direct Heath Care Services--Children, including CYSHCN

School-based dental sealant programs continue. State funds support the SAS Program. Matching funds continue from the private sector through Delta Dental of Wisconsin. Delta provides additional funds for program expansion and redesign of the data collection. The redesigned data collection will increase data quality and streamlining the data entry process. CHAW targets opportunities to reach CYSHCN through the school-based dental sealant program.

2. Wisconsin Oral Health Infrastructure Support--Infrastructure Building Services--Children, including CYSHCN

The Program continues to employ a Dental Sealant Program Coordinator through CHAW.

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

Technical assistance is currently being provided to over 40 statewide grantees through the Dental Sealant Program Coordinator and CHAW. In addition, the Seal-A-Smile end of year meeting will include continuing education training.

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

All SAS programs are required to collect and report both school and child level data to the OHP. These data include CYSHCN status based on a vetted questionnaire provided by the CYSHCN Program. Children identified with additional oral health needs receive care coordination. The data on CYSHCN are shared with the CYSHCN Program.

c. Plan for the Coming Year
1. Wisconsin Seal-A-Smile Sealant Program--Direct Heath Care Services--Children

The OHP anticipates continued funding to the current school-based dental sealant programs, as well as the creation of new programs. Funding has been allocated from State GPR to SAS. Matching funding will continue from the private sector through Delta Dental of Wisconsin. Delta Dental will be providing additional funds during the 2014-15 school year to specifically target new high risk schools in the Milwaukee area. The OHP will continue to actively engage LHDs, agencies and individuals to establish and or expand programs. The OHP will again be working with CHAW on the established goals and objectives and will be specifically targeting opportunities to reach CYSHCN through the school-based dental sealant program. The OHP will continue to require all SAS funded programs to collect data on CYSHCN based on the vetted questionnaire obtained by the CYSHCN Program.

2. Wisconsin Oral Health Infrastructure Support--Infrastructure Building--Children including CYSHCN

The Program will continue to contract with Children's Health Alliance to jointly administer the SAS Program with the OHP Dental Sealant Coordinator and provide training and guidance to new staff/programs. The OHP will work closely with the CYSHCN Program regarding the collection of data on dental sealant program participants who report as CYSHCN. The MCH funded State Dental Director will continue to play an active role in the SAS program.

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

Technical assistance will be provided to the statewide project grantees jointly with CHAW. The OHP will continue to work with the CHAW on the goals and objectives of the SAS Program and will continue to target school based opportunities to reach CYSHCN.

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

All SAS programs will continue to be required to collect and report both school and child level data to the OHP, but will be reporting it through the redesigned SEALS program. These data will continue to capture CYSHCN status. Children identified with additional oral health needs will be case managed to assure services are provided. In addition the data will be analyzed and used to show cost effectiveness of the SAS program.

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

Tracking Performance Measures

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective	2.5	2.5	2.5	1.4	1.1
Annual Indicator	1.7	1.5	1.2	0.9	0.9
Numerator	18	16	13	10	10
Denominator	1084021	1102987	1093790	1088658	1088658
Data Source	WI DHS/OHI 2011.	WI DHS/OHI 2012.	WI DHS/OHI 2013	WI DHS/OHI 2013	WI DHS/OHI 2013
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	1.1	1.1	1	1	1

Notes - 2013
Source: WI Department of Health Services, Division of Public Health, Office of Health Informatics. Wisconsin Interactive Statistics on Health (WISH) data query system, http://dhs.wisconsin.gov/wish. Injury Mortality Module. Data for 2013 will not be available until 2014, so 2012 data have been carried over.

Notes - 2012
Source: WI Department of Health Services, Division of Public Health, Office of Health Informatics. Wisconsin Interactive Statistics on Health (WISH) data query system, http://dhs.wisconsin.gov/wish. Injury Mortality Module.

Notes - 2011
Source: WI Department of Health Services, Division of Public Health, Office of Health Informatics. Wisconsin Interactive Statistics on Health (WISH) data query system, http://dhs.wisconsin.gov/wish. Injury Mortality Module.

a. Last Year's Accomplishments
1. MCH Early Childhood Systems--Infrastructure Building--Infants and Children

In 2013, the MCH Program continued the infrastructure and capacity building within the Keeping Kids Alive (KKA) and WI Healthiest Families (WHF) initiatives with all LHDs in the state. Training and TA for LHDs continued to be provided by Children's Health Alliance of WI for KKA and by MCH staff and partners for the WHF initiatives. Many local health departments utilized the WHF initiative to assess their communities' current child passenger safety programs and other related evidence based motor vehicle safety prevention strategies to promote systems building with community partners. Expectations for this work include working within community institutions to identify organizational policies that may enhance motor vehicle safety for children (i.e., hospital policy requiring a Child Passenger Safety technician to check all seats before a new baby is discharged). Further, via the new KKA Initiative, additional Child Death Review teams have been established so that approximately 90% of the infant and child population in the state is covered. Data will be available in the coming years to track outcomes and engage new partners.

The MCH Program provides technical assistance to support LHDs and tribal agencies to implement early childhood system-building activities. Education and technical assistance for LHDs is focused on assuring personal, social and structural support. To support personal motivation and ability, MCH Core Competencies and related resources were identified with links to the MCH Navigator to support development of competencies. A competency to develop a working understanding of the life course framework is included. For social support to promote peer-to-peer learning, an annual conference features presentation by local agencies. Community Awareness Events were planned in each region of the state to bring multiple partners together around early childhood development and toxic stress. Structural support was enhanced with site visits to most agencies. Feedback cards provided local agencies with comments and suggestions about the quality of their past year's work. In addition, Children's Health Alliance of WI was contracted to support CDR and FIMR teams with technical assistance, webinars, regional contractor meetings and an annual Keeping Kids Alive Summit.

Activities	**Pyramid Level of Service**			
Table 4a, National Performance Measures Summary Sheet	**DHC**	**ES**	**PBS**	**IB**
1. MCH Early Childhood Systems				X

b. Current Activities
1. MCH Early Childhood Systems--Infrastructure Building--Infants and Children

To support Fetal Infant Mortality Review and Child Death Review, 48 Child Death Review (CDR) teams cover 51 counties and 90% of the population. Additionally there are 7 counties with active Fetal Infant Mortality Review teams. Teams are multidisciplinary and prevention focused, and share information learned in their review processes to improve the health and safety of communities. LHDs are implementing KKA and addressing the WHF focus area of safety and injury prevention. Both of these areas have the potential to reduce child deaths from motor vehicle crashes. The emphasis is on community driven priorities and utilization of the life course framework. The MCH Program will continue to provide technical assistance in these areas to local communities along with their statewide partner, CHAW.

Technical assistance provided by the MCH Program staff continues with individual assistance related to competencies. A 4-part webinar series was developed titled "A Data-driven Approach to Building Early Childhood Systems" to assist agencies with assessment, planning, implementation, evaluation, sustainability and collective impact. The annual MCH Conference will be integrated with the Keeping Kids Alive Summit.

c. Plan for the Coming Year
1. MCH Early Childhood Systems--Infrastructure Building--Infants and children

LHDs and tribal agencies will continue to receive MCH block grant funds to support early childhood systems. This is multi-year work with agencies progressing through steps of assessment, planning, implementation, and evaluation and sustainability. The life course framework and core competencies based on the MCH Leadership competencies will continue to provide the foundation for this work. It is anticipated that over the course of five years, there will be improved and more comprehensive local systems of early childhood services for all children in Wisconsin. These connections should enhance a statewide structure to identify the circumstances surrounding infant and child deaths and implement preventive strategies for community action, including strategies to decrease the rate of deaths to children aged 14 years and younger caused by motor vehicle crashes.

Technical assistance will continue to be provided to LHDs implementing the WHF and KKA initiatives. Learning Communities will be implemented and will support peer coaching.

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

Tracking Performance Measures

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective	28	29	28	28	27
Annual Indicator	27.5	26.4	26.4	25.8	29.6
Numerator	3901	3621	3439	3288	3858
Denominator	14185	13715	13025	12728	13028
Data Source	CDC PedNSS 2010	CDC PedNSS 2010	CDC PedNSS 2011	WI WIC Report 2013	WI WIC Report 2013
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	32	34	36	38	40

Notes - 2013
Source: Wisconsin WIC Program; Report: BFQ2001-1; Breastfeeding Incidence and Duration Report - Statewide Totals; Report Date: 01/01/2013 to 12/31/2013.

Notes - 2012
Source: Wisconsin WIC Program; Report: BFQ2001-1; Breastfeeding Incidence and Duration Report - Statewide Totals; Report Date: 01/01/2012 to 12/31/2012.

Notes - 2011
Source: 2011 Pediatric Nutrition Surveillance System (PedNSS), Centers for Disease Control and Prevention. CDC is discontinuing the PedNSS.

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

The format and frequency of the Building Breastfeeding Competencies for WIC staff training and the Breastfeeding Peer Counseling training was revised and improved to be more responsive to local needs. The WIC Breastfeeding Support online training module continues to provide breastfeeding orientation and education for all staff. A 5-day Certified Lactation Specialist training was offered in May to 38 WIC staff and 16 community partners.

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

In February, the WIC Program trained 9 new breastfeeding peer counselors. Peers provided prenatal breastfeeding counseling and postpartum support in 59 local WIC projects statewide. Ongoing quarterly continuing education conference calls were provided for breastfeeding peer counselors and Breastfeeding Peer Counselor Program (BFPCP) Coordinators. The WIC Breastfeeding Incidence and Duration Report for 2013 indicated improved breastfeeding rates with the BFPCP. The rates for BFPCP for 2013 were initiation 72.4%, 3 month duration 52.7% and 6 month duration 29.8%. The rates for non-peer projects were initiation 68.4%, 3 month duration 50.7% and 6 month duration of 27.4%. WIC provided 884 electric pumps and 2,540 manual pumps in calendar year 2013.

3. Wisconsin Breastfeeding Coalition (WBC)--Population-Based Services--Pregnant and breastfeeding women

June 2013, the WBC held the 3rd annual Breastfeeding Summit in Plover. The focus of the Summit was making sense of breastfeeding data with Dr. Lori-Feldman-Winter as keynote speaker. The Breastfeeding Friendly Child Care Training was provided to 19 childcare centers in Wood County, 22 child care centers

in Racine and Kenosha Counties, 10 childcare centers in the Heart of Wisconsin Breastfeeding Coalition area and 6 childcare centers in the Northwoods Breastfeeding Coalition area.

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

August 2013 the Building Bridges training was provided in Rhinelander & Woodruff hospitals to inform, influence, and impact breastfeeding friendly practices. 65 health care providers attended including physicians, nurses, dietitians, peer counselors and other health professionals from 22 health organizations. The number of local breastfeeding coalitions was 26 in 2013. The WBC maintained non-profit organizational status, maintained website and Facebook page and established a newsletter.

Activities **Table 4a, National Performance Measures Summary Sheet**	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Breastfeeding Education, Promotion, and Support		X		
2. Breastfeeding Peer Counseling and Breast Pump Distribution		X		
3. Wisconsin Breastfeeding Coalition			X	
4. Collaboration and Partnerships: Breastfeeding Coalitions				X

b. Current Activities
1. Breastfeeding Education, Promotion, and Support--Enabling Services

The training -- Using Loving Support to Grow and Glow in WIC -- Building Breastfeeding Competencies for local WIC staff is now available as an online training. A WIC Breastfeeding Support online training module provides orientation and education for all staff. Biennial WIC conference in June will provide topics on breastfeeding including food intolerances, breast pumps, building low milk supply, community-wide approaches impacting breastfeeding, and managing a peer program.

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

WIC Program trained 13 new breastfeeding peer counselors. Peers serve in 58 local WIC projects statewide. Quarterly continuing education conference calls are provided for the peer counselors and BFPCP Coordinators.

3. WBC--Population-Based

WBC will hold its 4th annual summit in Stevens Point focusing on supporting exclusive breastfeeding in the hospital and promoting breastfeeding among disparate populations. Key speakers are Kathie Marinelli, MD, IBCLC, FAAP, United States Breastfeeding Committee Chair and Michael Young MD, FAAP, University of Connecticut School of Medicine.

4. Collaboration and Partnerships: Breastfeeding Coalitions--Infrastructure Building

Building Bridges training will be held in central, western and southern parts of the state. The Mothers' Milk Bank of the Western Great Lakes has 8 locations in Wisconsin.

c. Plan for the Coming Year
1. Breastfeeding Education, Promotion, and Support--Enabling Services--Pregnant and breastfeeding women

Using Loving Support to Grow and Glow in WIC -- Building Breastfeeding Competencies for local WIC staff will continue to be offered. Breastfeeding Peer Counseling training will continue to be offered. The WIC Breastfeeding Support online training module will continue to provide breastfeeding orientation and education for all staff.

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

The CY 2015 goal will be to continue to maintain the Breastfeeding Peer Counselor Program in 58 WIC projects statewide with a focus on increasing breastfeeding rates among WIC participants.

3. Wisconsin Breastfeeding Coalition--Population Based Services--Pregnant and breastfeeding women

The State WIC Breastfeeding Coordinator will continue to serve on the executive committee of the WI Breastfeeding Coalition and the Wisconsin Partnership for Activity and Nutrition (WI PAN) Coalition Support Team committee. The WI Breastfeeding Coalition will continue to provide materials, organizational tools, and strategies for breastfeeding promotion to local breastfeeding coalitions, hospitals, health departments, and other key stakeholders and increase the coordination of breastfeeding interventions and the number of evidence based strategies that are implemented statewide. As part of WI PAN, the Nutrition, Physical Activity and Obesity Prevention group will be working on increasing access to breastfeeding friendly environments and improving hospital maternity care practices in 2015.

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

The WI Breastfeeding Coalition will continue to work with local breastfeeding coalitions to facilitate and foster connections between hospital and community resources and expand the breastfeeding support in child care center initiative to additional local breastfeeding coalitions and other areas of the state.

Early Childhood Systems
Wood County Health Department is continuing its work to increase early childhood systems support for exclusive breastfeeding by holding community events, by recruiting additional businesses to be included as breastfeeding friendly locations to breastfeed or pump, and by having hospital staff provide a consistent exclusive breastfeeding message and an established breastfeeding discharge and follow-up plan.

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

Tracking Performance Measures

Annual Objective and Performance Data	**2009**	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	97.5	96	96.5	99	99
Annual Indicator	95.7	96.4	98.9	98.3	99.0
Numerator	66688	64509	66108	64729	65215
Denominator	69654	66948	66823	65824	65844
Data Source	WI WETRAC 2010	WI WETRAC 2010	WI WETRAC 2011	WI WETRAC 2013	WI WETRAC 2014
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	99	99	99	99	99

Notes - 2013
Data issue: Wisconsin Sound Beginnings, the State of Wisconsin's Early Hearing Detection and Intervention (EHDI) program maintains an electronic database called the Wisconsin EHDI Tracking, Referral and Coordination (WE-TRAC) system. Hearing screening results are reported on the Wisconsin State Lab of Hygiene (WSLH) blood screening card. Birth hospitals perform a hearing screen and record the results on the blood screening card and send the card to the WSLH. Data are entered from the blood screening card into the WSLH database. Hearing specific information is then messaged from the WSLH database to WE-TRAC. Processing logic and business rules dictate how records are handled. Records with PASS/PASS results are archived and records with a REFER (did not pass) or MISSING results are

placed on a birth hospital or out of hospital provider queue for follow-up. For babies who refuse the blood screen but accept hearing screening, the organization can submit a request to add this case into WE-TRAC. In May 2010, Wisconsin Act 279 was enacted. The bill requires the physician, nurse-midwife or certified professional midwife who attended the birth to ensure that the infant is screened and that parents are advised of the results. This passage of the legislation was especially important, because Wisconsin has a high out-of-hospital birth population. The EHDI program has a longstanding working relationship with Wisconsin Guild of Midwives. The organization has a number of screeners that are shared between practices. Most screenings typically occur at the 1 week visit, which are not counted in the prior to hospital discharge data.

Notes - 2012

Data issue: If infants die or the parents/guardian refuses a hearing screening, that is noted on the blood card. Therefore, the denominator in NPM 12 was adjusted to remove cases of refusal and expiration. Wisconsin Sound Beginnings, the State of Wisconsin's Early Hearing Detection and Intervention (EHDI) program maintains an electronic database called the Wisconsin EHDI Tracking, Referral and Coordination (WE-TRAC) system.

Hearing screening results are reported on the Wisconsin State Lab of Hygiene (WSLH) blood screening card. Birth hospitals perform a heel stick and a hearing test, record the results, and send the card to the WSLH. Data are entered from the blood screening card into the WSLH database. Hearing specific information is then messaged from the WSLH database to WE-TRAC. Processing logic and business rules dictate how records are handled. Records with PASS/PASS results are archived and records with a REFER (did not pass) or MISSING results are placed on a birth hospital or out of hospital provider queue for follow-up.

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Notes - 2011

Data issue: If infants die or the parent/guardian refuses a hearing screening, that is noted on the blood card. Therefore, the denominator in NPM 12 was adjusted to remove cases of refusal and expiration. Wisconsin Sound Beginnings, the State of Wisconsin's Early Hearing Detection and Intervention (EHDI) program maintains an electronic database called the Wisconsin EHDI Tracking, Referral and Coordination (WE-TRAC) system.

Hearing screening results are reported on the Wisconsin State Lab of Hygiene (WSLH) blood screening card. Birth hospitals perform a heel stick and a hearing test, record the results, and send the card to the WSLH. Data are entered from the blood screening card into the WSLH database. Hearing specific information is then messaged from the WSLH database to WE-TRAC. Processing logic and business rules dictate how records are handled. Records with PASS/PASS results are archived and records with a REFER (did not pass) or MISSING results are placed on a birth hospital or out of hospital provider queue for follow-up.

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a. Last Year's Accomplishments
1. Outreach/Public Education--Enabling Services--Pregnant women, mothers, and infants

"Just in time" packets were sent to providers. Hearing screening and blood screening information and materials were posted under a new integrated section of the DHS website. A new promotional poster was also created to promote the integration of the hearing and blood programs.

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

WSB coordinated follow-up for infants who do not pass the hearing screening and evaluated the accuracy of risk factors now visible in WE-TRAC. WSB expanded educational opportunities for traditional birth attendants on newborn screening. WSB investigated babies that appeared to have no recorded blood screen and recommended follow-up protocols for SLH.

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

WSB supported the annual Statewide Parent Conference and professional pre-conference. Regional Parent Guides contacted families to encourage follow-up. Parent Guides called families of children diagnosed with hearing loss to ensure they understood the systems and services available.

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

119 babies were identified with hearing loss. Many were referred to Birth to 3 via WE-TRAC and others were referred directly by their care provider.

5. EHDI Workgroup--Infrastructure Building--CYSHCN

The Hearing Subcommittee of the Newborn Screening Umbrella Advisory Committee met in October. Three Hearing Subcommittee workgroups met throughout the year.

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

WSB continued to utilize the 3 step follow-up protocol to prevent loss to follow-up in the hearing screening and follow-up system focusing on medical home outreach, direct family to family support and in-home and community hearing screening.

Activities	**Pyramid Level of Service**			
Table 4a, National Performance Measures Summary Sheet	**DHC**	**ES**	**PBS**	**IB**
1. Outreach/Public Education		X		
2. WI Sound Beginnings (WSB)/Congenital Disorders Program			X	
3. Support Services for Parents		X		
4. Birth-3 Technical Assistance Network				X
5. EHDI Workgroup				X
6. Reduce Lost to Follow-up				X

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

"Just in time" packets continue to be sent to providers. EHDI Quality Improvement initiatives have begun in low performing communities of practice.

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

WSB continues to coordinate follow-up for infants who do not pass the hearing screening and expand educational opportunities for traditional birth attendants on newborn screening. WSB is investigating ways to improve the efficiency of the birth certificate blood screen hearing screening match in the data system.

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

WSB will participate in the annual Statewide Parent Conference and professional pre-conference. Regional Parent Guides continue to contact families to encourage follow-up. Parent Guides call families of children diagnosed with hearing loss to ensure they understood the systems and services available.

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

Babies identified with hearing loss are referred to Birth to 3 via WE-TRAC. WSB has a new MOU with the State Birth to 3 Program that allows the program to offer child specific support to local Birth to 3.

5. EHDI Workgroup--Infrastructure Building--CYSHCN

The Hearing Subcommittee of the Newborn Screening Umbrella Advisory Committee will meet in October.

c. Plan for the Coming Year

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

"Just in time" packets will continue to be sent to providers. Additional EHDI Quality Improvement initiatives will begin in low performing communities of practice.

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

WSB will continue to coordinate follow-up for infants who do not pass the hearing screening and expand educational opportunities for traditional birth attendants on newborn screening. WSB will continue to improve the efficiency of the birth certificate blood screen hearing screening match in the data system.

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

WSB will participate in the annual Statewide Parent Conference and professional pre-conference. Regional Parent Guides continue to contact families to encourage follow-up. Parent Guides call families of children diagnosed with hearing loss to ensure they understood the systems and services available.

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

Babies identified with hearing loss are referred to Birth to 3 via WE-TRAC. WSB has a new MOU with the State Birth to 3 Program that allows the program to offer child specific support to local Birth to 3.

5. EHDI Workgroup--Infrastructure Building--CYSHCN

The Hearing Subcommittee of the Newborn Screening Umbrella Advisory Committee will continue to meet.

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

Tracking Performance Measures

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective	2.6	2.5	2.2	2.2	3.5
Annual Indicator	2.8	2.4	3.5	1.7	1.7
Numerator	36000	31000	46000	22000	22000
Denominator	1292000	1286000	1305000	1280000	1280000
Data Source	WI DHS/OHI 2010	WI DHS/OHI 2011	WI DHS/OHI 2012	WI DHS/OHI 2014	WI DHS/OHI 2014
Is the Data Provisional or Final?				Provisional	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	3.4	3.2	3.1	3	3

Notes - 2013
Data issue: These data are filled in for 2013. Additionally, the Family Health Survey was not conducted in 2013, therefore data will not be available for 2013. For 2014, the Family Health Survey is in the field, and data will most likely be available late 2015 or 2016.
Source: WI Department of Health Services, Division of Public Health, Office of Health Informatics, Family Health Survey, 2013. Numerator: Weighted data. Denominator: Weighted data.
Notes - 2012
Data issue: The reports indicator is 1.8%; TVIS calculated 1.7%. Comparisons between 2012 FHS estimates and estimates from previous years of FHS data should be made with caution.
Source: WI Department of Health Services, Division of Public Health, Office of Health Informatics, Family Health Survey, 2013. Numerator: Weighted data. Denominator: Weighted data.

Notes - 2011
Data issues: 1) Estimated numbers have been rounded to the nearest 1,000. The annual Wisconsin Family Health Survey is a random digit dial telephone survey that collects and reports information about health status, problems, insurance coverage, and use of health care services among Wisconsin residents. The survey has questions about health-related limitations and chronic conditions for persons greater than age seventeen.
Source: WI Department of Health Services, Division of Public Health, Office of Health Informatics, Family Health Survey, 2013. Madison, Wisconsin: 2013. Numerator: Weighted data. Denominator: Weighted data.

a. Last Year's Accomplishments
1. BadgerCare Plus Initiative Continues--Enabling Services--Pregnant women, mothers, infants and children, including CYSHCN

The MCH/CYSHCN Program supported the BadgerCare Plus Program in the DHS/DHCAA that provides health insurance for all children in the state by working with partners throughout the state. ABC for Health and FV have worked to assure families of CYSHCN have market place coverage and/or Medicaid.

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

During 2013, strategies were implemented from ABC for Health/Covering Kids Strategic Plan to assure all kids have health insurance coverage to meet prevention and chronic care needs.

Multiple trainings are available and include: Overview of Health Benefits Counseling and the Health Care Finance Landscape, Health Insurance Basics, Insurance Consumer Rights and Responsibilities, Claims Denials, Issues for Special Populations, Managed Care Rights and Responsibilities, Medical Home for CYSHCN, Overview of Medicaid in WI, Eligibility Basics, HealthCheck and other Medicaid Benefits, Social Security Disability Programs, Disability Determination Process, SSI Eligibility Basics, and Appeals.

3 Health Insurance Marketplace--Enabling Services--Pregnant women, mothers, infants and children, including CYSHCN

It was decided that the federal government will assume full responsibility for running a health insurance marketplace in Wisconsin beginning in 2014. If Wisconsin decides at a later point to establish a state based exchange they will have the opportunity to make the switch.

Activities	**Pyramid Level of Service**			
Table 4a, National Performance Measures Summary Sheet	**DHC**	**ES**	**PBS**	**IB**
1. BadgerCare Plus Initiative Continues		X		
2. "Covering Kids" Program		X		
3. Health Insurance Marketplace		X		

b. Current Activities
1. BadgerCare Plus Continues--Enabling Services--Pregnant women, mothers, infants and children, including CYSHCN

Changes were made to the BadgerCare Plus program 4/1/14. BadgerCare Plus Core and Basic Plans ended. Children with family incomes up to 306% FPL remain eligible BadgerCare Plus. Children in families above 306% FPL are no longer able to buy into Medicaid, but have the option to purchase health insurance through the federal Marketplace with tax credits available up to 400% FPL. See (www.dhs.wisconsin.gov/badgercareplus)

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

ABC for Health through the Covering Kids and Covering Kids with Special Needs (CKSN) project is working to provide information related to ACA, health care coverage and access issues. They address issues such as insurance denials, limited benefits, terminations, poor coordination of services, and lack of access to care providers.

3. Health Insurance Marketplace--Enabling Services--Pregnant women, mothers, infants and children, including CYSHCN

The WI Office of the Commissioner of Insurance provides Navigators/Non-navigator Assisters/Certified Application Counselors that can be accessed from the Navigator Overview page at (http://oci.wi.gov/navigator/overview.htm). DHS and Office of the Commissioner of Insurance released a Joint Report: The WI Health Insurance Market and WI Entitlement Reforms (www.dhs.wisconsin.gov/health-care/index.htm).

c. Plan for the Coming Year
1. BadgerCare Plus Continues--Enabling Services--Pregnant women, mothers, infants and children, including CYSHCN

The MCH Program will continue to work with Medicaid.

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

ABC for Health will continue to offer numerous trainings to HealthWatch groups and others relating to health care coverage and access. Multiple trainings fall under categories including Insurance, Managed Care, Medicaid, and Social Security Disability Programs. In addition to these trainings, ABC staff has the experience and expertise to offer trainings on many other issues related to navigating the health care system, ACA, and insurance issues for children with special health needs. (http://safetyweb.org/projects/cksn/training.asp).

3. Consumers Guide to Health Care--Enabling Services--Pregnant women, mothers, infants and children, including CYSHCN.

The Wisconsin Department of Health Services will continue to provide resources to assist residents in finding and choosing insurance. Information for Wisconsin about the Health Insurance Marketplace under the ACA is available from HealthCare.gov with the Enrollment for Health (E4Health) Wisconsin (http://e4healthwi.org/for-consumers). The website will continue to provide resources for consumers as well as for organizations helping people to apply. An online Enrollment Directory is available on the site and lists Wisconsin organizations that provide health insurance enrollment services, including organizations that are Certified Application Counselor Organizations.

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

Tracking Performance Measures

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective	29.9	29.8	29.7	29.6	29.5
Annual Indicator	30.5	30.7	30.6	30.8	30.8
Numerator	18385	18412	18258	17715	16759
Denominator	60280	59975	59668	57609	54395
Data Source	CDC PedNSS 2010	CDC PedNSS 2010	CDC PedNSS 2011	WI WIC Report, 2013	WI WIC Report, 2013
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	29.4	29.4	29.4	29.2	29.2

Notes - 2013
Source: Wisconsin WIC Program; Report: NTRQ2009-1; BMI Summary Report - Statewide Totals; Report Date: 10/01/2013 to 3/31/2014.

Notes - 2012
Source: Wisconsin WIC Program; Report: NTRQ2009-1; BMI Summary Report - Statewide Totals; Report Date: 10/01/2012 to 3/31/2013.

Notes - 2011
Source: 2011 Pediatric Nutrition Surveillance System (PedNSS), Centers for Disease Control and Prevention. CDC is discontinuing the PedNSS. We will use an alternative source for subsequent years.

a. Last Year's Accomplishments
1. Increased Knowledge of Healthy Behaviors--Enabling Services--Children over the age of 2

Local health departments (LHDs) and local coalitions implemented evidence-based strategies around key health behaviors linked to HW 2020 and the WI Nutrition, Physical Activity and Obesity (NPAO) State Plan. 70 local coalitions participated in planning, implementing and evaluating evidence-based strategies that promote healthy eating, physical activity and healthy weight in all sectors.

Fit Families, Supplemental Nutrition Assistance Program - Education (SNAP-Ed), a successful behavior change program for families with children aged 2 to 4, served 625 families in 9 WIC Projects. Fit Families has adopted parts of the national model with the primary goals of increasing the time children play actively and increasing fruit and vegetable consumption among children.

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

LHDs and coalitions implemented evidence-based strategies to improve food and nutrition environments to make the healthy choice the easy choice. Strategies included: farm-to-school/childcare, active schools, Active Early-Healthy Bites (childcare), breastfeeding friendly maternity care practices, active community environments and food systems.

The percent of coalitions implementing environmental changes increased from 29% in 2010 to 60% in 2013. Five percent of communities implemented local laws or ordinances related to obesity prevention. Organizational policy changes were enacted by 26% of coalitions. Some Title V funded LHDs identified collaboration, coalition building, community organization, health teaching and policy development activities related to healthy eating, weight and physical activity as they moved forward with their Wisconsin Healthiest Families work.

3. Needs Assessments and Plans--Infrastructure Building--Children over the age of 2

Communities with Community Transformation Grants used the CDC tool to complete assessments and develop action plans.

The WALHDAB developed a guide for LHDs to conduct community needs assessments and pilots. The Wisconsin CHANGE for Healthy Communities Project funded 12 Wisconsin communities at approximately $10,000 each for assessment, partnership building, and action planning.

4. Nutrition and Physical Activity Coalitions-Collaboration and Partnerships--Infrastructure Building--Children over the age of 2

The 2nd edition of the Wisconsin Nutrition, Physical Activity and Obesity State Plan was released in June.

70 local coalitions (an increase from 54 in 2011) implemented evidence-based practices and environmental approaches to prevent obesity. CTG's 24 local communities worked with key partners on farm-to-school and recreational use agreements.

Activities Table 4a, National Performance Measures Summary Sheet	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Increased Knowledge of Healthy Behaviors		X		
2. Community Campaigns, Environment and Policy Change			X	
3. Needs Assessments and Plans				X
4. Nutrition and Physical Activity Coalitions-Collaboration and Partnerships				X

b. Current Activities
1. Increased Knowledge of Healthy Behaviors--Enabling Services

Fit Families SNAP-Ed partners with WIC on nutrition and physical activity to serve 1150 families.

LHDs and local coalitions implement strategies around health behaviors linked to the NPAO State Plan.

46 WIC projects select the education plan to increase purchase of fruits and vegetables by families. 11 WIC projects select the education plan on Baby Behavior which includes being attentive to baby cues and not overfeeding.

2. Community Campaigns, Environment and Policy Change--Population-Based Services

The NPAO State Plan addresses healthy food retail in underserved areas and active community environments.

LHDs and coalitions implement strategies to improve food and nutrition environments.

3. Needs Assessments and Plans--Infrastructure Building

LHDs and coalitions support a healthier environment for children in the early care and education setting.

A LHD infrastructure project improves the collaborative selection and implementation of effective programs and policies to improve health outcomes. CTG's 24 communities complete assessments and action plans.

4. Nutrition and Physical Activity Coalitions--Collaboration and Partnerships--Infrastructure Building

63 coalitions implement evidence-based practices and environmental approaches to prevent obesity. CTG communities work with partners on farm-to-school and recreational use agreements. 10 CHANGE coalitions are funded.

c. Plan for the Coming Year
1. Increased Knowledge of Healthy Behaviors--Enabling Services--Children over the age of 2

Fit Families, Supplemental Nutrition Assistance Program -- Education (SNAP-Ed) will expand the focus on Nutrition and Physical Activity activities. The WIC Program is in a key position to assist with prevention efforts, by promoting healthful eating and physical activity to families with young children. Fit Families has adopted parts of the national model with the primary goals of increasing the time children play actively and increasing fruit and vegetable consumption among children.

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

The Nutrition, Physical Activity and Obesity State Plan will continue to address healthy food retail in underserved areas with two community pilots; access to electronic benefit transfer for farmers' markets in underserved communities; activity, nutrition and breastfeeding support in early care and education environments; and stronger worksite compliance with federal lactation accommodation laws.

3. Needs Assessments and Plans--Infrastructure Building--Children over the age of 2

Work will continue on "Active Early" and "Healthy Bites" to support a healthier environment for children in the early care and education setting. The resource kits are designed to provide low-cost, no cost strategies and resources to providers, parents and educators to promote physical activity and good nutrition in early childhood. It also seeks to educate providers, parents, and educators about the importance of healthy living to support positive role modeling and their individual wellness.

The NPAO State Plan will continue to address access to breastfeeding friendly environments in birthing facilities.

4. Nutrition and Physical Activity Coalitions-Collaboration and Partnerships--Infrastructure Building--Children over the age of 2

The NPAO partnership with the Wisconsin Obesity Prevention Network will continue. The NPAO website will be maintained.

SNAP-Ed projects, including FIT Families, will collaborate with other partners on policy, systems, and environmental changes.

Local coalitions have planned many interventions: 24 on breastfeeding support, 13 on early care and education, 33 on the food system, and 27 on active community environments.

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

Tracking Performance Measures

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective	13.5	13.5	14	13.3	13
Annual Indicator	15.1	13.4	13.4	13.0	13.0
Numerator	10395	8793	8793	25345	25345
Denominator	68841	65684	65684	194999	194990
Data Source	WI PRAMS, 2007-08	WI PRAMS, 2009-10	WI PRAMS, 2009-10	WI PRAMS, 2009-11	WI PRAMS, 2009-11
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	13	13	13	13	13

Notes - 2013
Data issue: These data are from Wisconsin PRAMS (Phase 6) and from the 2009 - 2011 weighted data set that is representative of Wisconsin resident mothers who had a live birth from 2009-2011. The survey asks if moms smoked cigarettes in the past 2 years. If the moms answered yes, she's asked the quantity of cigarettes she smoked during the last 3 months of her pregnancy. The numerator represents those mothers who said they smoked during the last three months of pregnancy, and the denominator represents Wisconsin resident mothers. Phase 7 is in the field now for 2012-2014, but the data are not available. Therefore, we did not change our objectives.

Notes - 2012
Data issue: These data are from Wisconsin PRAMS (Phase 6) and from the 2009 - 2011 weighted data set that is representative of Wisconsin resident mothers who had a live birth from 2009-2011. The survey asks if moms smoked cigarettes in the past 2 years. If the moms answered yes, she's asked the quantity of cigarettes she smoked during the last 3 months of her pregnancy. The numerator represents those mothers who said they smoked during the last three months of pregnancy, and the denominator represents Wisconsin resident mothers. Phase 7 data (available in 2013, but not as of this date. Therefore, we did not change our objectives.

Notes - 2011
Data issue: These data are from Wisconsin PRAMS (Phase 6) and from the 2009 - 2010 weighted data set that is representative of Wisconsin resident mothers who had a live birth. The survey asks if moms smoked cigarettes in the past 2 years. If the moms answered yes, she's asked the quantity of cigarettes she smoked during the last 3 months of her pregnancy. The numerator represents those mothers who said they smoked during the last three months of pregnancy, and the denominator represents Wisconsin resident mothers.

a. Last Year's Accomplishments
1. First Breath--Enabling Services--Pregnant women, mothers, and infants

The Title V Program continued its First Breath Prenatal Smoking Cessation Program partnership with the Wisconsin Women's Health Foundation (WWHF). First Breath is a program that helps pregnant women in Wisconsin quit smoking by integrating cessation strategies into existing prenatal services including those provided by public health and private healthcare. Since 2001, First Breath has served nearly 15,000 pregnant women who want to quit smoking. On average 65% of the women who have participated in First Breath have decreased or quit tobacco use during pregnancy. Last year, 86% of women in the program quit, abstained, or cut back on their tobacco use during pregnancy: 31% were smoke-free and 55% reduced their tobacco usage by the end of their third trimester. In 2013, 1,459 women enrolled in First Breath services among the 163 participating sites in Wisconsin, including local public health departments and health care systems.

First Breath continued a grant from the Office on Women's Health to work with eight FQHCs on smoking cessation for women of childbearing age, to include a postpartum peer mentoring initiative. First Breath continued work on another federal grant focusing on smoking cessation services for Medicaid members. In 2013 the WWHF established a new website for women to explore smoking cessation information and supportive resources intended to enhance the individual First Breath services during pregnancy and through the first year postpartum (www.firstbreathmoms.org).

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

The MCH Program staff worked with PNCC providers around the state to encourage their participation in the WWHF First Breath program as providers. In 2013 per the SPHERE MCH data system representing 3,573 women, 51% of women reported smoking prior to pregnancy, 37% of those women continued to smoke during pregnancy, 60% of the women who smoked during pregnancy reported a decrease in smoking during pregnancy, and 47% of women reported others in the home were smoking.

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

The Wisconsin Healthiest Women Initiative (WHWI) continued the pre/interconception pilot project with 5 women's health clinics around the state. These sites worked with women during pregnancy and continuing beyond to encourage maintenance of behavior changes established during pregnancy. Smoking cessation is a focus of this pilot.

Activities **Table 4a, National Performance Measures Summary Sheet**	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. First Breath		X		
2. Prenatal Care Coordination		X		
3. Preconception Services		X		

b. Current Activities
1. First Breath--Enabling Services--Pregnant women, mothers and infants

Currently, 163 First Breath sites are participating in the program. First Breath participants continue to be predominately of non-Hispanic white race, low income and low education level. To date, 363 women have been enrolled this year.

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

The PNCC providers are working regionally to establish and track benchmarks related to PNCC services. The Northern, Western, Southern, and Southeastern regions have selected smoking cessation as one of their benchmarks.

c. Plan for the Coming Year
1. First Breath--Enabling Services--Pregnant women, mothers and infants

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

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

The MCH staff will continue to work within the public health regions collaboratively with PNCC provider networks to monitor movement of benchmarks and implement targeted improvement efforts.

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

Tracking Performance Measures

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective	8.6	8.5	8.5	10.4	11.5
Annual Indicator	10.1	10.5	11.6	9.5	9.5
Numerator	41	42	46	37	37
Denominator	405998	399209	397537	388960	388960
Data Source	WI DHS/OHI 2011	WI DHS/OHI 2012	WI DHS/OHI 2013	WI DHS/OHI 2013	WI DHS/OHI 2013
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	11	10.5	10.5	10	10

Notes - 2013
Source: WI Department of Health Services, Division of Public Health, Office of Health Informatics. Wisconsin Interactive Statistics on Health (WISH) data query system, http://dhs.wisconsin.gov/wish. Injury Mortality Module. Data for 2013 will not be available until 2014, so 2012 data have been carried over. The objectives for this indicator are difficult to project because the number of events are small compared to the population size, and the number of events randomly fluctuate.

Notes - 2012
Source: WI Department of Health Services, Division of Public Health, Office of Health Informatics. Wisconsin Interactive Statistics on Health (WISH) data query system, http://dhs.wisconsin.gov/wish. Injury Mortality Module. The objectives for this indicator are difficult to project because the number of events are small compared to the population size, and the number of events randomly fluctuate.

Notes - 2011
Data issue: WI Department of Health Services, Division of Public Health, Office of Health Informatics. Wisconsin Interactive Statistics on Health (WISH) data query system, http://dhs.wisconsin.gov/wish. Injury Mortality Module. The objectives for this indicator are difficult to project because the number of events are small compared to the population size, and the number of events randomly fluctuate.)

a. Last Year's Accomplishments
1. MCH Early Childhood Systems--Infrastructure Building--Adolescents

Suicide prevention was a priority for some LHDs as they implemented MCH-funded activities for the WI Healthiest Families (focus area: safety and injury prevention and mental health) and Keeping Kids Alive initiatives. MCH and Injury and Violence Prevention Program staff work with LHDs to promote prevention, assessments, referrals and intervention via community systems development and local death review teams.

An example of this is Outagamie County is assisting with building capacity to assist with suicide prevention strategies through their Early Childhood Systems Objective by providing leadership and partnership in their CDR team and Safe Kids Coalition. Through the use of their data resources and assessments, safety and injury prevention, including suicide prevention, has been identified as a priority. A life course approach utilizing multiple data sources through the assessment process has supported partnerships with an already established community suicide prevention coalition. They began developing a plan for implementation of activities and strategies focusing on primary prevention.

2. Prevent Suicide Wisconsin (PSW)--Infrastructure Building--Adolescents

Prevent Suicide Wisconsin (PSW), the statewide coalition on suicide prevention and a chapter of Mental Health America, joined the Perfect Depression Care Learning Collaborative, an evidence based practice with the goal of "Zero Suicides within a patient population".

PSW received Garrett Lee Smith funding to support local agencies and coalitions to build infrastructure and support existing programs and activities.

3. Data--Infrastructure Building Services--Adolescents

The Burden of Suicide (BOS) update was revised by the Injury and Violence Prevention Program in collaboration with the Injury Research Center. The BOS update uses hospitalization, emergency department and violent death reporting system data to describe suicide across the life-span, including 15-19 year olds. MCH, Injury and Violence Prevention Program and Prevent Suicide WI provided technical assistance on data use of the Burden of Suicide, and the WISH interactive data system to obtain suicide specific data.

4. State Plan--Infrastructure Building--Adolescents

PSW, the Injury and Violence Prevention Program, and the Bureau of Prevention, Treatment and Recovery revised the state action plan for suicide prevention based on the new National Strategy.

Activities Table 4a, National Performance Measures Summary Sheet	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. MCH Early Childhood Systems				X
2. Prevent Suicide Wisconsin (PSW)				X
3. Data				X
4. State Plan				X

b. Current Activities

1. MCH Early Childhood Systems--Infrastructure Building--Adolescents

Many communities have identified suicide prevention as a priority either through assessments related to mental health, safety and injury and/or through their Child Death Review teams. With this identification, they are developing and implementing comprehensive plans to address the mental health needs of adolescence and families in their communities through a systems approach.

2. Prevent Suicide Wisconsin (PSW)--Infrastructure Building--Adolescents

PSW continues to provide TA specific to primary, secondary, and tertiary suicide interventions. PSW receives Garret Lee Smith funds and uses it to assist local suicide prevention coalitions address suicide. PSW awarded seven health care organizations grants to participate in the Perfect Depression Care Learning Collaborative.

3. Data--Infrastructure Building--Adolescents

The Injury and Violence Prevention Program is utilizing updated BOS data to present to interested parties across the state, including CDR teams, Maternal Mortality Review Teams, Coroner/Medical Examiner Association, and several national organizations.

4. State Plan--Infrastructure Building--Adolescents

The 2014 WI Suicide Prevention Strategic Plan will be completed and released. It will guide activities for Garret Lee Smith recipients, and MCH funded suicide prevention initiatives.

c. Plan for the Coming Year
1. MCH Early Childhood Systems--Infrastructure Building--Adolescents

MCH will continue the focus on system building including Mental Health as a focus area of WHF. Death Review Teams will continue to identify community needs and prevention strategies associated with adolescent suicides. For example, Columbia County will focus on preventing suicide and increasing access to mental health services. They plan to train as many community members as possible in the signs of depression and suicide and where to refer people for help and resources. Columbia County Prevent Suicide and Columbia County Connects to Prevent Substance Abuse hosted a county-wide Health Summit on March 3, 2014 for administration and staff in ten school districts in Columbia County to come together and review data from the biennial Youth Risk Behavior Survey and brainstorm more effective alcohol, drug abuse and suicide prevention programs.

2. Prevent Suicide Wisconsin (PSW)--Infrastructure Building--Adolescents

Garret Lee Smith funding will continue through 2015, with allocations aligned with the 2014 WI Suicide Prevention Strategy.

PSW secured the rights to "Mantherapy", and will promote this evidence-based interactive web-based program. It is a male focused approach to address stigma associated with help seeking behaviors and mental illness and is appropriate for males from adolescence up.

3. Data--Infrastructure Building--Adolescents

Data will continue to inform suicide prevention efforts.

4. State Plan--Infrastructure Building--Adolescents

PSW will lead the implementation and evaluation of the WI Suicide Prevention Strategy in collaboration with MCH, Injury and Violence Prevention Program, and the Injury Research Center. It is anticipated that the state plan will utilize evidence based strategies for suicide prevention at the population and system levels, which IVPP can provide assistance with training and systems development for implementation.

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

Tracking Performance Measures

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective	76	76	90	90.5	86
Annual Indicator	89.8	90.0	85.5	86.8	86.8
Numerator	741	737	740	700	700
Denominator	825	819	866	806	806
Data Source	WI DHS/OHI 2010	WI DHS/OHI 2012	WI DHS/OHI 2012	WI DHS/OHI 2013	WI DHS/OHI 2014
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	87	88	89	90	90

Notes - 2013
Data issue: Data for 2013 will not be available from the Office of Health Informatics until 2015.

Notes - 2012
Data issue: In Wisconsin, hospitals self-designate level of care. Wisconsin does not have a regulatory function to standardize these self-designations. 95% confidence intervals are: 88.0%, 85.6%.

Beginning in 2011, the State of Wisconsin implemented the 2003 US Revised Birth Certificate. We do not know yet whether the indicators are comparable, and we cannot compare 2011 data to previous years.
Source: WI Department of Health Service, Office of Health Informatics, Division of Public Health, 2014.

Notes - 2011
Data issue: In Wisconsin, hospitals self-designate level of care. Wisconsin does not have a regulatory function to standardize these self-designations. 95% confidence intervals are: 84.3%, 86.7%.
Beginning in 2011, the State of Wisconsin implemented the 2003 US Revised Birth Certificate. We do not know yet whether the indicators are comparable, and we cannot compare 2011 data to previous years.
Source: Provisional data from the Office of Health Informatics, WI Department of Health Services, 2013.

a. Last Year's Accomplishments
1. WAPC Efforts on Regionalization of Perinatal Care--Infrastructure Building--Pregnant women, mothers, infants

Hospitals in Wisconsin self-designate level of perinatal care. Wisconsin does not have regulatory function over the designations. Wisconsin Association for Perinatal Care has developed the Level of Care Self-Assessment Initiative. Through the self-assessment, hospitals are given the opportunity to self-identify based on criteria adapted from the American Academy of Pediatrics levels of care. WAPC started the initiative based on the 2004 AAP neonatal levels of care. 67 birth hospitals completed the self-assessment. The WAPC adopted the new levels of care criteria based on recommendations released in 2012 by the AAP and incorporated the four recommended levels into the existing levels.

Level I provides postnatal care to stable term infants or infants 35-37 weeks gestation and stabilizing care to infants who are ill or less than 35 weeks waiting transfer to a higher level of care;

Level II provides care to infants born at 32 weeks of gestation or later, weigh 1500 g or more with physiologic immaturity or are moderately ill with problems expected to resolve rapidly and are not anticipated to need subspecialty services on an urgent basis and stabilizing care to infants until transfer to a neonatal intensive care facility;

Level III provides sustained life support and comprehensive care for infants born before 32 weeks, weigh less than 1500 g, born at all gestations and weights with critical illness, provide prompt access to a full range of pediatric subspecialists, full range of respiratory support, perform advanced imaging with interpretation on an urgent basis;

Level IV is located within an institution with the capability to provide surgical repair of complex congenital or acquired conditions, maintain a full range of pediatric subspecialists on site, facilitate transport and provide outreach education. The complete tool can be found on the WAPC website (www.perinatalweb.org). WAPC has developed resources to guide hospitals through the process and information for consumers about the levels of care.

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

Medicaid continued to strive to improve the quality of perinatal care services to women by the health plans through the Pay for Performance Initiative for Healthy Birth Outcomes. Preliminary results of the evaluation of the pilot sites in the southeast region highlighted the need for coordination of care for at risk women during pregnancy. Medicaid began the process of expanding the initiative to 2 additional counties in the southern region, Rock and Dane. The MCH Perinatal Nurse Consultant participated in technical assistance sessions with the new counties and planning sessions with Medicaid for the revised health plan requirements.

3. Maternal Mortality Review--Population Based Services--Pregnant women, mothers, infants

The MCH staff participated in the CDC, HRSA, and AMCHP Maternal Mortality Review Initiative. Staff assisted with development of national guidelines for implementation of a Maternal Mortality Review. Wisconsin began a quality improvement effort of the WI MMR and as a result will be expanding the case review process to include all maternal deaths. The level of care of the delivering facility and appropriate transfer of care is included in the revised data collection.

Activities **Table 4a, National Performance Measures Summary Sheet**	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. WAPC				X
2. Medicaid Efforts on Prenatal Care Quality Improvement		X		
3. Maternal Mortality Review			X	

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

WAPC encouraged hospitals to participate in the self-assessment process. They are in the process of developing revised worksheets to match the revised levels of care.

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

The MCH Perinatal Nurse Consultant is participating in the review of the work plans submitted by the health plans for Rock and Dane counties for the Pay for Performance Initiative for Healthy Birth Outcomes. Additionally, MCH staff will be participating in the cultural awareness initiative being implemented by Medicaid with the health plans.

3. Maternal Mortality Review--Population Based Services--Pregnant women, mothers, infants

WI MMR is working on a report of the data from 2006-2010.

c. Plan for the Coming Year
1. WAPC Efforts on Regionalization of Perinatal Care--Infrastructure Building--Pregnant women, mothers, infants

WAPC will continue the effort to transition hospitals to completing the revised Level of Care self-assessments.

WAPC will continue to provide support to hospitals in the self-assessment process for level of perinatal care.

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

Medicaid will continue the Pay for Performance Initiative for Health Birth Outcomes in the southeast region and focus on expansion in the southern region. Medicaid will focus on offering best practice seminars to health plans and clinics who are participating in the initiative to improve the quality of the services delivered to pregnant women.

3. Maternal Mortality Review--Population-Based Services--Pregnant women, mothers, infants

MCH will continue to strive to improve the MMR process and align it with the other mortality reviews to develop a mortality review system. The report covering 2006-2010 data will be disseminated and

opportunities to release data trends more frequently will be explored. In addition, the MMR team will collaborate with WAPC and other partners to address both regionalization and perinatal safety.

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

Tracking Performance Measures

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective	84	82	83.4	84.3	74
Annual Indicator	83.4	84.2	73.2	76.5	76.8
Numerator	59060	57595	49604	51439	50074
Denominator	70824	68367	67744	67229	65235
Data Source	WI DHS/OHI 2010.	WI DHS/OHI 2012.	WI DHS/OHI 2013	WI DHS/OHI 2014	WI DHS/OHI 2014
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	75	76	77	78	78

Notes - 2013
Data issues: 1) Missings are excluded from denominator. 2) The 2013 birth data estimates are provisional and subject to change. Please interpret associated indicators with caution. Source: WI Department of Health Services, Division of Public Health, Office of Health Informatics, 2014.

Notes - 2012
Data issue: Beginning in 2011, the State of Wisconsin began using the 2003 US Revised Birth Certificate. Therefore, we cannot compare 2011 data to previous years.
Source: WI Department of Health Service, Office of Health Informatics, Division of Public Health, 2014.

Notes - 2011
Data issue: Data for 2011 are provisional from the Office of Health Informatics. Beginning in 2011, the State of Wisconsin implemented the 2003 US Revised Birth Certificate. Therefore, we cannot compare 2011 data to previous years.

a. Last Year's Accomplishments
1. Centering Pregnancy--Enabling Services--Pregnant women, mothers, infants

Through the Medicaid Medical Home OB Pilot, Centering Pregnancy group prenatal care is being offered to pregnant women at a greater risk for poor birth outcomes and late entry into prenatal care in the southeast region. Through individual March of Dimes grants, existing Centering Pregnancy programs have expanded in Milwaukee and new programs started in Kenosha and Racine. Additionally, one tribal site has implemented Centering Pregnancy.

Wisconsin PRAMS data indicate that an estimated 84.3% of women entered prenatal care during the first trimester of pregnancy. First trimester prenatal care was lowest among women who had less than a high school education (63.8%), women less than 20 years old (63.8%), and women of poverty (70.9%). The most common reasons for women not receiving prenatal care as early as desired were women not knowing they were pregnant (38.8%), not being able to get an appointment (35.9%), and insurance not starting early enough (26.3%).

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

The MCH Maternal/Perinatal Nurse Consultant continued to collaborate with the Women's Health staff to integrate PNCC services with family planning through the 'Just the Basics' practice guidelines. FP agencies are expected to coordinate services with existing local PNCC providers or provide PNCC services directly to women seeking confirmation of pregnancy. PNCC was integrated into all DCF Home

Visiting/Family Foundations (MIECHV) programs. Training and TA was provided to sites individually and in groups at regional PNCC provider network meetings. In 2013, 10,001 women received PNCC services, from 110 providers around the state, reaching 1/3 of the eligible women. Data for 3,573 of those women were captured in the MCH SPHERE data system identifying 80% initiated prenatal medical care in the first trimester and 4% had not started prenatal medical care yet. 37% of women started PNCC services in the first trimester. Of the women who initiated PNCC in the first trimester, 90% delivered an AGA weight infant and 88% delivered > 37 weeks gestation.

3. More and Better Family Planning/PNCC--Enabling Services--Pregnant women, mothers, infants

The MCH Maternal/Perinatal Nurse Consultant in collaboration with the Women's Health staff worked with local providers to enhance and expedite referrals to services for pregnant women. The local women's health clinics, health departments, and WIC agencies collaborated on positive personal referrals with the identification of pregnancy and sharing of health information to ease the burden for women. The focus was to improve access to early prenatal care and support referrals back to women's health services after pregnancy.

Activities Table 4a, National Performance Measures Summary Sheet	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Centering Pregnancy		X		
2. Prenatal Care Coordination (PNCC)		X		
3. More and Better Family Planning / PNCC		X		

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

The Medicaid Medical Home OB Pilot is expanding to both Dane and Rock counties. Centering Pregnancy is a part of the enhanced prenatal services being promoted to the new pilot sites.

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

MCH staff are working with local PNCC providers within the 5 public health regions to monitor and plan to improve benchmarks for PNCC services, including improving outreach early in pregnancy.

3. More and Better Family Planning/PNCC--Enabling Services--Pregnant women, mothers, infants

The MCH Maternal/Perinatal Nurse Consultant in collaboration with the Women's Health staff are providing training at PNCC provider regional meetings to promote the seamless system of care for women during pregnancy and postpartum as a standard of care. The Western and Southern Regions have identified pregnancy planning as a PNCC benchmark.

c. Plan for the Coming Year
1. Title V Funded Perinatal Services--Enabling Services--Pregnant women, mothers, infants

Centering Pregnancy will be encouraged in areas with high disparities in birth outcomes as a model to deliver enhanced prenatal care.

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

MCH staff will continue to work with PNCC providers across the 5 public health regions to improve the reach and quality of services to hard-to-reach women by collectively setting and monitoring benchmarks through SPHERE data. Providers will work together within their respective regions to strive to improve outreach and early engagement.

3. More and Better Family Planning/PNCC--Enabling Services--Pregnant women, mothers, infants

The MCH Maternal Perinatal Nurse Consultant will continue to work with the Women's Health staff to improve the collaboration between the local women's health clinics, public health departments, and WIC agencies to provide personal referrals to services for pregnant women and enhance the sharing of information so that a seamless system of care is achieved. Additionally, education and technical assistance to providers on the comprehensive annual women's visit will be provided to improve the health of women in between pregnancy.