State Performance Measures

State Performance Measure 01: *Percent of eligible women enrolled in the Wisconsin Medicaid Family Planning Waiver during the year.*

Tracking Performance Measures

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective	21	22	25	25	25
Annual Indicator	24.0	25.3	23.5	23.8	25.0
Numerator	67883	71524	68757	69788	73147
Denominator	282970	282970	292970	292970	292970
Data Source	WI DHS/ DHCAA 2009	WI DHS/ DHCAA 2010	WI DHS/ DHCAA, Policy Research 2012	WI DHS/ DHCAA, Policy Research 2013	WI DHS/ DHCAA, Policy Research 2014
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	25	25	25	25	25

Notes - 2013
Objectives are held at level at 25% for 2012-2018. Wisconsin reduced GPR-Family Planning funding in 2012 and restricted organizations eligible to receive grant funds and, thereby, the statewide system of community based family planning services, through which over 75% of Medicaid family planning services are provided. Accurate projections are impossible due to uncertainty of impact. Statewide access is likely to decrease.

Notes - 2012
Objectives are held at level at 25% for 2012-2017. Wisconsin reduced GPR-Family Planning funding in 2012 and restricted organizations eligible to receive grant funds and, thereby, the statewide system of community based family planning services, through which over 75% of Medicaid family planning services are provided. Accurate projections are impossible due to uncertainty of impact. Statewide access is likely to decrease.

Notes - 2011
Objectives are held at level at 25% for 2011-2016. Wisconsin has proposed to eliminate GPR-Family Planning funding in 2011, which supports the statewide system of community based family planning services, through which over 75% of Medicaid family planning services are provided. Accurate projections are impossible due to uncertainty of impact. Statewide access is likely to decrease.

a. Last Year's Accomplishments
1. Outreach and Enrollment--Enabling Services--Women of Reproductive Age

In 2010, Wisconsin obtained approval to expand the Family Planning Waiver (coverage for contraceptive and related reproductive health care) to men: enrollment began May, 2010. Following passage of the federal health care reform legislation, Wisconsin submitted a Medicaid State Plan Amendment, the first in the nation, making services a standard part of Medicaid Services. The official name was Badger Care Family Planning Only Services (BC-FPOS). Eligibility was increased to 300% of poverty. A priority for community-based women's health programs is eligibility screening and "managed enrollment" into BC-FPOS. The MCH Program continues to provide technical assistance to facilitate providers incorporating these new practices into their package of services. At the end of calendar year 2013, 73,147 persons were enrolled in BC-FPOS. Enrollment remained level from 2012 to 2013. (73,104 enrolled in December 2012.) Statewide and County-Specific Data on Enrollment is available at (www.forwardhealth.wi.gov/WIPortal/portals/0/staticContent/Member/caseloads/481-caseload.htm)

The Milwaukee Adolescent Pregnancy Partnership (MAPPP) promotes outreach and enrollment in the WI Medicaid Family Planning Only benefit. Activities have expanded into the Beloit and Racine communities. These communities are teamed up quarterly with Milwaukee staff meetings which allows for technical assistance training and exchange of best practices.

Activities Table 4b, State Performance Measures Summary Sheet	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Outreach and Enrollment		X		

b. Current Activities

1. Outreach and Enrollment--Enabling Services--Women of Reproductive Age

BC-FPOS enrollment was 72,747 in Jan. 2014; 73,498 in Feb.; 74,599 in Mar.

All community-based women's health providers, under contract with MCH Program, have the capacity to provide immediate temporary enrollment to eligible persons and provide same-day services and supplies. The standard of intervention is to provide temporary enrollment and to initiate an application for continuous enrollment (or re-enrollment) at the same visit. Managed enrollment is an expected standard of intervention: to assist patients and clients in submitting all necessary documentation necessary for enrollment confirmation in the 30-60 day period following temporary enrollment. Community based providers actively assist enrollees with required verifications and documentation to support faster determination of eligibility and enrollment.

Previously released MCH Program Women's Health Guidelines (for patient care and administration) identify key standards of practice, and quality assurance/performance indicators to improve outreach, eligibility screening and enrollment, quality and comprehensiveness of care, and patient responsive care (for improved patient satisfaction and convenience). Implementing these guidelines in practices and coordinating BC-FPOS with other insurance benefits, such as marketplace insurance plans, is a priority in 2014. See NPM# 8 for additional adolescent pregnancy efforts.

c. Plan for the Coming Year

1. Outreach and Enrollment--Enabling Services--Women of Reproductive Age

The role of community-based women's health programs in screening clients for insurance eligibility, and actively assisting clients with enrollment will continue to be a key priority in 2015. Coordinating BC-FPOS with other insurance benefits, and supporting clients to navigate health care insurance enrollment processes will become an increasingly large role. Projections of future BC-FPOS enrollment are difficult with the changes occurring in Medicaid services and market place insurance plans. Enrollment is likely to remain level assuming community based providers are successful in informing clients regarding insurance eligibility and assisting client to navigate the systems required for enrollment.

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 Southeast Wisconsin communities that received an InSPIRE grant to provide programming for pregnant and parenting teens to delay repeat pregnancies and eliminate barriers to completing their education.

State Performance Measure 02: *Percent of children who receive coordinated, ongoing comprehensive care within a medical home.*

Tracking Performance Measures

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective	53.5	55	63	64	64
Annual Indicator	62.9	62.9	66.4	66.4	66.4
Numerator	799738	799738	854849	854849	854849
Denominator	1271037	1271037	1287423	1287423	1287423

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Data Source	NSCH/NCHS/CDC	NSCH/NCHS/CDC	NSCH/NCHS/CDC	NSCH/NCHS/CDC	NSCH/NCHS/CDC
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	65	65	65	65	65

Notes - 2013
Source: 2011-2012 National Survey of Children's Health, National Center for Health Statistics, Centers for Disease Control and Prevention.

Notes - 2012
Source: 2011-2012 National Survey of Children's Health, National Center for Health Statistics, Centers for Disease Control and Prevention.

Notes - 2011
Source: 2011-2012 National Survey of Children's Health, National Center for Health Statistics, Centers for Disease Control and Prevention.

a. Last Year's Accomplishments
1. Pregnancy Care and Beyond--Enabling Services--Women/Infants/Children

The Medicaid Prenatal Care Coordination (PNCC) benefit is promoted as a comprehensive program for women's health, focused on establishing a medical home during pregnancy and 60 days postpartum. In 2013, 10,001 pregnant women received PNCC services to reduce adverse pregnancy outcomes. After PNCC other Medicaid benefits offer support to infants/children that include Child Care Coordination (CCC) in Racine and Milwaukee and Targeted Case Management (TCM) through LHDs.

2. Early Screening--Population-Based Services--Infants and Children

The WI Statewide Medical Home Initiative (WISMHI) is funded as a CYSHCN Hub for the statewide Medical Home implementation. In 2013, 128 primary care clinicians and care team members received training on ASQ 3 and M-CHAT. WISMHI promotes developmental and autism screening and reinforces the Medical Home role in early hearing screening. In addition, WiSMHI trained six primary care clinic sites (including 65 clinicians and care team members) on use of pediatric mental health screening tools within well-child care, and one site (25 clinicians and care team members) on pediatric mental health community resources. WiSMHI also partnered with WI DHS' Early Intervention Program to pilot a joint release of information document between medical clinics and early intervention. The voluntary release is both HIPAA and FERPA compliant.

3. Oral Health--Population-Based Services---Children and CYSHCN

The Wisconsin Seal-A-Smile school based and linked dental sealant program provided screening, dental sealants, and fluoride varnish applications to children throughout the state. During the 2012-13 school year 34,372 children were served, including 5,534 CYSHCN.

4. Early Childhood Comprehensive Systems--Infrastructure Building--Young Children

The MCH Program continues to work with state and local partners to enhance the impact of ECCS funds to impact the early childhood system and the impacts of trauma and toxic stress in Wisconsin. Planning and implementation activities include alignment with other state projects such as: Project LAUNCH, MIECHV Program, and WHF and KKA activities to increase collaborations and impacts.

5. Project LAUNCH Grant--Population-Based Services--Young Children ages 0-8

Project LAUNCH worked directly with medical providers in the City of Milwaukee to provide them technical assistance and support around early identification of developmental delays and integrating

behavioral health into primary care. LAUNCH is also working with state and community partners including the State's MCH/CYSHCN and ECCS Programs to promote the early identification of developmental delays and the integration of behavioral health into primary care statewide through related systems development.

6. Medical Home-Foster Care--Enabling Services--Children ages 0-21

The State of Wisconsin State Plan Amendment to CMS for the Foster Care Medical Home (FCMH) program was approved. The DHS, the Department of Children and Families (DCF) and Children's Hospital of WI partnered to design and create a new Medicaid program to improve the delivery of health services for children in foster care and other out-of-home care. This new Care4Kids program creates a medical home team and ensures each child in foster care receives individual treatment in foster care. FCMH program goals include: 1) Integrated Health Service Delivery, 2) Access and Comprehensiveness, 3) Continuity and Coordination of Care, 4) Transitional Planning, 5) Consumer Satisfaction, and 6) Well-Being Outcomes.

Activities **Table 4b, State Performance Measures Summary Sheet**	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Pregnancy Care and Beyond		X		
2. Early Screening			X	
3. Oral Health			X	
4. Project LAUNCH Grant			X	

b. Current Activities

1. Pregnancy Care and Beyond--Enabling Services--Women/Infants/Children

MCH promotes care coordination services through Medicaid benefits including PNCC, CCC, and TCM.

2. Early Screening--Population-Based Services--Infants and Children

WISMHI continues to receive funds as the Medical Home Hub of Expertise. Activities and partnerships were expanded this year to support increased collaboration and outreach.

3. Oral Health--Population-Based Services--Children and CYSHCN

The Wisconsin Seal-A-Smile Program continues to provide screenings, dental sealants, and fluoride varnish to children throughout the state. The program continues to collect CYSHCN status through screening questions on program forms in order to uniformly collect information on CYSHCN served by the program. These data are provided to the CYSHCN Program in the Division of Public Health.

4. Early Childhood Comprehensive Systems--Infrastructure Building--Young Children

ECCS funds continue to be used to assist in the development of early childhood systems per the State Plan to integrate services and enhance infant and early childhood mental health efforts

5. Project LAUNCH Grant--Population-Based Services--Young Children ages 0-8

Project LAUNCH Activities are ongoing.

6. Medical Home-Foster Care--Enabling Services--Children ages 0-21

The Foster Care Medical Home initiative titled; Care4Kid was implemented January 1, 2014 in: Milwaukee, Waukesha, Racine, Kenosha, Ozaukee, and Washington counties.

c. Plan for the Coming Year
1. Pregnancy Care and Beyond--Enabling Services--Women/Infants/Children

MCH will continue to promote PNCC as a comprehensive program for women's health with a focus on establishing a medical home during pregnancy and 60 days postpartum. After PNCC other Medicaid benefits offer support to infants/children that include CCC in Racine and Milwaukee and TCM statewide through LHDs.

2. Early Screening--Population-Based Services--Infants and Children CYSHCN

The MCH Programs contract with the Northeast Regional Center who will continue to lead the WI Statewide Medical Home Initiative. Planned activities include a continued effort to promote the Medical Home educational materials and webcasts among partners. WISMHI maintains a database and email listserv of practices engaged in early identification/Medical Home activities. Relevant messages will continue to be sent out on the listserv monthly. Congenital Disorder Program contracts will continue coordination with the child's Medical Home including transition planning and linkages to the Regional Centers and CYSHCN Collaborators Network.
3. Oral Health--Population-Based Services--Children and CYSHCN

The Wisconsin Seal-A-Smile program will continue to provide screenings, dental sealants, and fluoride varnish to children throughout the state. In addition, the program will continue to identify and serve CYSHCN. Data on CYSHCN served by the program will continue to be provided to the CYSHCN Program in the Division of Public Health.

4. Early Childhood Comprehensive Systems--Infrastructure Building--Young Children

Following the successful receipt of funds for the ECCS: Building Health Through Integration grant, the MCH Program staff will continue to coordinate activities per the workplan to implement the ECCS project to address the mitigation of toxic stress and trauma using a multi-faceted approach.

5. Project LAUNCH Grant--Population-Based Services--Young Children ages 0-8

LAUNCH will continue to work with medical providers to improve and increase early intervention of developmental delays with medical providers in the City of Milwaukee and LAUNCH will work to share lessons learned throughout the state. LAUNCH will also continue to work with medical providers to support their efforts to integrate behavioral health into primary care and will explore opportunities to expand that integration throughout the state.

6. Medical Home-Foster Care--Enabling Services--Children ages 0-21

Establishing medical homes for children in foster care remains a priority for DHS.

State Performance Measure 03: *Percent of Black, non-Hispanic women who have had a live birth who report symptoms of depression after pregnancy.*

Tracking Performance Measures

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective			25	25	23
Annual Indicator	25.5	25.5	16.4	17.2	17.2
Numerator	1795	1795	1129	3362	3362
Denominator	7031	7031	6879	19541	19541
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	22	22	22	22	22

Notes - 2013

Source: 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. These data are not comparable to previous years' data because the question was asked differently. 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

Source: 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. These data are not comparable to previous years' data because the question was asked differently. Phase 7 data (available in 2013, but not as of this date), will be comparable to previous years. Therefore, we did not change our objectives.

Notes - 2011

Source: 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. These data are not comparable to previous years' data because the question was asked differently. Phase 7 data, which will be available in 2013, will be comparable to previous years. Therefore, we did not change our objectives.

a. Last Year's Accomplishments

1. PRAMS--Infrastructure Building--Pregnant women, mothers, infants

In 2011, the most recent PRAMS data, 16.4% of Black, non-Hispanic women reported experiencing symptoms of depression since the birth of a new baby. PRAMS fact sheets have been shared with PNCC, women's health, and home visiting providers.

2. Wisconsin Task Force on Perinatal Depression--Infrastructure Building--Pregnant women, mothers, infants

This multi-disciplinary task force consisting of public, private, academic partners and consumers worked collaboratively with the DCF Home Visiting program to implement training to select HV sites to provide mother/baby support group therapy to women at risk for depression. In 2013 this intensive work started with 6 mom/baby pairs in the Southern region. Home visiting providers and 2 academic partners led moms in group therapy sessions, both separately and with their babies. The sessions provided opportunities for women to process personal experiences in groups with peers and individually with therapists, to learn ways to calm and care for their baby, and to understand their baby's cues. Additionally, the sessions provided training for home visitors through their active involvement in the sessions and their passive observation of the group. To support screening and intervention by home visitors and PNCC providers, task force members worked with the MCH SPHERE Coordinator to develop a SPHERE Perinatal Depression screen using the Edinburgh Postpartum Depression Screening (EPDS) tool and an action plan screen. Additionally, the Task Force developed and shared talking points to share with committees and providers on the impact of postpartum depression on early parenting decisions.

3. MCH Early Childhood Systems--Infrastructure Building--Infant and Children

The WI Healthiest Families initiative was implemented with LHDs to support a system of services related to mental health as well as family supports, child development and safety and injury prevention. In 2013, 9 LHDs selected to focus on mental health and 33 were addressing family supports.

They were charged with completed community assessments to identify services, programs and resources that address the mental health and social emotional wellness of infants and children, and families. They were then charged with developing a community plan to address gaps in services.

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

In 2013 87% of women receiving services through PNCC and home visiting programs were screened for depression during the postpartum period; of those identified as at risk for depression, 38% were referred for treatment, 42% were already receiving services, and 18% declined a referral, per WI SPHERE.

Activities Table 4b, State Performance Measures Summary Sheet	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. PRAMS				X
2. Wisconsin Task Force on Perinatal Depression				X
3. MCH Early Childhood Systems				X
4. Prenatal Care Coordination (PNCC)		X		

b. Current Activities

1. PRAMS--Infrastructure Building

MCH staff are using PRAMS fact sheets and sharing data on disparities in women experiencing stress, depression symptoms and other contributing social determinants to report to Women's Health, PNCC, and home visiting providers.

2. WI Task Force on Perinatal Depression--Infrastructure Building

Academic task force members are working with the MCH Perinatal Nurse Consultant to develop a modular, web based training on perinatal mood disorders for PNCC, women's health, and home visitors. The DCF HV sites are expanding mother/baby therapy groups to additional locations.

3. MCH Early Childhood Systems--Infrastructure Building

LHDs are implementing WHF with 15 agencies focusing on mental health; 34 addressing family supports. LHDs are developing or implementing community plans. MCH Program is collaborating with the WI Alliance for Infant Mental Health to build capacity through the Infant Mental Health Certificate Program.

4. Prenatal Care Coordination--Direct Services

MCH staff are working collaboratively with IVPP and FP/RH staff to improve the capacity of PNCC providers addressing the co-morbidity of depression, violence and AODA issues of women of childbearing age. Working with external partners, a pilot project is being developed to coordinate services between Women's Health Clinics and Domestic/Intimate Partner Violence Service Providers.

c. Plan for the Coming Year

1. PRAMS--Infrastructure Building--Pregnant women, mothers, infants

The MCH program will continue to use PRAMS data to share the disparities in women experiencing stress and symptoms of depression with healthcare, public health and social service providers.

2. Wisconsin Task Force on Perinatal Depression--Infrastructure Building--Pregnant women, mothers, infants

A completed modular, web based, training on perinatal mood disorders will be available. The DCF Home Visiting program will develop a train-the-trainer process to expand the number of sites able to implement mom/baby group therapy.

3. MCH Early Childhood Systems--Infrastructure Building--Infant 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/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 build capacity to address maternal depression and the development and wellness of children and families.

4. Prenatal Care Coordination (PNCC)--Direct Services--Pregnant women, mothers, infants

MCH staff will continue to collaborate with the Interpersonal Violence Prevention Program and Women's Health-Family Planning/Reproductive Health providers to build systems to better support women who have experienced trauma.

State Performance Measure 04: *Percent of women who have had a live birth who report having an unintended or unwanted pregnancy.*

Tracking Performance Measures

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective			34	34	33
Annual Indicator	35.4	37.6	37.6	37.3	37.3
Numerator	24382	24604	24604	72415	72415
Denominator	68841	65374	65374	194249	194249
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	34	34	34	34	34

Notes - 2013
Source: 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. 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
Source: 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. Phase 7 data (available in 2013, but not as of this date), will be comparable to previous years. Therefore, we did not change our objectives.

Notes - 2011
Source: 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: 1) Thinking back to just before you got pregnant with your new baby, how did you feel about becoming pregnant? Unintended or unwanted pregnancy was defined by a response of "I wanted to be pregnant later" or "I didn't want to be pregnant then or at any time in the future."

a. Last Year's Accomplishments
1. PRAMS--Infrastructure Building--Pregnant women, mothers, infants

The MCH Program continues to use the PRAMS fact sheets and share data on pregnancy intendedness. PRAMS 2009-2010 data showed 38% of new mothers did not intend pregnancy and 46% of mothers with unintended pregnancy reported doing nothing to prevent pregnancy.

2. Women's Health Now and Beyond Pregnancy--Enabling Services--Pregnant women, mothers, infants

The 4 women's health sites piloting the provision of interconception care to women shared lessons learned at the annual Women's Health-Family Planning/Reproductive Health provider meeting. Focusing on 'More and Better' services, the WH-FP/RH and MCH staff worked with PNCC and family planning providers to improve the number of women who reconnect with women's health after pregnancy. In 2013, as reported in SPHERE, 45% of pregnant women would have desired the pregnancy later or not at all. Also according to SPHERE, 24% of pregnant women reported a less than 17 month pregnancy interval.

3. Wisconsin Healthiest Women Initiative--Infrastructure Building--Pregnant women, mothers, infants

The MCH Program collaborated with statewide partners working on developing a website to provide resources to communities, health systems, education systems, public and private partners, and consumers on preconception health for women and men of childbearing age. A Statewide partnering agency, the Wisconsin Alliance for Women's Health, provided training to providers and teens on communication about health. The Wisconsin Adolescent Health Care Communication Program (WAHCCP) was introduced to PREP sites.

Activities	**Pyramid Level of Service**			
Table 4b, State Performance Measures Summary Sheet	**DHC**	**ES**	**PBS**	**IB**
1. PRAMS				X
2. Women's Health Now and Beyond Pregnancy		X		
3. Wisconsin Healthiest Women Initiative				X
4. Building Networks for Women's Health				X

b. Current Activities

1. PRAMS--Infrastructure Building Services--Pregnant women, mothers, infants

The MCH Program will continue to use PRAMS data to monitor this performance measure.

2. Women's Health Now and Beyond Pregnancy--Enabling Services--Pregnant women, mothers, infants

The MCH Program is working with the FP/RH program to promote the integration of women's health after pregnancy as a standard of care for both PNCC and WH-FP/RH providers, to increase the number of women who receive a reproductive life plan and interconception health care. The 'More and Better' standards are an expectation of the annual women's health visit for all women's health providers. Trainings have been provided at regional PNCC provider meetings where PNCC, WIC, FP/RH providers are all encouraged to attend.

3. Wisconsin Healthiest Women Initiative--Infrastructure Building--Pregnant women, mothers, infants

The MCH program continues to support the everywomanwi.org website. The CoIIN team is focusing on improving the rates of both postpartum and adolescent well visits. The WAHCCP will be introduced in additional locations.

4. Building Networks for Women's Health--Infrastructure Building--Pregnant women, mothers, infants

The MCH Program is working with the FP/RH program and the Injury/Violence Prevention Program (IVPP) to identify ways to support women who have experienced violence through coordinated systems of care.

c. Plan for the Coming Year

1. PRAMS--Infrastructure Building--Pregnant women, mothers, infants

The MCH Program will continue to use PRAMS data to monitor this performance measure.

2. Women's Health Now and Beyond Pregnancy--Enabling Services--Pregnant women, mothers, infants

The MCH Program will continue to work with the FP/RH program to promote the integration of women's health after pregnancy as part of the standard of care for both PNCC and WH-FP/RH providers, to increase the number of women who receive a reproductive life plan and interconception health care. The 'More and Better' standards will remain an expectation of the annual women's health visit for all women's health providers.

3. Wisconsin Healthiest Women Initiative--Infrastructure Building--Pregnant women, mothers, infants

The MCH Program will continue to support the Everywomanwi.org preconception health portal and work with statewide partners to move pre and interconception pilot outcomes and lessons learned to additional women's health care settings and across programs within DPH. In addition, MCH staff will collaborate with partners on the preconception health and interconception care CoIIN team to improve the number of women who receive pospartum visits and the number of adolescents who receive wellness visits with providers. MCH staff will work with Wisconsin Medicaid to promote required postpartum visits as part of the Medical Home OB Pilot pay for performance initiative and will work with the Wisconsin Alliance for Women's Health and United Way of Greater Milwaukee to improve the quality of adolescent wellness visits through improved communication between adolescents and health care providers.

4. Building Networks for Women's Health--Infrastructure Building--Pregnant women, mothers, infants

The MCH, FP/RH, and IVPP programs will work with local agencies to develop community systems to improve services to women and men of reproductive age who have experienced violence. The local participating agencies are expected to: 1) develop a policy to implement a working relationship between agencies and positive/active referrals between agencies, 2) develop a process to track and measure referral follow-up time and quality, 3) identify common tools to use for screening of trauma and health, 4) identify a system for support of emergent needs, 5) complete a community based plan to coordinate the needs of women and men seeking services from multiple agencies.

State Performance Measure 05: *Rate per 1,000 of substantiated reports of child maltreatment to Wisconsin children, ages 0 - 17, during the year.*

Tracking Performance Measures

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective	6	6	3.6	3.6	3.5
Annual Indicator	4.0	4.1	3.9	3.8	3.8
Numerator	5207	5327	5210	5060	5060
Denominator	1314412	1310250	1326208	1317557	1317557
Data Source	WI DCF 2010	WI DCF 2011	WI DCF 2012	WI DCF 2013	WI DCF 2013
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	3.5	3.4	3.4	3.4	3.4

Notes - 2013
Data issue: Data for 2013 are not available from the 'Wisconsin Department of Children and Families until fall 2014 or early 2015.

Notes - 2012
Source: Wisconsin Department of Children and Families. Wisconsin Child Abuse and Neglect Report. Annual Report for Calendar Year 2012 to the Governor and Legislature s 48.891(0)Wis. Stats. available at: (www.dcf.wisconsin.gov/cwreview/reports/CAN.htm)

Notes - 2011
Data issue: Data for 2012 are not available from the Wisconsin Department of Children and Families until fall 2012 or early 2013.

a. Last Year's Accomplishments
1. Home Visiting Programs including Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program--Enabling Services--Infants and Young Children and their families

The Home Visiting Nurse Consultant provided leadership in planning and implementation of evidence-based home visiting models, technical assistance to sites, and development/provision of training. SPHERE continues to be updated as needed. Work will be done to continually improve data collection procedures as well as improve data use and analysis for program continuous quality improvement.

2. Support for Together for Children conference--Population-Based Services--Infants and Young Children and their families

The MCH Program continued to provide support for the Together for Children conference.

3. Adverse Childhood Experiences (ACE)--Infrastructure Building--Infants and Young Children and their families

Since 2010 in collaboration with DHS Mental Health and Substance Abuse, WI Children's Trust Fund, WI Department of Children and Families, Child Abuse Prevention Fund of Children's Hospital of Wisconsin, the FHS has fiscally pooled resources to purchase the ACE modules for the BRFS survey, analyze and disseminate the data. All publications available at (www.wichildrenstrustfund.org). It is recognized that ACE, or trauma history impact the trajectory of a life and are vital to the process of forming a differential diagnosis in both public and private health care.

Utilization of ACE to assess trauma history began in the Department of Corrections, Juvenile Justice Systems. Home visiting programs report utilizing a trauma history tool. Gaps in the use of trauma history assessment were noted in prenatal care, WIC, and children's health. Based on ACE data for 2011 and 2012, 58% of WI residents had one ACE and 25% with one ACE had 4+. The 4th year of data collection through the BRFS was completed. The BRFS, including the ACE questions, were translated into Spanish in 2013.

4. Early Childhood Comprehensive Systems Grant--Infrastructure Building--Infants and Children

WI was awarded the Early Childhood Comprehensive Systems(ECCS): Building Health through Integration grant. An ECCS Project planning team formed to review project goals, discuss potential collaborative opportunities, and to develop project activities. The team included the Project LAUNCH State Coordinator, Department of Health Services, Pediatric Medical Home Project Administrator, Children's Hospital of Wisconsin-Fox Valley, Wisconsin Alliance for Children's Mental Health, Maternal Child Health, Department of Health Services, Home Visiting Coordinator, DCF and Wisconsin Trauma Project.

A Wisconsin-specific Child Parent Psychotherapy (CPP) learning collaborative proved to be challenging however the ECCS project team partnered with the State of Minnesota. Ten Wisconsin clinicians attended the State of Minnesota Child Parent Psychotherapy Learning Collaborative (Cohort 1).

Activities	**Pyramid Level of Service**			
Table 4b, State Performance Measures Summary Sheet	**DHC**	**ES**	**PBS**	**IB**
1. Home Visiting Programs including MIECHV		X		
2. Support for Together for Children Conference			X	
3. Adverse Childhood Experiences				X
4. Early Childhood Comprehensive Systems Grant				X

b. Current Activities
1. Home Visiting Programs including Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program--Enabling Services--Infants and Young Children and their families

The MCH Program continues to provide support to the DCF MIECHV Program as it impacts the MCH population of women, infants, children and families in the identified at-risk communities, including the reduction of child abuse and neglect. In the third year of implementation of the project, the State MCH Program continued to provide leadership to assure all programs within their oversight are strongly represented in these efforts and integration opportunities are encouraged. The Home Visiting Nurse Consultant will continue to strengthen the collaboration between the MCH Program and initiatives and the Home Visiting Program at DCF and other partners.

2. Support for Together for Children conference--Population-Based Services--Infants and Young Children and their families

The Together for Children conference was supported.

3. ACE--Infrastructure Building--Infants and Young Children and their families

Joint Resolution 59 was passed relating to early childhood brain development; policy decisions will acknowledge and take into account the principles of childhood toxic stress. Collaboration continues for collection and analysis of ACE data. Questions on poverty and neglect were added to BRFS.

4. ECCS Grant--Infrastructure Building--Infants and Children

CPP Cohort 1 is underway.

c. Plan for the Coming Year
1. Home Visiting Programs including Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program--Enabling Services--Infants and Young Children and their families

The MCH Program will continue to provide support to the DCF MIECHV Program and the Home Visitor Nurse position will be critical to that support. In its fourth year of implementation the program may expand to include additional sites.

2. Support for Together for Children conference--Population-Based Services--Infants and Young Children and their families

The MCH Program will continue to provide support for the Together for Children conference.

3. Adverse Childhood Experiences (ACE)--Infrastructure Building--Infants and Young Children and their families.

Work will expand with Departments of Corrections, Public Health, WCASA, FP/RH, MCH programs. The ACE Master Trainers program will be implemented in WI with guidance of R. Anda.

4. Early Childhood Comprehensive Systems Grant--Infrastructure Building--Infants and Children

Five Community Awareness Events coordinated in 2014 will increase community awareness of trauma informed care, identify 3 sites for participation in an ECCS Pilot Project and solicit clinicians for the CPP Cohort 2. Cohort 1 will be completed in June 2015. A listserv will be created to increase awareness of trauma informed care and serve as a venue for ongoing communication.

A partnership will be established with the University of Wisconsin-Madison, Infant and Early Childhood Mental Health Certificate program to determine how the ECCS project might serve as a catalyst for additional training activities with the University. Although the next steps are not finalized, we are working

towards using the ECCS funding as a catalyst to create an additional clinical year of training for the certificate program. The plan is to build the necessary infrastructure and training resources to enable the University to run subsequent CPP cohorts after the ECCS grant is complete.

State Performance Measure 06: *Percent of children age 10 months to 5 years who received a standardized screening for developmental or behavioral problems.*

Tracking Performance Measures

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective			30	30	35
Annual Indicator	25.9	25.9	25.9	33.7	33.7
Numerator	87900	87900	87900	37625	37625
Denominator	338982	338982	338982	111646	111646
Data Source	NSCH, NCHS, CDC, 2007	NSCH, NCHS, CDC, 2007	NSCH, NCHS, CDC, 2007	NSCH, NCHS, CDC, 2011/2012	NSCH, NCHS, CDC, 2011/2012
Is the Data Provisional or Final?				Final	Final
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	35	35	35	35	35

Notes - 2013
Data source: 2011/2012 National Survey of Children's Health. Data Resource Center for Child and Adolescent Health.

Notes - 2012
Data source: 2011/2012 National Survey of Children's Health. Data Resource Center for Child and Adolescent Health.

a. Last Year's Accomplishments
1. Developmental Screening of children--Population-Based Services--Children, including CYSHCN

Training on development screening was provided to 128 clinicians and care team members at 9 clinical sites. The training had a significant impact at the West DePere Clinic. Clinicians had been using the Denver II and initially felt they were meeting their patients' needs. After receiving training on the ASQ-3, the clinicians chose to administer both the developmental checklist and the ASQ-3 at every well-child visit during a 6 month period. At the end of the pilot, they were able to compare data from 150 well child visits and found they identified concerns in 12% more children with the ASQ-3. The pediatric clinicians were highly satisfied with these data and decided to replace the developmental checklist with the ASQ-3. The clinic manager and clinicians from this pilot group recommended implementation of the ASQ-3 within the entire Prevea Health system at every well-child visit. The West DePere pilot, their data collection, and their recommendation to Prevea Health leadership lead to system wide implementation of the ASQ-3. Prevea Health decided to begin with implementation of the ASQ-3 at all family practice clinics. An internal staff member, who will be responsible for training all clinic locations, has been identified and trained by WiSMHI.

2. Social-emotional screening of young children--Population-based Services--Children, including CYSHCN.

Six clinical sites (totaling 65 clinicians and care team members) were trained in Pediatric Mental Health Screening Trainings.

3. Education and training--Enabling Services--Children, including CYSHCN

WISMHI provided training to primary care practices throughout the state on the implementation of developmental screening called Early Identification and Referral (EIR). WISMHI continued its outreach to

clinics, community health centers, tribal clinics, and GLTIC. Results of the survey of primary care provider's developmental screening practices were shared with the WIAAP, WAFP, CYSHCN Collaborators and other key partners and an article for publication is being drafted. Learn the Signs, Act Early (LTSAE) materials continue to be distributed at trainings along with Milestone Moments booklets for families. Pediatric mental health community resource training was conducted at one clinic (totaling 25 clinicians and care team members). WISMHI, Project LAUNCH, and other stakeholders have partnered to develop a Children's Psychiatry Consultation Program for primary care clinicians that will increase their capacity to support the behavioral needs of children in their care.

4. MCH Early Childhood Systems--Infrastructure Building--Infants and Children

LHD's received MCH funding to implement the WI Healthiest Families initiative for systems-building activities related to child development as well as family supports, mental health and safety and injury prevention. Desired outcomes related to child development include: 1) increase the number of service providers using a valid developmental screening tool such as the ASQ with results communicated to the Medical Home, and 2) increase collaboration to adopt AAP recommendations by systems of care and community partners.

Fifteen LHD's and eight Tribal agencies focused on child development and screening. For example, the Sheboygan County Division of Public Health was actively engaged at the county level assessing, planning and implementing their community developed logic model to build a system in the area of growth and development. The agency provided leadership to incorporate a community approach utilizing the life course framework to assist in building capacity with partners to assure evidence based growth and development assessments (ASQ and ASQ-3) were being utilized. Data was collected to assist with ongoing evaluation and to assure that referral services and prevention strategies are being implemented throughout the jurisdiction. This initiative is related to the Sheboygan County Health Improvement Process and Plan to address primary prevention in the maternal and child population.

Activities **Table 4b, State Performance Measures Summary Sheet**	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Developmental Screening of Children			X	
2. Social-emotional Screening of Young Children			X	
3. Education and Training		X		
4. MCH Early Childhood Systems				X

b. Current Activities

1. Developmental Screening of Children--Population-Based Services--Children, including CYSHCN

WISMIHI and Project LAUNCH provide follow-up and technical assistance to trained clinicians to support their continued implementation of developmental screening.

2. Social-emotional screening of children--Population-Based Services--Children, including CYSHCN

WISMIHI and Project LAUNCH provide follow-up and technical assistance to trained clinics to support their continued implementation of social emotional screening.

3. Education and training--Enabling Services--Children, including CYSHCN

WISMHI will continue EIR, outreach to community health centers and tribal clinics, and promotion of developmental screening via listserv. LTSAE materials continue to be distributed at trainings with Milestone Moments booklets for families. WISMHI, Project LAUNCH, and others have partnered to develop a child psychiatry consultation line for primary care clinicians to increase their capacity and support the behavioral needs of children in their care. Clinician training and outreach will likely be included in the program model. ECCS grant provides opportunities to collaborate across agencies to increase awareness of early childhood trauma and toxic stress through community events

4. MCH Early Childhood Systems--Infrastructure Building--Infants and Children

LHDs continue to use MCH funds for WHF for systems approaches to support child development.

c. Plan for the Coming Year

1. Developmental Screening of Children--Population-Based Services--Children, including CYSHCN

WISMIHI will continue to provide follow-up and technical assistance to trained clinics to support their continued implementation of developmental screening.

2. Social-emotional screening of children--Population-Based Services--Children, including CYSHCN

WISMIHI will provide follow-up and technical assistance to trained clinics to support their continued implementation of social emotional screening.

3. Education and training--Enabling Services--Children, including CYSHCN

WISMHI will continue to provide training to primary care practices and health care systems throughout the state on the implementation of developmental screening. WISMHI will continue its outreach to community health centers, tribal clinics, and GLTIC. LTSAE materials will continue to be distributed at trainings along with Milestone Moments booklets for families. WISMHI will continue to promote developmental screening via its listserv. WISMHI and other stakeholders will support the implementation of a child psychiatry consultation line for primary care clinicians that will increase their capacity to support the behavioral needs of children in their care. Clinician training and outreach will likely be included in the program model.

4. MCH Early Childhood Systems--Infrastructure Building--Infants and Children

Technical assistance will continue to be provided by MCH staff to support LHDs as they progress through steps of assessment, planning, implementation, evaluation and sustainability. For example, a Learning Community will be established to bring together agencies selecting the child development focus area and peer coaching will be implemented. Collaboration with the Waisman Center's Learn the Signs. Act Early. grant will provide WI-specific materials to the local agencies and support early childhood systems building activities related to child development.

State Performance Measure 07: *Percent of children under 1 year of age enrolled in Wisconsin's Birth to 3 Program during the calendar year.*

Tracking Performance Measures

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective			1.1	1	1
Annual Indicator		1.0	0.9	1.1	0.9
Numerator		716	655	713	632
Denominator		73086	69446	67744	67974
Data Source		WI DHS IFPS	WI DHS IFPS 2011	WI DHS IFPS 2011-12	WI DHS IFPS 2012 APR
Is the Data Provisional or Final?				Final	Provisional
	2014	**2015**	**2016**	**2017**	**2018**
Annual Performance Objective	1	1	1	1	1

Notes - 2013

Data Source: Numerator: Wisconsin Program Participation System (PPS), October 1, 2013 Child Count, WI Birth to 3 Program. Denominator: WI Department of Health Services, Office of Health Informatics, Provisional number of resident births.

Our objectives are per OSEP APR: .96% - 2012, .95% - 2013, .95% - 2014, .95% - 2015, 0.95% - 2016, 0.95% - 2017, 0.95%-2018. The TVIS does not accept objectives less than 1.0%.

Notes - 2012
Data Source: Numerator. Wisconsin Program Participation System (PPS) U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS), "Report of infants and toddlers receiving early intervention services in accordance with Part C," 2010. (www.ideadata.org/PartCData.asp) WI DHS, Birth to 3 program, 2012. Denominator: WI Department of Health Services, Office of Health Informatics, Provisional number of resident births.
Our objectives are: .96% - 2012, .97% - 2013, .98% - 2014, .99% - 2015, 1.0% - 2016, 1.0% - 2017. The TVIS does not accept objectives less than 1.0%.

Notes - 2011
Data Source: Numerator. Wisconsin Program Participation System (PPS) U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS), "Report of infants and toddlers receiving early intervention services in accordance with Part C," 2010. (www.ideadata.org/PartCData.asp) WI DHS, Birth to 3 program, 2012. Denominator: WI Department of Health Services, Office of Health Informatics, US Census, 2010.
Our objectives are: .96% - 2012, .97% - 2013, .98% - 2014, .99% - 2015, 1.0% - 2016. The TVIS does not accept objectives less than 1.0%.

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

Fifteen LHDs and Great Lakes Inter-Tribal Council (8 tribal communities) addressed the child development focus area of the WI Healthiest Families initiative. MCH staff collaborated with the Wisconsin Early Childhood Collaborating Partners (WECCP) that consists of CYSHCN coordinators, Home Visitors, Local Public Health Nurses, Birth to 3 Coordinators, CESA, Early HeadStart, HeadStart, daycare providers/early childhood centers, and other members of Early Childhood Interagency Councils (ECIC). This group has been working with early childhood providers, parents and families on education, referral and follow-up. Some of the primary focus areas have been child development, safety and injury prevention, family support, brain development and mental health issues.

2. Healthy Children's Committee--Infrastructure Building--Children, including CYSHCN

During 2013, the Aligned Screening and Assessment Project Team continued to work with the Governor's Early Childhood Advisory Council. The team is in the process of finalizing a best practice review of screening practices and periodicity that will be disseminated to partners and used to guide policy and programs.

3. Screening within Medical Home--Infrastructure Building--Children, including CYSHCN

The CYSHCN Program funded WI Statewide Medical Home Initiative's (WISMHI) Pediatric Medical Home Collaborators Group that includes representation from Birth-3, Title V CYSHCN/MCH, WIAAP, WAFP, Project Launch, WISADDS, and DHS Mental Health Leadership continued to meet. A joint release form for referral to Birth-3 that is HIPPA/FERPA compliant (www.dhs.wisconsin.gov/forms/F0/f00688.doc) was promoted. In 2013, WISMHI provided: 9 trainings reaching 128 clinicians and care team members on the ASQ 3 and M-CHAT, 6 trainings (65 health care providers) on mental health screening, and piloted a training on mental health community resources (1 clinic with 25 providers). Trainings were generally done in partnership with the Regional Center for CYSHCN and local Birth-3 (Part C) provider. In addition, WISMHI partnered with the LTSAE Ambassador. Wisconsin-specific Milestone Moments booklets were made available to pediatricians and family physicians, Regional Centers, public health departments, Children's Long-Term Support professionals, WIC professionals, and others working with families of young children. WISMHI and WI First Step (24/7 CYSHCN hotline) continue to promote Easter Seal's Make the First Five Count Campaign.

4. Wisconsin Sound Beginnings (WSB)--Infrastructure Building--Children, including CYSHCN

WSB's WE-TRAC data system continued to make direct referrals to the Birth-3 program for those infants diagnosed as deaf or hard of hearing (d/hh). In 2013, 90 (92%) infants diagnosed with Permanent Hearing Loss were referred to Birth-3; 2 babies with Transient Conductive Hearing Loss were referred for a total of 92 referrals to Birth-3.

Activities Table 4b, State Performance Measures Summary Sheet	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. MCH Early Childhood Systems				X
2. Healthy Children's Committee				X
3. Screening within Medical Home				X
4. Wisconsin Sound Beginnings (WSB)				X

b. Current Activities

1. MCH Early Childhood Systems--Infrastructure Building--Infants and Young Children including CYSHCN

15 LHDs along with GLITC (8 tribal communities) work in the child development focus area of the WI Healthiest Families initiative to support early screening, identification and referral to Birth-3. Work continues to build Early Childhood Interagency Councils and increase the involvement and collaboration with LHDs.

2. Aligned Screening and Assessment Project Team--Infrastructure Building--Children, including CYSHCN

The Aligned Screening and Assessment Project Team is in the process of finalizing a best practice review of screening practices and periodicity that will be disseminated to partners and used to guide policy and programs.

3. Screening within Medical Home-Infrastructure Building--Children, including CYSHCN

The Pediatric Medical Home Collaborators Group promotes the HIPPA/FERPA compliant joint release form through health care provider newsletters, listserv and monitors its use. WISMHI and WI First Step (24/7 CYSHCN hotline) continue to promote Easter Seal's Make the First Five Count Campaign. WISMHI with Regional Centers provides trainings and TA to health care systems on ASQ 3 and M-CHAT, mental health screening and mental health community resources. WISMHI makes available LTSAE materials.

4. WI Sound Beginnings (WSB)--Infrastructure Building--Children, CYSHCN

1st Q 2014, time to diagnosis was 89 days.

c. Plan for the Coming Year

1. MCH Early Childhood Systems--Infrastructure Building--Infants and Young Children including CYSHCN

LHDs and tribal agencies will continue to receive MCH block grant funds to support early childhood systems building through the WHFI. This is multi-year work with local and tribal agencies progressing through steps of assessment, planning, implementation and evaluation/sustainability. The life course framework and core competencies based on the MCH Leadership competencies will continue to provide the foundational framework. Efforts to evaluate this work will be implemented. The project anticipates 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 support early screening, identification and referral to the Birth to Three programs for necessary intervention services. Work will continue to build local Early Childhood Interagency councils and increase collaboration with LHDs.

2. Aligned Screening and Assessment Project Team of the ECAC--Infrastructure Building--Children, including CYSHCN

The Aligned Screening and Assessment Project Team will disseminate a best practice review of screening practices and periodicity to partners to guide policy and programs. The team plans to also develop guidance on assessment practices.

3. Screening within Medical Home--Infrastructure Building--Children, including CYSHCN

The CYSHCN Program and WISMHI will continue to promote developmental screening with standardized tools and promote early referral to Birth-3 among health care providers including the use of the joint release form. Outreach efforts will continue to focus on health care systems. All outreach and training will include promotion of the First Step hotline and referral website, Regional Centers, and Birth-3.

4. WI Sound Beginnings (WSB)--Infrastructure Building--Children, CYSHCN

WSB WE-TRAC data system will continue to make direct referrals to B-3.