

**Wisconsin Department of Health Services
Title V Maternal and Child Health Program**



Needs Assessment to Identify Priorities for 2011-2015

September 2010

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Executive Summary

"All of us share this world for but a brief moment in time. The question is whether we spend that time focused on what pushes us apart, or whether we commit ourselves to a sustained effort to find common ground, to focus on the future we seek for our children, and to respect the dignity of all human beings."

President Barack Obama, 2009

The Wisconsin Department of Health Services, specifically the Family Health Section in the Bureau of Community Health Promotion of the Division of Public Health, has a responsibility for carrying out the Title V Maternal and Child Health (MCH) Block Grant functions. As a recipient of the federal grant, Wisconsin is required to complete a statewide needs assessment every five years and develop a plan of action for addressing priorities identified during the process.

The vision of Wisconsin's Title V MCH leaders was to involve the community of interest and stakeholders in an ongoing strategic planning process to bridge the needs of women, infants, children, including children with special health care needs and families to the strategies for their solution. The Wisconsin Title V MCH Program embraced the unique opportunity the needs assessment process provided to implement statewide results-based accountability strategies to improve the health of the maternal and child health populations. As such, the needs assessment was conducted as part of a larger comprehensive strategic planning effort which not only identifies priorities, but also provides a roadmap for guiding local and state public health activities to address the priorities identified during the next five-year cycle of the Wisconsin Title V MCH Block Grant.

Consideration was given to multiple factors in selecting Wisconsin's priorities including findings from a review of data trends and data analysis; local health department input; statewide projects and funded organizations input; Maternal and Child Health Advisory Committee issue mapping and analysis; capacity assessment of the Family Health Section; and ongoing input from the Family Health Section staff.

The scope of the priorities for 2011-2015 is broad and can only be addressed through work undertaken in collaboration with a wide variety of internal and external partners. Statewide and local activities to address the priorities have been developed and will be implemented over the next five years. Many factors may influence the activities being implemented to address each priority. Although the activities may change over time, the priorities themselves will stay the same unless ongoing surveillance of the needs of mothers and children indicates changes are needed.

The eight priorities identified by the needs assessment process align with the Department of Health Services' State Health Plan, *Healthiest Wisconsin 2020* and the Bureau of Community Health Promotion's mission to have *Healthy People at Every Stage of Life*.

The priorities of the Wisconsin MCH Program for 2011-2015 are:

- a) Reduce **health disparities** for women, infants, and children, including those with special health care needs
- b) Increase the number of women, children, and families who receive preventive and treatment health services within a **medical home**
- c) Increase the number of children and youth with special health care needs and their families who access **necessary services and supports**
- d) Increase the number of women, men, and families who have knowledge of and skills to promote **optimal infant and child health, development, and growth**
- e) Increase the number of women, children, and families who have **optimal mental health and healthy relationships**
- f) Increase the number of women, men, and families who have knowledge of and skills to promote **optimal reproductive health and pregnancy planning**
- g) Increase the number of women, children, and families who receive **preventive screenings, early identification, and intervention**
- h) Increase the number of women, children, and families who live in a **safe and healthy community**

The Needs Assessment

The Wisconsin Department of Health Services, specifically the Family Health Section (FHS) in the Bureau of Community Health Promotion of the Division of Public Health (DPH), has a responsibility for carrying out the Title V Maternal and Child Health (MCH) Block Grant functions. As a recipient of the federal grant, Wisconsin is required to complete a statewide needs assessment every five years and develop a plan of action for addressing priorities identified during the process.

The ultimate goals of the Needs Assessment process are to:

- (1) **Improve Outcomes** for the MCH populations of pregnant women, mothers, infants up to age one, children and adolescents and children and youth with special health care needs and
- (2) **Strengthen Partnerships**, including the Federal Maternal and Child Health Bureau, Wisconsin Department of Health Services, other agencies and organizations that have an interest in the well-being of the MCH population, families, practitioners and the community.

1. Process for Conducting Needs Assessment

Goals and Vision

As the Title V Needs Assessment began, the FHS leadership was committed to utilize the opportunity of the required needs assessment to launch a more comprehensive strategic planning process beginning with the required Title V Needs Assessment in early 2009 and continuing with the development of specific goals and objectives of the strategic plan in 2010. Ultimately, the FHS hopes the strategic planning process will serve as a guide to achieve the most important outcomes which are improved health of Wisconsin's MCH populations, improved quality of MCH services, and improved efficiency of resource use.

In light of the strategic planning model, a key part of preparing for the needs assessment included a utilization review, which was conducted throughout the fall of 2008 and provided information on how local health department staff and the MCH Program staff felt their work connected to the priorities identified in the previous needs assessment process, how the data products developed for the previous need assessment were utilized and how they rated their satisfaction and level of involvement in the previous needs assessment activities. The qualitative findings from this utilization review contributed to the development of a vision and guiding principles which shaped the process to conduct this needs assessment. (Refer to [Appendix A: Utilization Review of Previous Needs Assessment by Local Health MCH Staff](#)).

Vision: The Title V Maternal and Child Health Needs Assessment will involve the community of interest and stakeholders in an ongoing strategic planning process to bridge the needs of women, infants, children including children with special health care needs to strategies for their solution.

Goal and Timeline: The MCH Needs Assessment provides a valuable opportunity to review data and assess strengths & challenges of Wisconsin as it relates to the health of the maternal and child populations. The comprehensive information gathered as part of the Needs Assessment process will meet a federal requirement of the Maternal and Child Health Bureau of HRSA and will be used to establish new state performance measures, identify program and policy recommendations for statewide programming and resource allocation and identify successful program strategies. The Needs Assessment document will serve as a guide for the Department of Health Services staff, local health departments and many MCH partners for the 5 year span beginning January 2011 through December 2015.

Purpose: The Title V Maternal and Child Health Needs Assessment will be a formal point in the ongoing strategic planning process at which the data is revisited and focused assessment activities in the intervening years are developed within the given framework of improving maternal and child health outcomes.

Guiding Principles:

- 1) Commitment by the Family Health Section management staff to lead the Needs Assessment;
- 2) Focus on promotion of health and wellness;
- 3) Use existing stakeholder groups to gather input, review process and validate results;
- 4) Integrate needs of maternal and child health populations into a life-course approach;
- 5) Fully involve Family Health Section staff in the Needs Assessment;
- 6) Incorporate the findings into system-wide strategic planning for the Title V Program;
- 7) Convey responsibility of all partners to address priorities for the MCH/CYSHCN population;
- 8) Transform any data gathered or analyzed into useful information for program & partners; and
- 9) Conduct strategic planning within the framework of HW2020 with a commitment to identifying and addressing disparities within the MCH/CYSHCN populations

Leadership

An operational structure for the Title V MCH Needs Assessment was established which included the establishment of three core leadership groups including: an MCH Needs Assessment Leadership Team, an MCH Expert Review Team and the MCH Advisory Committee.

The primary role and responsibilities of the **MCH Needs Assessment Leadership Team** included regularly and consistently sharing information with one another about the process for, provide direction in the planning of, and assure completion of the required five year Needs Assessment for the MCH Program. Members of the Leadership Team assured a strong alignment to the larger DPH planning process in the development of a state health plan, *Healthiest Wisconsin 2020*, occurring at the same time as the MCH Needs Assessment.

Wisconsin MCH Needs Assessment Leadership Team Members

Loraine Lucinski
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MCH Unit Supervisor
Division of Public Health

The primary role and responsibilities of the **MCH Expert Review Team** included ongoing involvement throughout the needs assessment process, specifically the capacity assessment; review of all decisions of the MCH Needs Assessment Leadership Team; attendance at and participation in all MCH Advisory Committee meetings; and maintaining a high level of awareness and knowledge to be a source of information for partners and constituents they interact with regularly. The MCH Expert Review Team consisted of close to 30 people in the Bureau of Community Health Promotion. (Refer to [Appendix B](#): MCH Expert Team Members).

The primary role and responsibilities of the **MCH Advisory Committee** included ongoing involvement throughout the needs assessment process, specifically the identification of the highest needs of the maternal and child health populations and providing guidance and direction to the Title V MCH Program to address the needs identified. The MCH Advisory Committee was expanded in 2008 in anticipation of the crucial role they have with the needs assessment process. The expansion of the MCH Advisory Committee was an intentional and thoughtful process to engage key MCH Leaders throughout the state of Wisconsin. Beyond the traditional representatives from public health, other participants included those from the WI Coalition Against Sexual Assault; Great Lakes Inter-Tribal Council; WI Association of Perinatal Care; WI Family Ties; Family Voices of WI; UW School of Medicine and Public Health; Children's Service Society of WI; Children's Hospital of WI; UW Waisman Center – LEND Program and Clinical Services; Infant Death Center of WI; Family Planning Health Services; Black Health Coalition of WI; WI Alliance for Women's Health; March of Dimes; Disability Rights WI; First Breath Program; and Mental Health America of WI. Parents of children with special health care needs were also represented. (Refer to [Appendix C](#): MCH Advisory Committee Invitees). In addition to the roles above, the members of the MCH Advisory Committee generated a comprehensive listing of values that provided the foundation for the strategic planning process and was embraced by all of those involved in the process. The values identified included:

Access for All: Work toward equity, equality, social justice, affordability, and elimination of disparities (racial, gender, disability); reduce physical barriers and simplify processes.

Accountability: Assure that what we do works, is based on evidence and best practices, is data driven with clear outcomes, and is continuously evaluated.

Collaboration and Partnership: Maximize the usefulness and impact of programs and policies through relationships with families and organizations; reach out to new partners (such as faith communities); encourage all to be at the table.

Community Responsiveness: Build and support responsive, integrated infrastructure and systems in local communities to address unique community needs.

Holistic & Ecological View of Health Across the Lifespan: Take into account the whole person in context; consider mental, physical and emotional health; look at families, communities, and other external factors influencing health throughout life.

Inclusiveness: Respect each individual's culture influenced by race, gender, geography, language, abilities and life experiences; start where they are at and meet them where they are at.

Individual Support: Approach work with respect, empathy, and compassion for each individual; build opportunities for resiliency, empowerment, and responsibility.

Innovation: Gather new ideas; build new partnerships; consider new approaches.

Prevention: Get to root causes of health; start young; acknowledge the impact of poverty, housing, food security, violence and stigma.

Quality Improvement: Understand needs, funding, existing services, gaps, overlap and duplication; be efficient and effective in using this understanding to design, implement, and redesign programs, policies, and organizational structures.

Methodology

Wisconsin's overall needs assessment methodology, framed within a strategic planning framework, included four main steps:

- **Pre-Strategic Planning**
“Developing a Plan for the Plan”
- **Gathering of Data and Assessment**
“What is impacting the health of women, children and families?”
- **Identification of Priority Areas**
“What do we need to do to improve the health of women, children and families?”
- **Identification of Activities and Outcomes**
“How can we best impact the priority areas identified to improve the health of women, children and families?”

Each of these four steps included a variety of key activities and strategies which resulted in a product or products that enabled the Title V MCH Program to move to the next step. These key activities are further described below:

Pre-Strategic Planning - “Developing a Plan for the Plan” From September 2008-December 2008

- ☑ Reviewed the previous Title V MCH Needs Assessment process conducted in 2005 to determine its impact and utilization, examine lessons learned, and build upon the strengths and identify improvements to the process;
- ☑ Reviewed other States Needs Assessment reports to better understand their processes and develop an efficient and effective framework for this needs assessment process;
- ☑ Surveyed Local Health Department Staff and MCH Advisory Committee Members at the Fall MCH Regional Forums to determine how they felt their work connected to the priorities identified in the previous needs assessment process and how the data products developed for the previous need assessment were utilized;
- ☑ Surveyed Family Health Section Staff at the Central and Regional Offices to determine how they rated their satisfaction and level of involvement in the previous needs assessment activities and how they felt their work connected to the priorities identified in the needs assessment process; and
- ☑ Generated a listing of values that are important to the key MCH stakeholders and serve as the “underpinning” of all of the planning and decisions throughout the needs assessment process.

As a result of these activities, a framework and plan to guide and implement the needs assessment process was developed.

Gathering of Data and Assessment - “What is impacting the health of women, children and families?” From January 2009-April 2009

- ☑ Qualitative Data was gathered as part of the 2008 MCH Program End of Year Report requirements from more than 100 entities that receive funding through the Title V Maternal and Child Health Block Grant to identify needs of the maternal and child health populations across the State;
- ☑ Stakeholder Input through MCH Advisory Committee provided an “on the ground” viewpoint of the needs of the maternal and child health population and when combined with the qualitative data from funded partners resulted in a comprehensive listing of the needs of mothers, children and families in Wisconsin;
- ☑ Assessment of progress for MCH Performance Measures and Outcomes through the review and analysis of quantitative data reported annually including existing health status indicators, performance measures, outcomes, and health systems capacity indicators to determine impact on previously identified needs; and
- ☑ Analysis of key MCH Population Indicators and comparison of quantitative data to stakeholder qualitative data to identify health determinants and the desired outcomes of the maternal & child populations.

As a result of these activities, a comprehensive listing of key health determinants, health risk and protective factors and health outcomes for the maternal and child populations was generated.

Identification of Priority Areas - “What do we need to do to improve the health of women, children and families?” From March 2009-August 2009

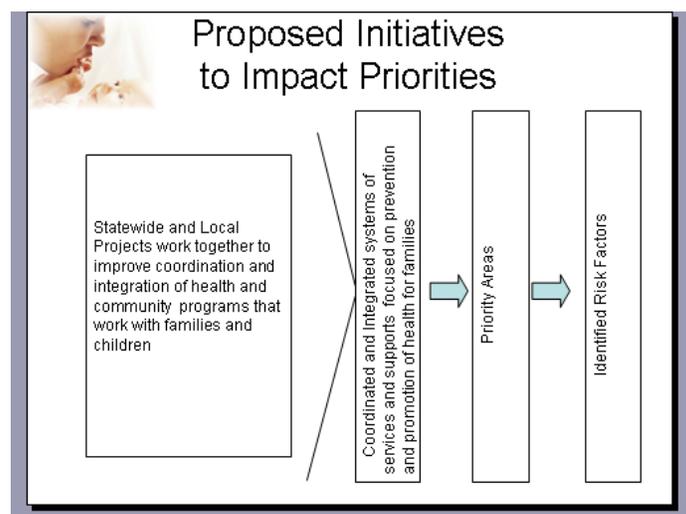
- ☑ In order to move beyond the very lengthy list of health determinants, health risk and protective factors, and health outcomes identified through the gathering of data and assessment, Issue Mapping conducted by the MCH Advisory Committee provided a way to identify opportunities which if addressed could impact multiple health needs;
- ☑ Capacity Assessment of Family Health Section which included a modified CAST-5 examining current programs by funding sources, by life stage, and by service and resulting in the identification of essential services and functions in which the MCH Programs excels as well as deficiencies targeted for improvement;
- ☑ Review Federal and State Requirements and Mandates of WI MCH Program to assure all essential services and responsibilities are integrated into future strategic planning activities; and
- ☑ Aligned the potential priorities with the focus areas identified in the Healthiest Wisconsin 2020 State Health Plan.

As a result of these activities, eight priority areas were identified which will drive the development of statewide and local activities to be implemented over the next five years.

Identification of Activities and Outcomes - “How can we best impact the priority areas identified to improve the health of women, children and families?” From September 2009-March 2010

- ☑ Framed priority areas around the Life Course Theory and Socio-Ecological Model to align with current research; and
- ☑ Developed a systems-oriented proposal of local and statewide projects/initiatives to impact the priorities identified.

As a result of these activities, a proposal of strategies and initiatives at a local and statewide level was developed to implement activities which will impact priorities in order to achieve the goal of optimizing the health and well-being of mothers, children and families.



Methods for Assessing Three MCH Populations

DPH has a 10 year plus history of advocating program integration. The MCH Program has been an active partner since the beginning and the current DPH Program Integration Workgroup is co-chaired by MCH Program staff. The staffing pattern of the MCH Program has reflected a life stage perspective by having a perinatal nurse consultant, infant/young child nurse consultant, and adolescent health coordinator. Two years ago the life course perspective was adopted by the DPH Integration Workgroup and included the development of the *Healthy People at Every Stage of Life* Framework. This framework identifies five life stages as defined by the Bureau of Community Health Staff. The Family Health Section has fully incorporated this framework and structured data collection for the Title V Needs Assessment around the life stages including:

Start Strong (Pregnant Mothers and Infants) [Component A]

Grow Safe and Strong (Early Childhood and School Age Children) [Component B]

Achieve Healthy Independence (Adolescents and Young Adults) [Component B]

Live a Healthy, Productive and Satisfying Life (Women of Reproductive Age & Partners) [Component A]

Data Collection for *Children and Youth with Special Health Care Needs* (CYSHCN) [Component C] was integrated into other childhood measures but was collected separately, when appropriate.

A combination of qualitative and quantitative data was utilized to assess the MCH populations. The combination of these two methods resulted in similar findings and provided validity of the findings.

Qualitative Data

More than 100 entities receive funding through the Title V Maternal and Child Health Block Grant. As part of the contractual relationship with each funded partner, a report is required to be submitted at the end of the calendar year which includes both a data report and a narrative report.

The 2008 MCH End of Year Report included three specific narrative questions designed to solicit input from partners regarding the connection of their activities and community health improvement plans to the previously identified needs and the unmet needs and emerging issues the families they serve are experiencing. The three questions were:

- 1) Provide a description of how all of your MCH programmatic activities advance one or more of the State's MCH Priorities.
- 2) What MCH related priorities were identified in your most recent community needs assessment process? Which of these are you currently or planning to work on in the upcoming year, two years, and five years?
- 3) Based on your experiences over the past year, what do you feel are the most important unmet needs and emerging issues impacting the health of mothers and children in your jurisdiction?

The responses to these questions were synthesized utilizing an **inductive content analysis process** to discover core meanings. A total of 86 responses were received from a variety of

partners which were included in the inductive content analysis. The data compiled as part of this evaluation is included as [Appendix D: Summary of Emerging Issues and Unmet Needs, 2008](#).

Quantitative Data

Quantitative data on the previously identified health priorities was updated and evaluated to determine impacts that have occurred over the past five years. The data compiled as part of this evaluation is included as [Appendix E: Progress on Previous MCH Priorities](#).

In addition, the 86 indicators reported on annually in the previous five Title V MCH Block Grant Reports were arranged by life stage and a trend analysis was conducted. The data compiled as part of this evaluation is included as [Appendix F: MCH Block Grant Measures by Life Stage](#).

The information gathered from both the quantitative and qualitative methods were analyzed to determine similarities and differences. A strong correlation was found between the qualitative and quantitative findings which gives both processes validity. The analysis confirmed the previously identified priorities continue to impact the health of mothers, children and families in Wisconsin.

Methods for Assessing State Capacity

A high level logic model was developed for the Title V MCH Program which clearly describes the relationships between the activities supported and conducted by the program to the outcomes expected. This logic model, which is included as [Appendix G: WI MCH Program Logic Model](#), served as a foundation for assessing the MCH Program's capacity. The Title V MCH Program believes the practice of public health is organized around the three core functions of assessment, policy development and assurance and the ten related Essential Public Health Services. To address the ability of the Wisconsin Title V MCH Program to perform the core functions and services, the Title V MCH Block Grant Performance Measures and Health System Capacity Indicators were examined by direct health care, enabling, population-based, and infrastructure building services. In addition, the Capacity Assessment for State Title V (CAST-5) instrument was modified and utilized to assess capacity to implement the ten essential services in the context of the MCH Program's specific statutory and organizational mission.

The modified CAST-V process included the following components: 1) Discussion of process indicators for each Essential Services, 2) Identify capacity needs for each essential service, 3) Conduct analysis of performance for each essential service, and 4) Summarize capacity needs across essential services. The capacity assessment was intended to create dialogue and collaboration among Title V staff and partners and to articulate a more defined vision for the Wisconsin MCH program. The findings compiled from the CAST-V assessment are included as [Appendix H: 10 Essential Services and Public MCH Program Functions](#).

In order to assure the MCH Program continues to meet the federal and state requirements, a chart was developed of these requirements and referenced often to examine the capacity of the MCH Program. This chart is included as [Appendix I: Federal and State Requirements of the Wisconsin MCH Program](#).

The combination of these methods assisted in the identification of strengths, weaknesses, opportunities and needs and more importantly, promoted strategic thinking about the MCH Program's mission and goals in a changing context. This is especially important as the MCH Program considers the impact of the health care reform legislation passed earlier in March of this year. Some of the considerations that the MCH Program will need to be ready for include:

- New programs on home visitation and teen pregnancy prevention.
- Coverage changes and insurance reforms and how they may impact Children with Special Health Care Needs Programs and the families they serve.
- New opportunities to support adolescent health and women's health.
- Community Health Center expansion and other primary care changes that will impact receipt of health care by the maternal and child health population.

Data Sources

The Title V MCH Program utilized several data sources to gather data for this needs assessment including Wisconsin's Title V internal data collection systems, SPHERE, PRAMS, WE-TRAC, and WBDP.

SPHERE: WI uses a web-based Secure Public Health Electronic Record Environment (for collecting data for MCH, CYSHCN, and Family Planning/ Reproductive Health that was developed in 2002 and released in 2003. SPHERE is designed as a comprehensive system to document and evaluate public health activities and interventions at the individual, household, community, and system level for selected programs in Wisconsin. There are currently 1,484 SPHERE users (active and inactive) representing 159 local organizations including all LHDs, Regional CYSHCN Centers, private not-for-profit agencies, private agencies including hospitals and clinics, and tribal health centers. Currently there are 238,143 clients in SPHERE and 963,464 activities. In 2009, SPHERE was used to document public health activities on 52,081 unduplicated clients with 153,488 Individual Public Health Activities; 2,790 Community Activities, and 1,494 System Activities.

Public health services provided to individual clients are reported as a snapshot in time. The Infant Assessment Summary Report based on infant assessments entered into SPHERE tells how many infants are being breastfed, sleeping in the back position, up-to-date on immunizations and well-child exams, and use a car seat. These data allows an agency to evaluate services that are being provided and the outcomes of those services. SPHERE required data is used for reporting the number of unduplicated clients served by the Block Grant and some outcome data.

MCH data sheets comparing annual state, regional, and local outcome data were developed and shared highlighting MCH priority areas, e.g. PNCC, Reproductive Health, Child Passenger Safety Seats, Infant Assessments, and Developmental Assessments.

PRAMS–Pregnancy Risk Assessment Monitoring System: In April, 2006, WI was awarded a five year PRAMS grant by CDC. WI PRAMS surveys a random sample of moms who have had a live birth, stratified by White, non-Hispanic; Black, Hispanic/Latina; and, Other, non-Hispanic. PRAMS results provide stark evidence of major disparities in household income, postpartum depression, co-sleeping practices, and pregnancy intention.

Wisconsin Birth Defects Registry (WBDR): The WBDR is a secure, web-based system that allows reporters to report one birth defect case at a time or upload multiple reports from an electronic medical records system. Reporters may also submit a paper form to the WBDR state administrator for inclusion in the registry. The WBDR collects information on the child and parents, the birth, referral to services, and diagnostic information for one or more of 87 reportable conditions. From mid-2004 through December 31, 2009, the WBDR received 2,652 birth defect reports from 68 organizations.

WE-TRAC (Wisconsin Early Hearing Detection and Intervention – Tracking Referral and Coordination): WE-TRAC is a web based data collection and tracking system created through a partnership between WI Sound Beginnings and the State Lab of Hygiene. WI Sound Beginnings, the State of Wisconsin’s EHDI program, uses WE-TRAC to ensure that every newborn has a hearing screening by 1 month of age, and if needed, receives diagnostic services by 3 months of age, and is enrolled in early intervention by 6 months of age. The system tracks organization specific information and provides statewide aggregate information.

The Title V MCH Program utilized timely data from several other sources, including:

- U.S. Census Bureau, American Fact Finder, 2006-2008 American Community Survey (<http://factfinder.census.gov>),
- U.S. Census Bureau, 2008 American Community Survey (<http://www.census.gov/acs>),
- WI Department of Administration, Demographic Service Center's 2009 Final Estimates Summary,
- State of WI, 2007-2008 Blue Book, compiled by the WI Legislative Reference Bureau, 2007,
- Anne E. Casey Foundation Kids Count Online Data (www.aecf.org/kidscount/data.htm),
- WI Department of Health Services (DHS), Division of Public Health (DPH), Office of Health Informatics (OHI), WI Infant Births and Deaths, 2008 (P- 45364-08). November 2009,
- WI DHS, DPH, OHI, WI Deaths, 2008 (P-45368-08). October 2009,
- WI DHS, DPH, OHI, WI Health Insurance Coverage, 2008 (P-45369-08). December 2009,
- WI DHS, DPH, OHI, WI Interactive Statistics on Health (WISH) data query system, (<http://dhfs.wisconsin.gov/wish/>),
- WI Council on Children and Families (www.wccf.org),
- Center on Wisconsin Strategy (COWS), (www.cows.org), and
- U.S. Bureau of Labor Statistics, Regional and State Employment and Unemployment Summary (www.bls.gov/news.release).

In addition, state-weighted responses from a variety of surveys were utilized including findings from the Youth Risk Behavior Surveillance System (YRBS) found at <http://www.dpi.state.wi.us/sspw/yrbsindx.html>; Wisconsin Family Health Survey, found at <http://dhs.wisconsin.gov/stats/familyhealthsurvey.htm>; National Survey of Children’s Health; and National Survey of Children with Special Health Care Needs, both of which can be found at <http://www.nschdata.org/Content/Default.aspx>.

Linkages between Assessment, Capacity and Priorities

Because the amount of state General Purpose Revenue available to support the public health programs in WI is among the lowest in the nation and because the amount allocated to Wisconsin through the Title V MCH Block Grant has shown a negative change in percentage for seven of the past ten years, the Needs Assessment presented a timely opportunity to develop a clearer and more defined direction for the Title V MCH Program. As such, it was important to examine the capacity of the MCH Program within the context of other initiatives occurring in the DPH so that the outcomes being achieved can be maintained while selecting more focused priorities and realistic outcomes that are closely aligned with the mission of the program. As part of the capacity assessment, key questions considered by the MCH Expert Review Team included “Is there another partner with key responsibility and resources to address this identified need? Is there another partner who is providing strong leadership in Wisconsin? If the MCH Program did not address this issue, who would? The answers to these questions led the MCH Program to focus on aspects of maternal and child health that are not specific health risks but rather are protective factors that will influence a child’s life trajectory.

The eight priorities identified for 2011-2015 differ slightly from the previously identified priorities because of the MCH Program’s increased emphasis on life-long prevention and the recent research on the life course theory. The eight priorities are not specific health risks or protective factors, but provide the base to support and implement interventions that target these factors as early as possible and acknowledge the role of families, the health system and communities to impact and influence the risk and protective factors of an individual.

Dissemination

Dissemination of the findings from the needs assessment will occur through two key mechanisms. First, the Needs Assessment document developed for submission with the Title V Block Grant Application will be distributed to all participants of the MCH Advisory Committee and posted to the Wisconsin MCH Program’s website for review throughout the year by key partners and stakeholders and easy access by the public.

Second, an evaluation process based on the participatory research model was conducted to identify methods to improve the understanding of and feedback received from the MCH Advisory Committee members and partners in future years. As such, a plan to strengthen the stakeholder input was developed which begins with the development of an Executive Summary of the findings of the needs assessment and initiatives addressing the priorities to allow more partners to become familiar with highlights of the needs assessment. Also, identified in the plan is a proposal to host a formal all-day MCH Advisory Committee Block Grant review to be held in the fall of 2010 where all MCH Advisory Committee members and other MCH Stakeholders will engage in a more in-depth review of the findings of the needs assessment.

Strengths and Weaknesses of Process

Using the values generated by the MCH Advisory Committee at the beginning of the needs assessment process as a measure of progress, the MCH Program was highly successful in interweaving the values throughout the process and it is apparent that the values served as a base for Wisconsin’s strategic planning framework.

Key strengths of the overall process include a) the ability to engage a wide variety of stakeholders from across the State in the needs assessment process and identification of priorities and proposed interventions to address the priorities. The combined expertise and investment contributed by the diverse partners and stakeholders strengthened the entire process; b) the timing of the needs assessment allowed the appropriate time for priority development to satisfy the MCHB Block Grant Guidance and timeframe and more critically, integrate with the statewide effort to develop a state health plan which was occurring simultaneously; and c) the priorities identified will allow the MCH Program to continue moving forward and integrate with the Healthiest Wisconsin 2020 focus areas throughout changing times. Although the original listing of potential needs generated by stakeholders represented a complex mixture of health outcomes, health indicators as well as behaviors or interventions that contribute to health outcomes, the process allowed consensus on priorities that are anticipated to impact a number of health outcomes within the context of a changing health care environment because of the Patient Protection and Affordable Care Act which includes a number of MCH-related provisions.

Implementation and sustainability of the strategic framework process will be an upcoming challenge of this process. Over the next year, the MCH Program will be pursuing completion of a strategic plan which is based on a systems-building approach and requires the buy-in from many local health department staff who have traditionally provided individual and community focused interventions. It is anticipated that by the end of 2010, the MCH Program will have in place a mechanism for continuous feedback from stakeholders, realistic targets, a plan for continuous data usage and updated logic models, and an increased ability of state and local staff to articulate their roles within the strategic planning process.

2. Partnership Building & Collaboration Efforts

As part of the capacity assessment conducted within the needs assessment process, improving partnerships was identified as an area to strengthen. Three specific action steps toward this goal were taken throughout the needs assessment process to assure participation and involvement from many partners including:

1. Expanded membership of the MCH Advisory Committee to include a greater number of MCH Partners, including parents, with close to 100 invited participants representing a wide variety of stakeholders, including staff from other DHS Programs, Departments of Public Instruction and Children and Families, and local health departments. Some of the partners and agencies participating included the WI Coalition Against Sexual Assault; Great Lakes Inter-Tribal Council; WI Association of Perinatal Care; WI Family Ties; Family Voices of WI; UW School of Medicine and Public Health; Children's Service Society of WI; Children's Hospital of WI; UW Waisman Center – LEND Program and Clinical Services; Infant Death Center of WI; Family Planning Health Services; Black Health Coalition of WI; WI Alliance for Women's Health; March of Dimes; Disability Rights WI; First Breath Program; and Mental Health America of WI. Parents of children with special health care needs were well represented on the MCH Advisory Committee as well and allowed for more in-depth discussion of needs of that population.
2. Focused utilization of the expanded MCH Advisory Committee in the identification of values to guide the needs assessment process, identification of needs of the maternal and child health populations, the development of issue maps and approval of strategies to

guide the direction of the MCH Program over the next five year cycle, especially identifying where collective resources could result in better outcomes for women, children and families in the state.

3. Conducted an evaluation process based on the participatory research model to identify methods to continue to engage the MCH Advisory Committee members and partners in the strategic planning process in future years.

These methods were successful in engaging a wide variety of stakeholders from across the State in the needs assessment process and identification of priorities and proposed interventions to address the priorities and strengthened the entire process.

3. Strengths and Needs of Population Groups & Desired Outcomes

Population of Wisconsin

- Wisconsin's population estimate on November 1, 2009, was 5,688,040.
- Females make up 50.3% of the state's population.
- The estimate for number of children under age of 18 was 1,317,847 or about one-fourth of the state's population.
- WI has become increasingly culturally diverse, with an estimated 14% of the population comprising African American, Hispanic/Latino, American Indian, and Asian populations.
- Wisconsin's child population is increasingly more diverse than the adult population. In 2008, people of color made up 22% of the population under 18, and only 8% of the adult population over 45.

Unemployment and Poverty

In 2004, WI's not seasonally adjusted unemployment rate was 4.9%, compared to the U.S. rate of 5.5%. Since then, according to the Bureau of Labor Statistics in 2009, WI's 2009 unemployment rate was 8.5%, compared to the U.S. rate of 9.3%. However, these rates do not reflect the U.S. economic crisis since the fall of 2007. In March 2009, Wisconsin's unemployment rate jumped to its highest rate in 26 years, 9.4%, passing the national rate of 9.0%.

Furthermore, the decline of the auto industry has hit WI especially hard, with the southeast portion of the state where General Motors has plants that closed in Beloit and Janesville. In March 2010, the Metropolitan Statistical Areas of Janesville, Racine, Sheboygan, and Wausau had unadjusted unemployment rates of 12.8%, 11.5%, 10.0%, and 10.6% respectively. In the City of Milwaukee, there are some estimates that almost 50% of African American men are unemployed.

Wisconsin women comprise less than 50% of the state's workforce, but they make up 55% of the state's working poor, those in households with income below the federal poverty level. Although there are a few signs of economic recovery in WI, such as slight gains in the manufacturing sector, generally, the employment picture is stagnant.

The range of the percentage of children who live in poverty by county is significant, from the counties with the highest poverty rates for children (Milwaukee at 25.2% and Vernon at 22.0%) to the counties with the lowest poverty rates for children (Ozaukee at 5.3% and Waukesha at

4.5%). Statewide poverty rates for children differ by race and ethnicity with Black, Hispanic and American Indian children impacted more than White children as the table below demonstrates:

	Percent in poverty	Percent of children aged 0-17 in poverty
Total	10.4	13.3
White	8.1	8.7
Black	32.1	41.9
Am. Indian	24.1	35.1
Asian	15.3	12.4
Hispanic	19.7	23.2
Two or more races	18.7	19.4

Furthermore, Wisconsin PRAMS data indicate significant disparities for household income. The following table demonstrates the percentage of Wisconsin mothers who report less than \$10,000 and more than \$50,000 per year before taxes, 2007 – 2008.

Race/ethnicity	Less than \$10,000	More than \$50,000
White, non-Hispanic	10%	49%
Black, non-Hispanic	48%	6%
Hispanic/Latina	32%	5%
Other, non-Hispanic	22%	6%

Leading Causes of Death

- In 2008, 54% of the leading causes of death were diseases of the heart, malignant neoplasms (cancer), and cerebrovascular diseases (stroke).
- For males, in 2008, the leading underlying cause of death for ages 1-44 were accidents; cancer was the leading cause of death for men ages 45-84.
- For females, accidents were the leading underlying cause of death among females ages 1-25; cancer was the leading cause of death among women ages 25-84.

Access to Health Insurance

According to the two-year average comparison based on national census data from 2006-2007, WI had the 2nd lowest uninsured rate for children at 5.3% and the 3rd lowest uninsured rate for the non-elderly population (0-64 years) at 9.6%. However, census data from 2008 released 9-09 indicates that WI slipped to fourth place for the overall rate of uninsured, behind Massachusetts, Hawaii, and Minnesota.

According to the 2007 WI Family Health Survey:

- 91% of Wisconsin residents were covered by health insurance for the entire year.
- 5% had no coverage for the entire prior year and of those, 90% were childless adults.
- Significant decrease in the rate of uninsured from 8% in 2006 to 6% in 2007.
- Percentage of children 0-17 uninsured all year decreased from 4% in 2006 to 2% in 2007.
- Over 99% of the elderly have coverage.
- African American, Hispanic and American Indian adults, ages 18-64, were more likely to be uninsured than were non-Hispanic white adults of the same age group.

- Nine percent of children 0-17 living in poor or near-poor households were uninsured for part or all of the past year, compared to 3% of children in non-poor households.

Starting Strong in Wisconsin

Vital statistics

In 2008, there were 72,002 live births to Wisconsin residents, 755 fewer than in 2007 (72,757). The 2008 crude birth rate in Wisconsin was 12.7 births per 1,000 total population, slightly lower than the 2007 rate (12.9). In comparison, the United States crude birth rate for 2006 (latest available data) was 14.2 per 1,000 population.

From 1998 to 2008, the percent of births to women in their teens and early thirties decreased, while the percent of births to women in their twenties increased. The proportion of births to women aged 35 and older remained the same.

From 1998 to 2008, the proportion of Wisconsin births to non-Hispanic white women decreased from 81% to 74%, while the proportion of births to Hispanics/Latinos increased from 5% to 10%. The proportion of births to women in other race/ethnicity groups remained roughly stable, with black/African American women accounting for 10% in both 1998 and 2008, American Indian women approximately 1 to 2% each year, and women in other groups approximately 3 to 4% each year.

In 2008, 15% of Wisconsin women who gave birth had not finished high school, down from 16% in 1998. Fifty-six percent of women who gave birth in 2008 had attended college for one year or more, compared to 51% in 1998.

The overall proportion of women who received first-trimester prenatal care was 82% in 2008, lower than in 1998 (84%). From 1998 to 2008, the proportion with first-trimester care decreased in all age groups except mothers aged less than 15 and 18-19, among whom it increased. The proportion with first-trimester care increased for blacks/African Americans and Laotians or Hmong, and decreased for whites, American Indians, Hispanics/Latinas, and the “other” race/ethnicity group.

The proportion of women giving birth who reported they smoked during pregnancy decreased from 18% in 1998 to 14% in 2008.

Infant mortality

Often used as a measure of a society's overall well-being, infant mortality is a significant issue. In Wisconsin, total infant mortality and white infant mortality declined gradually over the 1986-2008 period. 501 infants under the age of one year died in 2008. The 2008 infant mortality rate was 7.0 infant deaths per 1,000 live births, compared to 6.4 in 2007 and 7.2 in 1998. The 2005 U.S. infant mortality rate (the latest available) was 6.9 infant deaths per 1,000 live births.

The White rate in Wisconsin was 5.9, a slight increase from 5.3 in 2007, but a marked decrease from 7.2 in 1990.

In comparison, the black/African American infant mortality rate has remained much higher than the rate for other populations in Wisconsin for at least two decades. The black/African American infant mortality rate for 2008 was 13.8 deaths per 1,000 births to black/African American women. The black infant mortality rate in 1990 was 19.7; in 1997 it was at its lowest for the past two decades at 13.4. Since then it has increased steadily to 18.7 in 2001. Aside from some fluctuations the 2007 and 2008, rates are the lowest of this decade; nonetheless, in 2008, the ratio of the Black infant mortality rate to the White was 2.3. The black-white disparity ratio for infant mortality increased from 2.2 in 1990-1992 to a high of 3.5 in 2002-2004. Since 2002-2004, the black-white disparity ratio for infant mortality has decreased but the black/African American infant mortality rate was 2.8 times the white rate in 2006-2008.

The Hispanic/Latino infant mortality rate fluctuated over the past decade. The Hispanic/Latino infant mortality rate for 2008 was 7.0 deaths per 1,000 births to Hispanic/Latina women, compared to 6.4 in 2007 and 11.0 in 1998.

Based on three-year rolling average infant mortality rates, American Indian infant mortality has dropped markedly since 1986. The rate was 16.7 per 1,000 live births in 1986-1988 and 10.1 per 1,000 in 2006-2008.

Low birth weight/preterm

In 2008, 5,051 Wisconsin infants were low birth weight; that is, they weighed less than 2,500 grams (about 5.5 pounds) at birth. This total represented 7.0% of all births, the same as in 2007. In comparison, 8.3% of all infants born in the United States in 2006 weighed less than 2,500 grams. The rates varied by race and ethnicity. The rate for Black infants was 13.0%, White infants 6.3%, American Indian, Hispanic/Latinos, Laotian/Hmong, and other Asians were 8.0%, 6.3%, 7.9%, 7.0% and 6.9% respectively.

Among low birth weight infants, 898 (1.2% of all births) were born at *very* low birth weight (less than 1,500 grams or about 3.3 pounds) and were thus at the highest risk for health problems. The very low birth weight percentage was 1.0% of births to whites, 2.8% of births to blacks/African Americans, 1.8% of births to American Indians, 1.3% of births to Hispanics/Latinas and 1.0% of births to Laotians or Hmong.

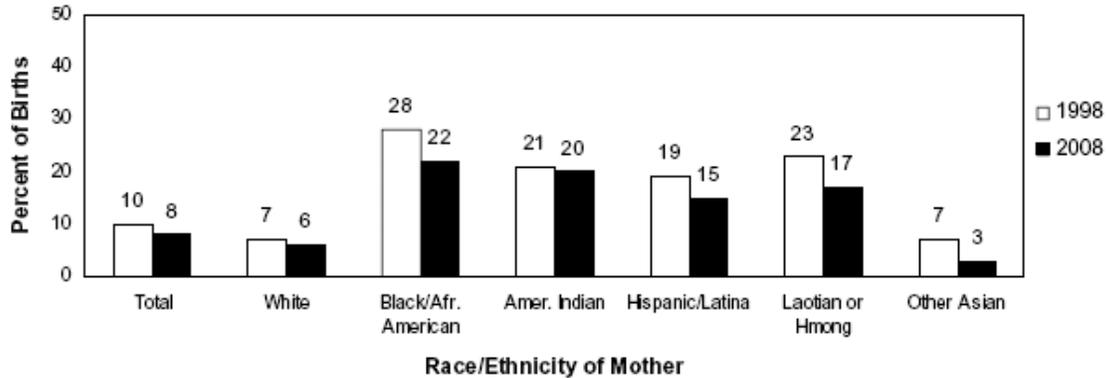
In 2008, 11.1% (7,970) of infants in WI were born prematurely (with a gestation of less than 37 weeks). Non-Hispanic Black women had the highest percentage of premature babies at 16.8%, followed by teenagers less than 18 years old at 16.0%, women who were unmarried 13.5%, women who smoked during pregnancy 13.3%, and American Indian women 12.7%). The 11.1% of all births resulting in prematurity is the same proportion as in 2007.

First trimester prenatal care

In 2008, 82.2% of pregnant women received first trimester prenatal care. The race/ethnic group with the highest rate was White women at 86.2%, followed by other Asian women at 82.2%, American Indian women at 72.5%, Hispanic/Latina women at 71.3%, African American women at 70.2%, and Laotian/Hmong at 56.1%.

Teen birth rate

In 2008, for teens <20 years, there were 6,096 births (rate of 31.3 per 1,000), or 8.5% of all births in Wisconsin. Teen birth rates for <20 years by race/ethnicity in Wisconsin, 1998 to 2008 have continued to decline however at a different rate based on race/ethnicity as the following table demonstrates:



Preconception Health

The Title V MCH Program is in the process of developing a full report on preconception health indicators for Wisconsin women which will be completed later in 2010, however WI PRAMS 2007-08 data highlights the need for focused efforts related to preconception health. Some preliminary findings include:

- 45% of all and 67% of African American pregnancies are unplanned;
- 14% of all and 25% of African American women experience postpartum depression;
- 95% of the women who reported smoking in the past 2 years reported smoking in the 3 months prior to pregnancy;
- 53% of all and 62% of African American women did not take a multivitamin the month prior to pregnancy.

Growing Safe and Strong in Wisconsin

The following table summarizes key health and system performance measures for Wisconsin as measured by the National Children's Health Survey:

Children's Health and System Performance Measures for Wisconsin

Measure	Nationwide Overall Results	Statewide Overall Results	Statewide BY Special Health Care Needs		Statewide BY Health Insurance Type	
	% <u>Pop. Est.</u> Nationwide	% <u>Pop. Est.</u> Statewide	% <u>Pop. Est.</u> CSHCN	% <u>Pop. Est.</u> Non- CSHCN	% <u>Pop. Est.</u> Public	% <u>Pop. Est.</u> Private
CSHCN: Child has one or more ongoing health condition requiring above-routine amount or complexity of health services (children age 0 to 17 years)	19.2 14,136,454	20.3 266,540	--	--	27.7 76,816	18.3 173,887
Chronic Conditions: Child currently has one or more of 21 chronic health conditions specified (children age 0 to 17 years)	43.0 31,728,058	41.5 545,745	89.9 239,523	29.2 306,222	57.2 158,573	36.8 349,996
Weight Status: Height-to-weight ratio (BMI) at or above 85th percentile for child's age and sex (children age 10 to 17 years)	31.6 10,001,679	27.9 162,772	34.8 51,270	25.6 111,502	35.5 35,588	25.8 113,739
Developmental Risk: Parent concerns indicate moderate or high risk for developmental or behavioral problems (children age 4 months to 5 years)	26.4 6,135,063	22.8 89,258	43.4 23,289	19.5 65,969	35.3 35,310	18.2 49,980
Uninsured: Child does not currently have health insurance coverage (children age 0 to 17 years)	9.1 6,697,766	5.7 75,332	5.1 13,476	5.9 61,857	--	--
Insurance Gaps: Child is currently uninsured or was uninsured for one or more periods of time during past 12 months (children age 0 to 17 years)	15.1 11,098,007	10.4 135,752	8.9 23,528	10.7 112,224	14.2 39,207	2.2 21,213
Insurance Adequacy: Coverage does not meet child's health needs, does not allow child to see health care providers they need, and/or family's out-of-pocket medical expenses are unreasonable (currently insured children, age 0 to 17 years)	23.5 15,744,885	27.4 338,931	31.3 78,903	26.4 260,028	23.9 66,273	28.4 270,473
Well Visits: Child had one or more preventive medical care visits during past 12 months (children age 0 to 17 years)	88.5 64,575,112	84.2 1,098,682	92.8 245,637	82.0 853,045	88.2 243,616	84.7 801,027
Dental Visits: Child had one or more preventive dental care visits during past 12 months (children age 1 to 17 years)	78.4 54,293,506	80.2 1,002,195	84.7 220,402	79.1 781,793	71.4 188,417	83.4 752,859

Measure	Nationwide	Statewide	Statewide BY Special Health Care Needs		Statewide BY Health Insurance Type	
	% Pop. Est. Nationwide	% Pop. Est. Statewide	% Pop. Est. CSHCN	% Pop. Est. Non- CSHCN	% Pop. Est. Public	% Pop. Est. Private
Surveillance: Parent reports that a doctor or other health care provider asked basic questions about parent's concerns (children with health care visit in past 12 months, age 0 to 5 years)	48.0 11,267,674	58.7 233,569	61.5 32,963	58.3 200,605	44.8 45,128	64.8 183,018
Screening: Standardized developmental and behavioral screening (SDBS) was conducted during a health care visit (children who had at least one health care visit in past 12 months, age 10 months to 5 years)	19.5 3,880,957	25.9 87,900	31.1 13,503	25.2 74,397	25.5 22,202	25.4 60,875
Specialist Access: Parent reports small or big problem getting specialist care for child (children who needed care from a specialist doctor during past 12 months, age 0 to 17 years)	23.5 4,567,964	21.8 72,088	27.1 36,932	18.1 35,156	34.0 25,573	15.9 37,333
Mental Health Care Access: Child did not receive mental health services in past 12 months (children who need mental health treatment or counseling, age 2 to 17 years)	40.0 2,021,595	38.6 34,946	36.8 30,738	--	34.9 12,959	34.8 16,418
Medical Home: Child's health care meets all 3 basic criteria for Medical Home: 1) usual provider and place for care; 2) family-centered care; and 3) referral and coordination of health services, if needed (children age 0 to 17 years)	57.5 40,602,320	62.9 799,738	54.8 140,745	65.0 658,993	49.3 130,162	69.2 641,122
PDN: Child has personal doctor or nurse (PDN) who knows child and family well and is familiar with child's health history (children age 0 to 17 years)	92.2 67,685,757	93.4 1,226,811	96.9 258,216	92.5 968,595	87.8 243,282	96.0 912,725
Usual Source of Care: Child usually goes to a specific clinic, doctor's office, or other place for medical treatment or advice when ill (children age 0 to 17 years)	93.1 68,478,484	94.4 1,240,238	97.1 258,694	93.7 981,543	90.2 250,278	96.9 921,496
Family-Centered Care: Parent reports a trusting, collaborative, working partnership with child's health providers (children with health care visit in past 12 months, age 0 to 17 years)	67.4 46,915,042	71.8 895,433	67.8 174,454	72.8 720,979	61.2 156,774	77.0 706,965

Measure	Nationwide	Statewide	Statewide BY Special Health Care Needs		Statewide BY Health Insurance Type	
	Overall Results	Overall Results				
	% Pop. Est. Nationwide	% Pop. Est. Statewide	% Pop. Est. CSHCN	% Pop. Est. Non- CSHCN	% Pop. Est. Public	% Pop. Est. Private
Effective Care Coordination: Family received all care coordination wanted and is satisfied with communication among providers (children who used 2+ types of health service in past 12 months, age 0 to 17 years)	68.7 20,570,730	73.3 364,530	62.5 120,747	80.1 243,783	62.7 74,710	77.2 268,858
Care Coordination Help: Family received any help with care coordination (children who used 2 or more types of health service in past 12 months, age 0 to 17 years)	20.7 11,141,474	17.8 162,816	19.8 48,095	17.0 114,721	16.9 32,753	18.0 121,637
Extra Help Not Needed: Family did not need extra help with care coordination (children who used 2 or more types of health service in past 12 months, age 0 to 17 years)	88.3 47,501,137	92.0 844,664	82.3 200,382	95.4 644,282	80.3 155,155	95.5 643,952
Quality Index: Child's health care meets criteria for each of three essential system performance measures: 1) adequate insurance, 2) a medical home, and 3) at least one preventive care visit in the past 12 months	45.3 28,798,831	44.8 533,764	42.6 103,154	45.3 430,610	36.9 96,941	47.2 435,241

Achieving Healthy Independence in Wisconsin

Sexual Behavior

Many of the sexual risk behaviors reported by high school students on the YRBS have decreased significantly since 1993. However a significant percentage of students are still engaging in risky sexual behaviors and putting themselves at risk for negative health outcomes.

- During 1993-2009 a significant decrease occurred in the percentage of students who reported ever having had sexual intercourse (47%-41%).
- The long-term trend of high school students who reported having had sexual intercourse with at least one partner in the last three months has remained unchanged, 33% in 1993 to 29% in 2009.
- The percentage of students who reported sexual intercourse before the age of 13 decreased during 1993-2009 (7%-3%).
- The percentage of students who reported multiple sexual partners (four or more) decreased during 1993-2009 (14%-10%).

Suicide

The youth suicide rate in Wisconsin consistently exceeds the national average. Wisconsin YRBS data indicate a clear downward trend in the percent of students who report feeling sad or hopeless and those seriously considering suicide. However the long-term trend for students who have made a plan to attempt suicide or attempted suicide has remained relatively stable.

- One out of five high school students reported feeling sad or hopeless almost every day for two weeks or more in a row in the past 12 months.
- During 1993-2009 a significant decrease occurred in the percentage of students who reported having seriously considered suicide in the past 12 months (27%-13%).
- The percentage of students who reported making a plan about how they would attempt suicide decreased from 2005 to 2007 (15%-10%) but then did not change significantly during 2007-2009 (10%-11%).
- Students who reported they have attempted suicide in the past 12 months has significantly decreased from 1993 to 2009 (8%-6%).

Cigarette usage

The trend of decreasing cigarette and other tobacco use among Wisconsin high school students now stretches over a decade. In 2009 Wisconsin saw significant decreases on most measures of tobacco use on the YRBS.

- In 2009, 44% of high school students reported trying a cigarette at least one time in their life compared to 64% in 2001.
- The prevalence of students who smoked a cigarette before the age of 13 decreased from 27% in 1993 to 9% in 2009.
- During 1993-2009 a significant decrease occurred in the percentage of students who reported smoking a cigarette on one or more of the past 30 days (32%-17%).

Motor vehicle crashes

The leading cause of death among youth (5-17 year olds) in Wisconsin. Fortunately we have seen a significant increase in the percent of Wisconsin high school students who report wearing a seat belt and not being a passenger in a car driven by someone who has been drinking alcohol. Unfortunately a significant percent of high school students still report drinking and driving and not consistently wearing a seat belt.

- During 1993-2009 a significant decrease occurred in the percentage of students who reported never or rarely wearing a seat belt when riding in a car driven by someone else (29%-15%).
- One out of four students reported riding with a driver who had been drinking alcohol at least once in the past 30 days.
- Fourteen percent of 11th grade students and 17% of 12th grade students reported driving after drinking alcohol at least once in last 30 days.

Alcohol Usage

In 2009, a large percentage of Wisconsin high school students reported drinking alcohol. The percentage of students reporting binge drinking (five or more drinks of alcohol in a row) in Wisconsin is higher than most states.

- During 1993-2009 a significant decrease occurred in the percentage of students who reported drinking alcohol in the past 30 days (48%-41%).

- Twenty-five percent of students reported binge drinking (5 or more drinks of alcohol in a row) in the past 30 days.

Physical Activity and Nutrition

Overall, Wisconsin high school students report inadequate levels of physical activity and consumption of fruits and vegetables. The percent of overweight and obese high school students, as measured on the YRBS, has not changed since 1999.

- One-fourth of high school students are overweight or obese according to their height and weight (self-reported) for their age. Males are more likely to be obese compared to females.
- Only one out of five students reported eating five or more fruits and vegetables per day over the last week.
- Twenty-three percent of students reported drinking one or more cans, bottles, or glasses of pop per day over the last seven days. Males were significantly more likely to drink pop compared to females.

Children and Youth with Special Health Care Needs *Growing Safe and Strong and Achieving Healthy Independence*

The most recent data collected in 2005-2006 through the National Survey of Children with Special Health Care Needs found approximately 200,000 children or 15.3% of children in Wisconsin meet the MCHB definition for having a special health care need. This ranks Wisconsin 22nd out of the 50 states and the District of Columbia for percent of CYSHCN and higher than the national estimate of 13.9%. This state rate has increased from the 2001 Survey finding of a prevalence of CYSHCN of 13.4%.

Black children are significantly more likely than White children to have a special health care need at 19% which is higher than the national prevalence rate of 15%. Wisconsin ranks 10th overall for prevalence of Black children with special health care needs.

The prevalence of CYSHCN is higher for those who live in urban core areas (16.5%) compared to those who live in a suburban area (13.8%), large town (13.6%) or small town/rural areas (13.6%). Across all geographic areas, CYSHCN are more likely to live in households at 0-99% of the Federal Poverty Level.

Wisconsin has a higher prevalence of CYSHCN at every age group compared to national prevalence rates including 9.5% of children 0-5 years of age; 17.5% of children 6-11 years of age; and 18.3% of adolescents 12-17 years of age.

Key Data Indicators for CYSHCN:

Child Health	<u>State %</u>	<u>National %</u>
• CSHCN whose conditions affect their activities usually, always or a great deal	23.2	24.0
• CSHCN with 11 or more days of school absences due to illness	11.4	14.3

Health Insurance Coverage	<u>State %</u>	<u>National %</u>
• CSHCN without insurance at some point in the past year	6.4	8.8
• CSHCN without insurance at time of survey	1.6	3.5
• Currently insured CSHCN whose insurance is inadequate	34.4	33.1
Access to Care		
• CSHCN with any unmet need for specific health care services	15.5	16.1
• CSHCN with any unmet need for family support services	5.9	4.9
• CSHCN needing a referral who have difficulty getting it	15.1	21.1
• CSHCN without a usual source of care when sick (or who rely on the ER)	5.1	5.7
• CSHCN without any personal doctor or nurse	5.2	6.5
Family-Centered Care		
• CSHCN without family-centered care	28.8	34.5
Impact on Family		
• CSHCN whose families pay \$1,000 or more out of pocket in medical expenses per year for the child	20.2	20.0
• CSHCN whose conditions cause financial problems for the family	17.2	18.1
• CSHCN whose families spend 11 or more hours per week providing or coordinating the child's health care	9.6	9.7
• CSHCN whose conditions cause family members to cut back or stop working	21.7	23.8

4. Program Capacity by Pyramid Levels

SERVICES FOR PREGNANT WOMEN, MOTHERS, INFANTS

Reproductive Health

A key goal of the Wisconsin MCH Family Planning, Reproductive/Sexual Health, and Early Intervention (FP/RSH/EI) Program is to provide quality, cost-effective, confidential contraceptive and related reproductive health care through a statewide system of community-based clinics. These clinics are medical (health care) homes for addressing a significant part of the primary and preventive care recommended for reproductive-age women: provided in specialized health care setting separate from but coordinated with their other sources of primary health care. Over 50,000 women receive care through this statewide system of services.

One of the highest priorities in this next 5-year cycle will be to increase access to services and quality of care. Guidelines (patient care and administration) will be updated, and quality assurance indicators/performance measurements will be established to improve accountability for implementation and quality improvement. New standards of practice and priority areas will be introduced. These priority practices include improved access to: dual protection (simultaneous intervention for unintended pregnancy and STD risk reduction); emergency contraception; postpartum contraception; reproductive life plans; FPW eligibility screening and enrollment; medical homes for reproductive/sexual health and other primary health care;

consistent health messaging; and screening, assessment and intervention for sexual violence and abuse. Early intervention and continuity of care are two other related standards of practice that will be emphasized in the 2011-2015 cycle.

Improved partnerships with PNCC will be a high priority for implementing these new priority areas and establishing new standards of practice. The Women's Health Now and Beyond Pregnancy will be expanded to implement best practices developed in model projects with PNCC providers to improve timeliness of post partum contraception through new practice standards, reproductive life planning, healthy birth spacing, interconception and women's health.

Screening and assessment for sexual assault and abuse is a new service priority because women who have experienced or witnesses violence (child physical or sexual abuse, sexual assault, and/or domestic violence) are at greater risk for complications around family planning and reproductive health. Women who have experienced violence are at risk for poor birth outcomes (low birth weight and pre-term), negative labor and delivery experiences, and difficulty in implementing and sustaining breast feeding. Through MCH-funded programs serving women prenatally and postpartum 19 % were identified as experiencing abuse and personal safety issues (SPHERE 2009). A new collaboration has begun between Family Planning/Reproductive Health, IVPP, WIC, and Maternal Health programs to explore message delivery, assessment and follow-up on issues related to violence for women utilizing these services.

The Title V MCH Program contracts with Health Care Education and training, Inc., which manages the Region V Title X Family Planning training project, to provide training and technical assistance on these and other 5-year priorities to community based health programs, and private health care providers.

Preconception Health

The Wisconsin Association for Perinatal Care (WAPC) and the Infant Death Center of Wisconsin (IDCW) were funded to produce materials and provide education to support preconception services as part of the routine care for all women. In collaboration with Medicaid, DPH provided guidance on interconception services for women with a previous poor birth outcome identified through the Medicaid high-risk birth registry. The Women's Health Now and Beyond Pregnancy initiative extended interconception care for women receiving PNCC services.

In 2011, the Title V MCH program will begin funding preconception initiatives that focus on: 1) integrating depression screening and tobacco cessation services into family planning/reproductive health programs, 2) integrating select preconception services into the routine care provided to women of childbearing age by the health plans of WI, and 3) establishing a collaborative to develop and implement a preconception plan for the state.

Maternal Health

The Wisconsin Association for Perinatal Care (WAPC) is funded by the MCH Program through 2010 as the statewide project to Improve Maternal Care and Maternal Health. WAPC provides education and training to support perinatal practices in the hospital and clinical settings. Through multi-disciplinary committees in 2009-2010, WAPC developed an Algorithm for Preconception Care for clinical providers; the Methadone Project Educational Toolkit for clinical

providers; and the Expectant Father Wish List for community members. A conference is hosted annually and regional forums in 2009 provided education for health care providers on the use of antidepressants in pregnancy and while breastfeeding.

The Wisconsin Maternal Mortality Review Team (MMRT) was established in 1997 under the auspices of the DHS to collect, evaluate, and analyze all maternal deaths occurring in the State of Wisconsin. This multi-disciplinary collaborative makes recommendation on maternal care practices to improve maternal outcomes. The MCH Program has partnered with WAPC to support this effort with case abstractions and a report publishing 5 years of findings.

Infant Health

The Infant Death Center of Wisconsin (IDCW) is funded by the MCH Program through 2010 as the statewide project to Improve Infant Health and Reduce Disparities. IDCW brings partners together building coalitions to support the Healthy Birth Outcomes; Healthy Babies in Wisconsin and the Milwaukee Hospital Collaborative to support perinatal outcomes. In addition to individual bereavement support to families the IDCW provided education to public and private health care partners on safe infant sleep and reducing the risk of SIDS.

MCH provides education on infant care practices. The Great Beginnings Start before Birth curriculum continues to be offered statewide to LHD and home visitation programs providing services to families during both the prenatal and postpartum period.

With an increase in sleep related infant deaths in the Southeastern Region of WI, MCH has collaborated with the City of Milwaukee Health Department to hold a Safe Sleep Summit to focus on increasing awareness of preventable losses and develop a plan for improving messages on safe infant sleep to the community.

Newborn Screening

In Wisconsin, infants are screened for 47 different congenital disorders and for hearing loss. Infants diagnosed receive referral, follow-up care and links to services. The early screening team includes staff from the congenital disorders, early hearing detection and intervention (EHDI), and the statewide genetics program. The Newborn Screening staff collaborates with the State Lab of Hygiene to continuously improve Wisconsin's early screening initiatives and promote the health and well being of newborns and their families. The NBS Advisory Committee and six, soon to be at eight, subcommittees meet biannually and advise and provide expertise regarding NBS testing, diagnosis and patient care. Staff members participate in the Region 4 Genetics Collaborative to share resources, best practice models and new technologies related to newborn screening.

SERVICES FOR CHILDREN AND ADOLESCENTS

Child Health

Children's Health Alliance of WI (CHAW) receives MCH funding for statewide initiatives to address childhood injury and violence prevention (IVP). CHAW supports training, technical assistance and data analysis for LHDs and other community partners. An emphasis has been placed on initiating the Child Death Review (CDR) process in more counties. The maintenance

of a statewide network with training and resources dedicated to childhood IVP has been expanded to include on-line trainings.

In 2011, the MCH program will develop the Keeping Kids Alive project through a statewide partnership. The focus of the project will be to establish systematic reviews of fetal, infant and child deaths throughout WI and to support the implementation of actions based on findings both locally and statewide. The project will provide technical support to local death review and community action teams; to promote the use of standardized data collection e.g. National CDR system and FIMR system.

In 2011, MCH dollars will also support local and statewide efforts to build a system of integrated and coordinated health promotion and prevention for children and their families incorporating four Bright Futures health promotion themes: family supports, child development, mental health, and safety/injury prevention.

Systems of Care

State initiatives to promote connected service systems for children and adolescents have been implemented under the leadership of the State MCH Program. Since 2003 MCH has partnered with many state public and private agencies to implement the Early Childhood Comprehensive System (ECCS) grant. Under the leadership of MCH, ECCS has strengthened the linkages among key partners with a broad focus on early childhood policies, programs, and services. Work over the last year has strengthened links among providers of service to young children in the areas of the five critical components of the ECCS grant: access to health insurance and medical home, mental health and social-emotional development, early care and education, parent education and family support by linking with the state collaborative, Wisconsin Early Childhood Collaborating Partners (WECCP).

Because of the strong system work that occurred by linking ECCS with WECCP, new opportunities have arisen that will further strengthen the movement toward a connected system of programs at the state level to support the services for young children at the state and community levels. Wisconsin was successful in competing for a Project LAUNCH grant which was awarded September 2009 because of the foundational work of ECCS. The application process for Wisconsin Project LAUNCH (Linking Actions for Unmet Needs in Children's Health), a cooperative agreement funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), was built upon existing work and relationships that have been at the forefront of efforts of the ECCS grant. Project LAUNCH will focus work to promote child wellness in target neighborhoods of the City of Milwaukee that are excessively burdened by issues associated with poor child health including: a high percentage of infants born at low birth weight, late entry of pregnant women into prenatal care, childhood lead poisoning, high rates of sexually transmitted diseases, high rates of poverty and unemployment, lack of education, excessive use of drugs, high crime rates, and high teen pregnancy rates.

ECCS grant activities complement the work of Project LAUNCH and both efforts will be coordinated to inform the work of Governor Jim Doyle's Advisory Council on Early Childhood Education and Care (ECAC). The ECAC was appointed in 2008 as part of the Head Start

reauthorization that required council of key state department leaders and partners of influence to recommend policy that affects the system of services for young children and their families.

In August of 2009, the MCH program initiated work to promote integration of *Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents, Third Edition*, into public health practice for children in Wisconsin. Released in 2008, *Bright Futures* provides detailed information on well-child care for health care practitioners. In partnership with American Academy of Pediatrics (AAP), an all day work shop was held on August 17, 2009 to provide overview of the use of Bright Futures in public health practice. Wisconsin is providing a series of live webcasts jointly sponsored by the AAP and the state DHS, DPH, Family Health Section. During 2010, webcasts will focus on the needs of public health nurses and each will feature a specific *Bright Futures* theme: oral health, injury prevention, healthy nutrition, and healthy weight.

Adolescent Health

In the area of adolescent health, WI has been in a leadership role by having its Youth Policy Director, as the President of the National Network of State Adolescent Health Coordinators, participate in the drafting of priorities for the new Federal Office of Adolescent Health and help to develop a national adolescent health strategic plan. In 2011, MCH hopes to be successful in several new federal grants to improve our internal adolescent health staffing capacity to enhance collaborative efforts of MCH programming.

SERVICES FOR CYSHCN

Regional CYSHCN Program Collaborations

Five Regional CYSHCN Centers receive MCH Block Grant funds to:

- Provide a system of information, referral, and follow-up services so all families of CYSHCN and providers have access to complete and accurate information.
- Promote a Parent-to-Parent support network to assure all families have access to parent support services and health benefits counseling.
- Increase the capacity of LHDs and other local agencies, such as schools, to provide service coordination.
- Work to establish a network of community providers of local service coordination.
- Initiate formal working relationships with LHDs and establish linkages for improving access to local service coordination.

Core services are information, referral, and follow-up including health benefits services for families and providers. The emphasis is on the 6 National Performance Measures related to CYSHCN. Regional Centers are actively fostering collaboration with key partners including: cross-referral discussions with Children's Long-Term Care Redesign pilot site; sharing resources with Early Childhood Collaborating Partners (including ECCS); facilitating the spread of Medical Home to local medical practices through the administration of Medical Home Local Capacity Grants and direct team facilitation; offering families with children registered with the Wisconsin Birth Defects Prevention and Surveillance program referral and follow-up services; and cross-referring with WIC nutritionists. The Collaborators Network continues to expand to include not only the CYSHCN Centers, Great Lakes Inter-Tribal Council, Family Voices of WI,

and Parent-to-Parent but also the WIC-CYSHCN Network and MCHB funded CYSHCN Oral Health Project.

Wisconsin's CYSHCN Program provides parent support opportunities for families through the five Regional CYSHCN Centers, Parent to Parent and Family Voices. The Regional CYSHCN Centers assure all families of CSHCN have access to parent support services. As reported for 2009 in SPHERE, centers referred 222 parents to support groups, provided informal parent matching, referred parents to Parent to Parent and linked with local parent partners including Family Voices to determine and disseminate parent support opportunities.

Parent-to-Parent of Wisconsin receives MCH funding to provide one-to-one matching for families, train support parents, and seek referrals for new parents who want to be matched. Parent-to-Parent of WI has outreached to providers including those providing services to children newly identified by the Congenital Disorders Program. By December 2009 there were 263 trained support parents in the Parent-to-Parent database and 117 matches. P2PWI translated their curriculum into Spanish, trained non-English speaking support parents and is matching hard-to-reach families in Milwaukee. P2PWI maintains a listserv and Facebook page for support parents.

Family Voices of WI receives MCH funding to build a parent network of informed decision makers, through training, information dissemination and analysis of unmet needs. Family Voices works with the CYSHCN Program to disseminate parent support information to parents through a listserv and mailings. Family Voices conducts trainings for parents to enhance their decision making skills and a parent support component is incorporated into these trainings.

Statewide Genetics System

Children's Hospital of Wisconsin receives MCH Block Grant funds to support the WI Genetics System. In 2009, the WI Genetics System held outreach clinics throughout the state, educated primary healthcare providers at an annual Genetics in Primary Care conference, worked toward genetic counselor licensure and was active in the Region 4 seven state genetics consortium. In addition to the 2009 activities which will be continued in 2010, the State Genetics Website will be redesigned to give it a more functional capacity as the center of genetic information and resources in WI. Monies will also be provided to the WI Stillbirth Service Program to update a file system and transfer data because the program recently moved to a different institution.

Autism

WI Medical Home Autism Spectrum Disorder (ASD) Connections Initiative - Funds from the Combating Autism Act Initiative (September 2008-August 2011) support the Wisconsin Medical Home Autism Spectrum Disorder (ASD) Connections Initiative (Connections) as a State Implementation Grant for Improving Services for Children and Youth with Autism Spectrum Disorder and other Developmental Disabilities and is housed within the CYSHCN Program. This project design uses contracts with key partners including the Waisman Center and the Regional Centers for CYSHCN to strengthen the state's infrastructure and support for families with CYSHCN. Through this work a Community of Practice on ASD/DD has been established as an approach to bring together diverse stakeholders from around the state. Parents are central to this work, with two co-chairs who are both parents of children with ASD. Trainings to

primary care providers have increased the number of physicians implementing early developmental and ASD screenings. An electronic repository houses Connections resources, links to key websites and a Medical Home Webcast Series. Regional resource mapping is being conducted in the five DPH regions of the state with the outcomes of strengthening collaborations and identifying new resources.

Birth Defects Surveillance and Prevention Program

The Wisconsin Birth Defect Prevention and Surveillance Program under statute s.253.12 is required to maintain birth defects registry of diagnosed birth defects of any Wisconsin child age birth up to 2 years of age; requires reporting by pediatric specialty clinics and physicians; protects confidentiality; establishes an advisory council; provides for primary prevention strategies to help decrease occurrence; provides education about prevention of birth defects; develops a system for referrals to early intervention; and has limited service provisions. Funding is \$95,000 annually from a surcharge on birth certificates. Each Children and Youth with Special Health Care Needs regional center has designated staff to access birth defect reports from the WBDR. The information is used to assure children with birth defects and their families are contacted and referred to appropriate services. See Birth Defects Registry above or CYSHCN Program - Birth Defect Prevention and Surveillance System Website at <http://dhs.wisconsin.gov/health/children/birthdefects/index.htm>.

The Wisconsin Birth Defect Prevention and Surveillance program currently funds the following prevention initiatives:

- Birth Defects Nutrition Consultant Network to build nutrition services capacity for identification, interventions, and referral of infants and children with birth defects seen in WIC at 17 sites.
- Wisconsin Stillbirth Service Program at Marshfield Clinic Research Foundation investigates the causes of stillbirth, provides diagnostic information and educational materials to medical personnel and families.
- Women's Health Now and Beyond Pregnancy Project improves preconception health for high risk, low-income women receiving Medicaid Prenatal Care Coordination services; Project sites promote healthy spacing of pregnancies and provide vitamins containing folic acid and health and nutrition education to women before potential subsequent pregnancies.
- Folic acid survey module in the Behavioral Risk Factor Surveillance System (BRFSS) survey (biennial).
- A folic acid training module for family planning providers to assure women in family planning clinics know and understand the importance of taking vitamins with 400 mcg of folic acid every day for at least 3 months prior to becoming pregnant.

CAPACITY TO PROVIDE CULTURALLY COMPETENT CARE

WI has become increasingly culturally diverse, with an estimated 14% of the population comprising African American, Hispanic/Latino, American Indian, and Asian populations. Numerous studies and reports have documented, including the most recent *Wisconsin Minority Health Report, 2001-2005*, a disproportionate burden of poor health that persists among racial and ethnic minority populations in Wisconsin. The report goes on to say that in addition to birth

outcomes, “these health inequalities exist for a broad range of conditions, including chronic and communicable diseases...some of these result from differences in the availability of health and preventive services, while others reflect historical and continuing differences in social and economic conditions.” The University of Wisconsin Population Health Institute published *The Health of Wisconsin, Report Card for July 2007* in which Wisconsin received a ‘D’ for its overall health disparity grade.

Wisconsin’s Title V program has a long-standing commitment to promoting culturally competent and linguistically appropriate services, including for its diverse racial and ethnic populations, individuals with disabilities, and families of CYSHCN. The MCH Program promotes the elimination of health disparities as one of its highest priorities, through its partnerships with Wisconsin’s Minority Health Program, *Healthiest Wisconsin 2020*, and other state and local efforts. Providing services with cultural humility, cultural competency, and linguistic appropriateness have the “potential to improve access to care, quality of care, and, ultimately, health outcomes” <http://dhs.wisconsin.gov/health/MinorityHealth/index.htm>.

Resources are allocated to meet the unique needs of Wisconsin’s African American communities. For example, the WI Partnership Program and the University of Wisconsin School of Medicine and Public Health have launched a \$10 million initiative—The Lifecourse Initiative for Healthy Families (LIHF)--to investigate and address the high incidence of African-American infant mortality in the state. WI’s Title V Program was instrumental in identifying those areas of the state with the highest numbers and rates of African American infant mortality, namely, the 4 communities of Milwaukee, Racine, Kenosha, and Beloit, the communities of focus for this initiative. One MCH Lifecourse Collaborative will be funded in each community and must include a broad range of stakeholders and members, including members of the community to be served. \$200,000 is available for each of the communities of Racine, Kenosha, and Beloit and \$250,000 for Milwaukee, for this first planning phase. Each collaborative will spend the next 12-18 months developing a multi-year implementation plan to reduce poor birth outcomes and meet the unique needs of the African American families in their communities. Title V managers and staff will continue to provide ongoing guidance for this initiative.

Community collaborations seek to employ community-driven, culturally competent services. One example of a community collaboration is the ABCs for Healthy Families project and recently launched Journey of a Lifetime campaign, funded through the HRSA First Time Motherhood/New Parents Initiative, to improve birth outcomes for African American infants in southeastern WI. Through this grant, we have been able to integrate the life-course perspective into current MCH programs; conduct an innovative social marketing campaign using texting and social networking sites to link women to preconception/interconception, prenatal, family support, and social services in Milwaukee and Racine; and to increase father involvement and support couples transitioning into their roles as new parents.

Focus groups have been conducted and support groups are lead by community facilitators. The project regularly consults with Milwaukee and Racine community advisory boards, and uses community members to conduct surveys, write editorials, and display our materials at conferences. All pictures within our materials are people within our communities, and the name of the campaign was suggested by a community member. We have been fortunate to partner

with a consultant who is highly committed to involving community members to make this work their own. This project has enabled us to attain a high level of performance in both the family participation and cultural competence MCHB performance measures.

COORDINATION OF STATE MCH AND CYSHCN PROGRAMS

The State MCH program and the CYSHCN program are both located in the Maternal and Child Health Program Unit. Staff collaborate on many activities and policy issues related to the MCH and CYSHCN population. The Wisconsin Title V Program contract with local partners and community-based organizations in the delivery of maternal and child health services, and those for children and youth with special health care needs.

COORDINATION TO ELIMINATE RACIAL AND ETHNIC DISPARITIES IN BIRTH OUTCOMES

Coordination to eliminate racial and ethnic disparities in birth outcomes has been identified as one of the highest priorities for WI. A number of activities have been identified which demonstrate the strong commitment of the MCH Program to provide leadership to reduce racial and ethnic disparities in poor birth outcomes by 2020, including infant mortality.

Awareness and Promotion

- **2003—Statewide Summit:** WI prioritizes racial and ethnic disparities in birth outcomes; Title V Program and other state and local MCH advocates sponsor statewide summit with national expert Dr. Michael Lu of UCLA who presents life-course perspective on reducing disparities in birth outcomes; Healthy Babies regional action teams supported by Title V funds, and subsequent summits have been held, co-sponsored by March of Dimes and the Assoc. of Women's Health, Obstetric and Neonatal Nurses
- **2004—Milwaukee Forum:** DHS/DPH host Milwaukee forum on Racial and Ethnic Disparities in Birth Outcomes with Mayor Barrett, Secretary Nelson, and Medicaid Program and expands focus of the issue to include Racine, Kenosha, and Beloit
- **2006—HRSA Community Strategic Partnership Review:** HRSA brings together key partners together to select infant mortality as the key population-based health indicator for collaborative state and local efforts in Milwaukee
- **2006 and ongoing—Statewide Advisory Committee on Eliminating Racial and Ethnic Disparities in Birth Outcomes:** established to advise the Department of Health Services in the implementation of the initiative's *Framework for Action* and held town hall meetings to raise awareness, monitor progress, and promote best practices; established workgroups on communication and outreach, data, evidence-based practices, and policy and funding; committee meets twice year; see web site for list of participating of organizations (<http://dhs.wisconsin.gov/healthybirths/>)
- **2007—UW Partnership Funds:** State Health Officer and Chief Medical Officer deliver presentation in April to the WI Partnership Fund of the UW School of Medicine and Public Health; Dean Robert Golden reports to the UW Regents in May that the school is willing to make a multi-year resource commitment to address the issue

- **2008-2009—Focus Groups and Social Marketing:** begin community-driven social marketing efforts with state Minority Health Program funds and federal funds; national experts brought on to technical advisory group
- **2008 and ongoing—DHS Performance Measure:** eliminating racial and ethnic disparities in birth outcomes has been selected as a department-wide performance measure and a DPH priority initiative that is tracked and monitored
- **2009—A Response to the Crisis of Infant Mortality:** Recommendations of the Statewide Advisory Committee on Eliminating Racial and Ethnic Disparities in Birth Outcomes released in July 2009 (<http://dhs.wisconsin.gov/healthybirths/advisory.htm>)
- **2009 and ongoing—Journey of a Lifetime Campaign:** DHS Secretary Timberlake launches campaign in Milwaukee and Racine; ABCs for Healthy Families and campaign are presented at MCHB Partnership meeting in Washington DC, Delaware conference, and National WIC Association conference
- **2010 and ongoing—text4baby:** DPH, Title V, and ABCs for Healthy Families join National Healthy Mothers Health Babies Coalition to promote text4 baby messages for pregnant and new moms
- **2010—Legislative Study on Infant Mortality:** a Legislative Council Study on Infant Mortality has been proposed, as the result of a legislative briefing on eliminating racial and ethnic disparities in birth outcomes, organized by Rep. Cory Mason of Racine at Wingspread in January 2010

State and Federal Funds

- **2005—Home Visiting in Milwaukee:** DPH awards \$4.5 million, 5-year TANF home visiting program to the City of Milwaukee Health Department; by 2007, program demonstrating positive birth outcomes in 6-central city zip code area; program expanded to additional zip codes
- **2007 and ongoing—Home visiting in Racine:** 2007 Wisconsin Act 20 authorizes \$500,000 of GPR each biennium to reduce fetal and infant mortality and morbidity in Racine—ongoing TA provided
- **2008-2010—ABCs for Healthy Families:** DHS receives \$498,000 from HRSA/MCHB for First Time Motherhood-First New Parents Initiative, 2-year federal social marketing grant to reduce African American infant mortality in Milwaukee and Racine
- **2009 and ongoing—Wisconsin Partnership Funds:** UW School of Medicine and Public Health announces \$10 million, 5-year Life-course Initiative For Healthy Families (LIHF) to improve birth outcomes and reduce African American infant health disparities in Milwaukee, Racine, Kenosha, and Beloit

Statewide Collaborative Efforts

- **2003 and ongoing—Healthy Start:** Title V staff participate on committees of Milwaukee Healthy Beginnings and Honoring our Children Healthy Start projects
- **2008 and ongoing—Medicaid:** Title V staff collaborate with Medicaid to redesign Prenatal Care Coordination services and certification and provide recommendations for establishing a registry for high risk pregnant women
- **2009 and ongoing—Wisconsin Medical Home Pilot for Birth Outcomes:** collaborate with Medicaid Program to establish a Medical Home Pilot and pay-for-performance benchmarks to reduce poor birth outcomes among high-risk pregnant women; implement evidence-based

practices recommendations and provide information on mental health and social services referrals for the new Medicaid Managed Care Organizations in southeastern Wisconsin

- **2009 and ongoing—FIMR:** Title V staff are working with the local health departments in Milwaukee, Racine and Madison/Dane County on continuing local or establishing regional FIMRs
- **2009 and ongoing—UW LIHF:** Title V Chief Medical Officer and Southeastern Regional Office Deputy Director are steering committee members of UW LIHF and MCH staff, including director of disparities in birth outcomes, are available to provide ongoing technical assistance
- **2009 and ongoing—Home Visiting:** jointly plan with Department of Children and Families for state and federal home visiting services, including Empowering Families of Milwaukee at the City of Milwaukee Health Department and Family Foundations home visiting services throughout the state
- **2009 and ongoing—Centering Pregnancy®:** DHS provided start-up funds for Centering Pregnancy® prenatal care at Milwaukee Health Services and will provide TA to other providers who want to promote it
- **2009-2010—Kellogg Action Learning Collaborative:** support the Partnership to Eliminate Racial and Ethnic Disparities in Infant Mortality, action learning collaborative on racism and fatherhood in Milwaukee; ABCs for Healthy Families will collaborate on messages for fathers
- **2009 and ongoing—PRAMS:** use the Pregnancy Risk Assessment Monitoring System data to help inform MCH program priorities
- **2006 and ongoing—Wisconsin Minority Health Program:** collaborate together and through Healthiest Wisconsin 2020 to improve birth outcomes for African American women
- **2008 and ongoing—WIC:** support WIC efforts to increase breast feeding and early enrollment for African American women participating in WIC and promote WIC services through Journey of a Lifetime campaign; presented the campaign at the National WIC conference in May 2010 in Milwaukee

See also the extensive catalog of “Initiatives Addressing Disparities in Birth Outcomes in Wisconsin”, compiled by the Center for Urban Population Health, April 2010. (www.cuph.org)

COORDINATION WITH MEDICAID

DHS recently implemented a number of important health care reform initiatives designed to increase access to health care for more low income Wisconsin residents. One of the most significant changes in improving access to health care in Wisconsin has been the implementation of the BadgerCare Plus program <http://dhs.wisconsin.gov/badgercareplus/> to include a wider group of eligible participants.

In February 2008, the BadgerCare Plus program expanded coverage to all uninsured children and increased the program income limits for pregnant women, parents, and self-employed residents. Since then there have been an enrollment increase in Wisconsin’s Medicaid and Children’s Health Insurance Program (CHIP) programs of 137,522 individuals.

More recently, the BadgerCare Plus Core Plan was implemented for low-income, childless adults without health insurance. As of 10-9-09, over 32,000 childless adults have been enrolled in the Core Plan. Because the number of applications submitted exceeds the available funding, the Department suspended enrollment into the program on October 9th and established a waitlist. In the 2010 Legislature, a proposal to implement a self-funded Basic Plan for those on the sizable Core Plan waiting list was enacted into law. The Legislature approved the basic plan which Badgercare Plus officials hope will serve as a bridge to the more comprehensive coverage options offered by the enactment of national health systems reform.

In addition, DHS is in the process of expanding the Family Care entitlement program statewide and recently implemented the Long Term Care Partnership Program to allow moderate income consumers access to affordable long-term care insurance regardless of assets. Finally, the Department is planning to eliminate the five year bar for immigrant pregnant women and children who are legally present in the U.S. to qualify for Medicaid and/or BadgerCare Plus and eliminate the “asset limit” for blind and disabled children who are in need of Medicaid long-term care.

State legislation was recently enacted to increase the maximum age for dependent coverage. Beginning January 1, 2010, adult children will be able to stay on their parents’ health insurance plan until they reach age 27, regardless of their school status.

While the expansion of BadgerCare Plus is a significant improvement for low income residents of WI, it does not address the underinsured or the adult population with income above program limits. It also does not address the rising cost of insurance premiums or the decreasing rate of employer sponsored insurance.

ACCESS is a set of online tools (<https://access.wisconsin.gov/access>) for public assistance programs, including FoodShare, Healthcare, Family Planning Waiver, and Child Care, that allows customers and prospective customers to assess eligibility for programs, check case benefits and report case changes and online program application. For many, this is an appealing alternative to office visits and phone calls and for some people, ACCESS is the first website they've ever used.

Although they may not own a personal computer, a growing number of customers do have access to computers -- through friends or family, at work, at school or at the library. Others use online tools with the help of staff/volunteers at food pantries, clinics, HeadStart programs, Community Action Agencies, WIC clinics, Job Centers, etc.

The goals of the ACCESS project are to:

- Increase participation in FoodShare, Medicaid, and other programs
- Improve customer service and satisfaction
- Improve FoodShare payment accuracy
- Ease workload for local agencies

The major components of ACCESS are:

- Am I Eligible? -- A 15-minute self-assessment tool for:
 - * FoodShare
 - * All subprograms of Medicaid
 - * SeniorCare and Medicare Part D
 - * Women, Infants and Children (WIC)
 - * The Emergency Food Assistance Program
 - * School meals and summer food assistance
 - * Tax credits (EITC, Homestead and Child Credit)
 - * Home Energy Assistance
- Check My Benefits -- An up-to-date information segment (begun 09/30/05) that includes:
 - * Displays information about Medicaid, FoodShare, SeniorCare, Child Care, SSI Caretaker Supplement benefits
 - * Information displayed is based on why customers call their workers
 - * Provides data directly from CARES (automated eligibility system)
 - * Data is "translated" to make it more understandable
 - * Data is furnished real time at account set-up, and is then updated nightly
- Apply For Benefits -- An online application for FoodShare, Medicaid, the Family Planning Waiver program, and Child Care

Prenatal Care Coordination (PNCC)

The PNCC program assists pregnant women with accessing medical, social, educational and other services during pregnancy and through 60 days following delivery. The program consists of outreach, assessment, care plan development, ongoing care coordination and health education. There are PNCC providers in all 72 counties, through LHDs; hospitals; health plans and other private non-profit agencies. In 2009 the Medicaid program worked collaboratively with MCH on revisions of the guidelines for PNCC to support increased outreach; increased intensity of services; and improved communication between PNCC provider and medical providers. The program is currently reaching approximately 17% of eligible women. Five regional PNCC Provider Groups are facilitated by MCH staff for technical assistance and education. The evaluation of PNCC outcomes using SPHERE data is encouraged. The Women's Health Now and Beyond Pregnancy project was implemented to enhance the PNCC postpartum services to include a focus on interconception care. The Medicaid program has included provision of PNCC in the health plan pay for performance initiative with education and technical assistance available from MCH staff.

Health Check

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program in WI Medicaid is known as the HealthCheck Program. HealthCheck promotes the early detection and treatment of health conditions associated with chronic illness or disabilities in children. WI Medicaid data has demonstrated since 1992 that children in HMOs are more likely to receive a HealthCheck exam than children in the Medicaid fee-for-service health reimbursement systems. For fiscal year 2009, the annual HealthCheck participation rate was at 89% with 422,965 screens completed out of 471,447 expected for all children ages birth to 20 years of age eligible for the BadgerCare Plus Program.

Medical Initiatives

WI's Medicaid Program recently announced its intention to contract with 4 managed care agencies in Southeastern WI for services through 2013. In addition to requiring these HMOs to reach annual performance benchmarks for diabetes testing, blood lead testing, childhood immunization, asthma management, tobacco cessation, emergency department utilization management, and dental utilization, "the organizations will be required to provide coordinated care for pregnant women known to be at high risk for poor birth outcomes". The Title V program was instrumental in contributing to the specifications for a medical home pilot for high-risk pregnant women, pay-for-performance guidelines, and the formation of a high-risk registry, to facilitate early care and intensive services to women with a history of, or at high-risk for, poor birth outcomes. Title V managers and staff will participate with Medicaid on an internal workgroup to oversee the implementation and monitoring of these efforts.

<http://dhs.wisconsin.gov/badgercareplus/partners/pdf/p-00162.pdf>

COORDINATION WITH OTHER HUMAN SERVICES PROGRAMS

Mental Health and AODA

Governor Doyle's Kids First Agenda of 2005 directed DHS to provide an annual progress report on the implementation of WI's Infant and Early Childhood Mental Health Plan. As a result, the DHS Infant Mental Health Leadership Team (DHS IMHLT) formed to integrate infant and early childhood mental health best practices and principles into all programs and services. Areas of collaboration include: Infant Mental Health Endorsement Process; Development and Distribution of Information on Post Partum Depression; WI Infant, Early Childhood and Family Mental Health Certificate program Summer 2010; Project LAUNCH (Linking Actions for Unmet Needs in Children's Health); Standardized Objectives for Screening; and Increasing Screening Practices Within Community Medical Homes (attachment DHS IMHLT Progress Report February 2010).

The Integration of Physical Health, Mental Health, Substance use and Addiction began through efforts between DHS, DPH and the Division of Mental Health and Substance Abuse Services. A Joint Statement of Integration and Action Guide were developed to bring public health, mental health, substance use, and addiction disorders together in a conceptual integrated framework to support optimal health for all achieved by promoting the integration of Physical Health, Mental Health, Substance Use and Addiction across the lifespan. The DHS Integration Initiative supports the following goals: 1) Decreasing DHS respective program barriers and silos, 2) Reducing duplication of resources and efforts while identifying common areas, and 3) Increasing integration of physical health, mental health, and substance use and addiction services into all systems/sectors/organizations.

<http://dhs.wisconsin.gov/mentalhealth/jointstatement/index.htm>

Social Services/Child Welfare

The social services and child welfare responsibilities lies within the State Department of Children and Families (DCF), a new state agency established in statute on 07/01/09. The mission of the DCF is to promote the economic and social well-being of WI's children and families and with passage of the budget combines the TANF program, W-2, and the state child welfare systems. DCF is committed to protecting children, strengthening families, and building communities. The child welfare service system in WI is primarily a county-operated, state-supervised system. The state provides program funding and oversees policy direction while

county human or social service departments provide child welfare services. Counties also contribute significant local tax levy to fund the child welfare program. Over the past biennium, county levy contributions have increased or general reductions have been made at the local level due to reductions in the availability of federal and therefore, state funding to county allocations.

Wisconsin has 11 recognized Indian Tribes that are involved in child welfare services in areas of the state, primarily through memoranda of understanding with county agencies. Tribes receive funding from DCF for some child welfare services as well as funds directly from the federal government. Two facets of the child welfare system are state operated, including the special needs adoption program for children with special needs and child welfare services in Milwaukee County.

The MCH program maintains working relationships with DCF and county social services to prevent child maltreatment and promote the health and well being of children in out-of-home placement. With the transfer of the funds for the Child Abuse and Neglect home visiting program to DCF in 2008, a transition plan was implemented for MCH to continue to support DCF in management of the home visiting programs to focus on sustaining program integrity and quality and to avoid disruption of services. In February 2010, DCF hired a home visiting coordinator to manage the home visiting programs and implement changes in allocating funds that addresses the risks for poor birth outcomes.

SSA, Voc Rehab, Disability Determination and Transitions

In accordance with federal Social Security Administration regulations, the WI Division of Health Care Access and Accountability, Disability Determination Bureau (DDB), determines if WI residents applying for disability benefits meet the criteria for Social Security Disability, Supplemental Security Income, Medicaid, Katie Beckett Program, and Medicaid Purchase Plan. Monthly the DDB sends names of all new child applicants regardless of eligibility to the CYSHCN program. The CYSHCN program sends information to families about the state's Regional Centers for CYSHCN and other resources that these families may find useful. Outreach by the Regional Centers includes contact with local SSA and Division of Vocational Rehabilitation (DVR) offices. DVR, SSA and the Regional Centers are youth-to-adult transition stakeholder participants with the State CYSHCN program in the WI Community of Practice (COP) on Transitions. This COP is a network of individuals and organizations that promote the successful transition for and with youth with disabilities and/or special health care needs to all aspects of adult life.

Birth to 3

The Children's Services Section located in the Division of Long Term Care (DLTC) is responsible for Birth to 3 (B-3), the Part C early intervention program, Family Support Program, Katie Beckett Program, Lifespan Respite and three Children's Waivers, which include coverage of children with autism. The CYSHCN Program and its Collaborators Network work closely with these programs to coordinate outreach and services to families and providers. The CYSHCN Program and B-3 pool resources to fund First Step, a 24/7 toll free hotline (includes TTY and language line) and website for parents and providers of CYSHCN. CYSHCN staff is on the State's B-3 Interagency Coordinating Council (ICC) and its Child Find Subcommittee along with the Children's Long-Term Support Council. The CYSHCN Program's Early

Identification Initiative connects local B-3 programs to primary care providers to promote early referral. Per statute, a B-3 staff is appointed by the DHS Secretary to serve on the Birth Defect Prevention and Surveillance Council. Beginning fall 2009 WI Sound Beginnings refers children who are identified as deaf and hard of hearing directly to B-3 via WE-TRAC, the EHDI data collection and tracking system. Beginning in April 2010 the SE Regional Center is part of a pilot program called Compass Wisconsin: Threshold. Threshold provides intake, application and eligibility determination for the children's waivers, Katie Beckett, Family Support and Community Options Program. The Regional Center is available to families looking for additional help or services.

COORDINATION WITH OTHER FEDERAL GRANT PROGRAMS

WIC

WIC Nourishing Special Needs is a collaborative project with WIC, CYSHCN and Birth Defects Prevention programs. The Birth Defects Nutrition Consultant Network (BDNCN) provides nutrition-related education and support to WIC clients and providers at 17 LHDs across the state. A 2008 evaluation of the BDNCN documented the following: 1) WIC registered dietitians were frequently the first to identify the need for assessment, diagnosis and referral for suspected health care problems related to birth defects resulting in a three-fold increase in referral of children with birth defects to the Wisconsin Regional CYSHCN centers, 2) improved communication and collaboration with other local agencies, medical providers/Tertiary Centers, and 3) improved integration of nutritional care with early intervention programs including Birth-3 and Head Start. The BDNCN has presented these results at the NBDPN conference, National WIC Association Conferences, the Wisconsin Public Health Association conference, and the Wisconsin Dietetic Association conference. This program currently serves about 15% of WIC clients.

Title XX

Family planning services is 1 of the mandated services under the Title XX Social Services Block Grant. Agencies receiving Title XX funds are to offer family planning services to clients, and make available a list of clinic supported by the WI MCH Family Planning Program. Community-based health organizations under contract with the MCH FP/RSH/EI Program have established and maintain close linkages with social service agencies: for outreach and as a community resource for continuity of care. Some county social service agencies directly contract with community-based family planning/reproductive health programs to support services for low-income uninsured patients who are not eligible for Wisconsin's Medicaid Family Planning Waiver (FPW). Many clients are eligible for FPW enrollment, and can obtain assistance through local Economic Support offices often co-located with social service agencies. Community based family planning/reproductive sexual health programs are a source of confidential care for many adolescents requiring services to reduce the risk of STDs and unintended pregnancy. Sexual abuse screening is a priority issue addressed as part of adolescent health care. Community based organizations work closely with local social services agencies involving sexual abuse issues.

Healthy Start

The Black Health Coalition's (BCH) Milwaukee Healthy Beginnings Project (MHBP) is 1 of 2 Federal Healthy Start projects in WI. MHBP provides prenatal services to African American women in Milwaukee residing in 7 high-risk zip codes and incarcerated pregnant women in

Milwaukee. The program collaborates with the community on the Milwaukee Fatherhood Initiative; the City of Milwaukee Health Department on safe infant sleep ; with DPH Disparities in Birth Outcomes by serving on the Statewide Advisory Committee and the Action Learning Collaborative on Fatherhood. The MHBP brings other providers serving high-risk pregnant women in the Milwaukee area together to collaborate on areas of overlap and identify solutions to fill gaps in services. In 2011 the MHBP plans to enhance preconception/interconception services, expand the service area for prenatal services and improve breastfeeding support for African American women in Milwaukee.

The Healthy Start project with Great Lakes Inter-Tribal Council, Honoring Our Children (HOC), provides maternal/child health nurses, on-site coordinators, and outreach workers at tribal sites for outreach, case management, health education, depression screening and referral, and interconception care for pregnant and postpartum women, infants, children under the age of two, and their families. Funding from the Title V MCH program supports expanded HOC services. Project outcomes are documented using the SPHERE data system developed by the WI Title V program. SPHERE data is monitored by the tribal sites and used to evaluate and improve the project. Title V representatives support the HOC Project through: 1) technical assistance and education related to perinatal health, reproductive health and children with special health care needs, 2) participation on the HOC Project Advisory Committee, and 3) participation on the Interconception Care Learning Community team. Representatives from both Healthy Start Projects contributed to the development of the Title V needs assessment and the State Health Plan, *Healthiest Wisconsin 2020*.

COORDINATION WITH THE STATE DEPARTMENT OF PUBLIC INSTRUCTION (DPI)

DPI and DHS collaborative efforts include promotion of the Governor's School Health Award to improve the nutrition and physical activity of school children as outlined in the *Wisconsin Nutrition and Physical Activity State Plan* for schools. The criteria can be used as a self-assessment tool for schools to begin the process of creating a healthy school environment www.schoolhealthaward.wi.gov. DPI involves DHS in the development of the physical activity and nutrition questions on the WI Youth Risk Behavior Survey (YRBS) and analysis and interpretation of the data. Data is included in the *Obesity, Nutrition and Physical Activity in WI* Report <http://dhs.wisconsin.gov/health/physicalactivity/Dataindex.htm>.

The WI Partnership for Activity and Nutrition (WI PAN) requested a legislative council study on childhood obesity. Both DPI and DHS provided testimony. The committee recommendations include: 1) inclusion of a wellness component in a child care quality rating system, 2) school nutrition standards for foods and beverages available on the school campus, 3) annual physical fitness assessment (FitnessGram) for grades 3-12, and 4) built environment. These served as a framework for WI to successfully compete for a grant from the American Reinvestment and Recovery Act funds, Component II, to develop strategies that increase physical activities in schools <http://www.legis.state.wi.us/lc/committees/study/2008/LPOP/index.htm>.

The MCH program provides ECCS Grant dollars to DPI to support the work of 6 WI Early Childhood Regional Community Coaches in all five DHS regions and in Milwaukee. The Coaches assist local communities in planning four-year-old kindergarten collaborations and

provide training and technical assistance on implementation of standards for early learning and to promote development including social-emotional wellness.

A representative of DPI serves on the Sexual Violence Prevention Planning Committee and assisted in developing the goal that recognizes community leaders play both a formal and informal role in preventing sexual violence. A strategy to assist in progress toward goal achievement is that teachers and staff at pre-K through high school have access to information and training on age-appropriate strategies to address violence/sexual violence on WI campuses. The strategy will guide the committee's work in the upcoming 5 years.

The Guide By Your Side (GBYS) program of WI Sound Beginnings, the state's Early Hearing Detection and Intervention (EHDI) program, is supported by DPI. The program provides support and knowledge to families from trained parents of children who are deaf or hard of hearing. The program helps make connections with at risk and newly identified families and provides unbiased information related to methods of communication. The EHDI program, promotes the use of the GBYS program to birth units, clinics, and audiologists statewide.

DHS and DPI continue to collaborate on statewide and local abstinence, teen pregnancy, STI and HIV/AIDS prevention efforts. Partnership continues to focus on implementation of the Milwaukee Adolescent Pregnancy Prevention Partnership through a 4 year funded Milwaukee Collaborative that was developed and now monitors a Milwaukee driven, community-based partnership to reduce teen pregnancy and sexually transmitted infections.

DHS and DPI have several staff that actively lead and participate in the WI Suicide Prevention Initiative (SPI), which includes maintaining the Guidelines for Suicide Risk Assessment. A Suicide Prevention Summit was held in March 2009 at which priorities were identified to develop a statewide infrastructure to support local and community-based suicide prevention coalitions. DHS and DPI have drafted model MOU language that can be used between community agencies and school districts. DHS and DPI collaborated on the development and training of toolkits for suicide prevention and mental health awareness.

The DPI Bullying Prevention Curriculum has sold over 5,000 copies nationwide. The support of this project initially came from DHS. DPI and DHS participated in a Bullying Policy meeting held 07/17/09, which made suggested revisions to guidelines for Bullying Prevention for SB 154 requirements.

DPI and DHS participate in the WI School Crisis Preparedness Committee. This committee sponsors the annual fall School Crisis Preparedness Conference and is planning the annual School Safety Week.

COORDINATION WITH FEDERALLY QUALIFIED HEALTH CENTERS

The MCH program has worked with Milwaukee Health Services, Inc. to implement group prenatal care, Centering Pregnancy and group pediatric care, Centering Parenting. The initial outcomes have shown a 96% rate of term births; 96% child spacing of 12 months; 50%

breastfeeding initiation. The MCH program assisted with providing a Father Circle simultaneously with the Centering Pregnancy.

The CYSHCN Program through its contracts with the Regional Centers has worked with select community health centers and its primary care providers to establish resource and outreach materials for Latino families and promote Medical Home implementation including developmental screening. The CYSHCN Program has worked with the Primary Care Association on access to health and dental care for individuals with disabilities as part of a series of Disabilities and Disparities regional meetings led by the Division of Long Term Care.

There are currently 14 of the 17 FQHC's that are directly providing preventive and restorative dental care at 26 delivery sites throughout the state. This is an increase from 2008, when WI FQHC's had eighteen delivery sites and provided 151,423 dental visits to 59,040 unduplicated patients. Several of these agencies are specially equipped to meet the unique needs of CYSHCN. In addition 43 dental professionals in 4 FQHC's received didactic and clinical training to increase and enhance their knowledge and skill base as it relates to treating CYSHCN. This training is being replicated across the state in FQHC's as a result of a HRSA grant award.

COORDINATION WITH UNIVERSITIES

The MCH/CYSHCN programs coordinate with the UW School of Medicine and Public Health, Nursing, Population Health, and Waisman Center on a variety of program activities such as: UCEDD/LEND on early identification and Autism Spectrum Disorders Connections Initiative, EHDI learning collaborative, and Pediatric Pulmonary Center on youth with special needs transitions. The oral health program partners with the Marquette Dental School and 2 technical colleges to improve dental access and provide provider training. Title V provides student mentoring for pediatric and family medicine residents, fellows, MPH students and undergraduates. The UW Extension system is also a partner in training and education. Relationships exist with the State Laboratory of Hygiene, Medical College of WI, the Schools of Nursing at the UW-Milwaukee and Marquette, the UWM School of Communication, and technical schools on topics such as oral health, perinatal care, family planning, home visiting, medical home, birth defects surveillance and prevention, and early hearing detection and intervention.

UW-Madison School of Nursing has received funding from HRSA since 10/2006 for Linking Education and Practice (LEAP) for Excellence in Public Health Nursing Project; implemented in partnership with other Schools of Nursing in the state and DPH. The purpose of the LEAP Project is to improve competency for public health nursing practice in a changing public health system by educating public health nurses, student nurses, and nursing faculty in the knowledge and skills required for providing population-based, culturally competent public health nursing services. A focus during 2010 is on competencies to provide services to MCH populations.

Developed in part with ECCS funds and through leadership of the MCH program, the UW Infant, Early Childhood and Family Mental Health Certificate Program-Foundations Certificate was developed as the pathway within a one year program intended for professionals from multiple disciplines who seek professional development in providing infant and family

consultation and relationship-based services to young children and their families within the context of reflective practices. The first one-year training will begin in June 2010. Additional information about the curriculum can be found at the following website:

<http://www.dcs.wisc.edu/pda/mental-health/infant.htm>.

5. Selection of State Priorities

The priorities of the Wisconsin MCH Program for 2011-2015 differ slightly from previously identified priorities because of the MCH Program’s increased emphasis on life-long prevention, increased understanding of the social-ecological model of health improvement and recent research on the life course theory. The eight priorities are not specific health risks or protective factors, but identify key areas to support and implement interventions that will target a myriad of factors as early as possible while acknowledging the role of families, the health system and communities on the risk and protective factors impacting an individual’s health.

The priorities of the Wisconsin MCH Program for 2011-2015 are:

- a) Reduce **health disparities** for women, infants, and children, including those with special health care needs
- b) Increase the number of women, children, and families who receive preventive and treatment health services within a **medical home**
- c) Increase the number of children and youth with special health care needs and their families who access **necessary services and supports**
- d) Increase the number of women, men, and families who have knowledge of and skills to promote **optimal infant and child health, development, and growth**
- e) Increase the number of women, children, and families who have **optimal mental health and healthy relationships**
- f) Increase the number of women, men, and families who have knowledge of and skills to promote **optimal reproductive health and pregnancy planning**
- g) Increase the number of women, children, and families who receive **preventive screenings, early identification, and intervention**
- h) Increase the number of women, children, and families who live in a **safe and healthy community**

Current Priorities (2011-2015)	Previous Priorities (2005-2010)
Increase the number of women, children and families who receive preventive and treatment health services within a medical home	Assure a Medical Home For All Children
Increase the number of women, children and families who live in a safe and healthy community	Decrease Intentional and Unintentional Childhood Injuries
Increase the number of women, children and families who have optimal mental health and healthy relationships	Assure Mental Health Services For All Population Groups

Current Priorities (2011-2015)	Previous Priorities (2005-2010)
Increase the number of women, children and families who receive preventive screenings, early identification and intervention	Assure Health Insurance and Access to Health Care for all Assure Dental Health for All Children
Increase the number of women, men and families who have knowledge of and skills to promote optimal infant and child health, development and growth	
Increase the number of women, men and families who have knowledge of and skills to promote optimal reproductive health and pregnancy planning	Improve Access to and Utilization of Contraceptive Services
Reduce health disparities for at-risk women, children and families	Improve Disparities in Birth Outcomes among Minority Populations
Increase the number of children and youth with special health care needs and their families who access necessary services and supports	
	Promote Healthy Lifestyles to Achieve Healthy Weight - Overweight and At Risk for Overweight
	Decrease Smoking and Tobacco Use Among Women and Children

The Maternal and Child Health Program proposes to address the eight priority areas through a system building approach. By using Bright Futures as a guide to develop a coordinated and integrated system of health promotion for families most at risk for poor health outcomes in communities, the health of all women and children in Wisconsin will be improved over their entire life course.

This proposal is based on the work of Neal Halfon, Michael Lu, and others who have made the case that the system of health services and supports needs to be transformed to make behavior that promote health and development of children more likely to occur. A coordinated and integrated service delivery system will minimize developmental risks and optimize health development trajectories by: 1) linking health service provisions and 2) integrating the relationships among all the organizations serving individuals at different stages in their lives. This would replicate at the institutional level the continuity once provided by single providers in small stable communities, providers that might have been familiar with individuals over several decades and across several generations.

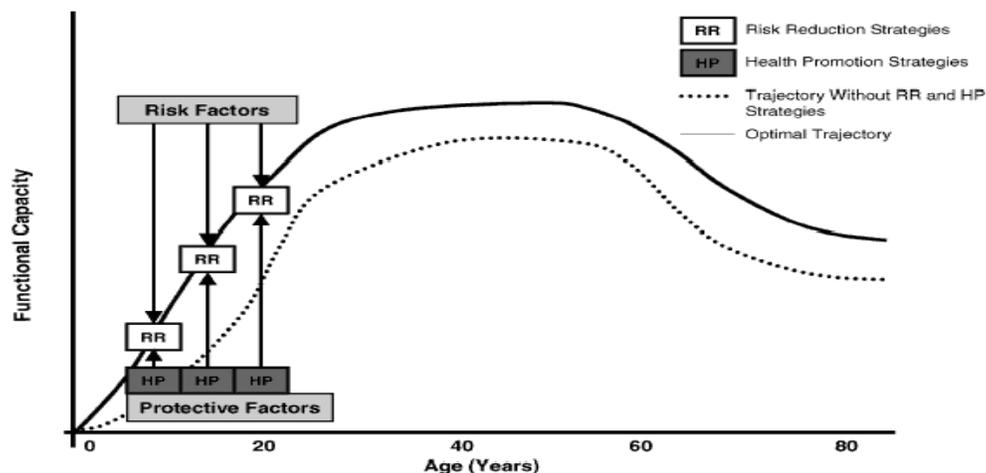


FIG. 4. How risk reduction and health promotion strategies influence health development. This figure illustrates how risk reduction strategies can mitigate the influence of risk factors on the developmental trajectory, and how health promotion strategies can simultaneously support and optimize the developmental trajectory. In the absence of effective risk reduction and health promotion, the developmental trajectory will be suboptimal (dotted curve). *Source:* Halfon, Inkelas, and Hochstein 2000, 455.

The MCH Program will provide funding for local communities to bring together health and community partners to examine how current local efforts can be improved to impact the priority areas identified. Through a learning community model, community leaders will receive training, technical assistance, and consultation and connect to others engaged in the same work to identify best practices, standards and evaluate progress being made.

The model may best be described through a proposed example. A community applies to receive funding to improve the delivery of and coordination among early childhood health professionals to increase the number of children who receive preventive screening. The specific goal is to improve how children in their jurisdiction are identified with developmental delays and provided early intervention services and support. The funding provides them with a leader to facilitate and coordinate the following activities:

- 1) Identify and engage the community partners who have a role in assuring the health and development of children in their community.
- 2) Map how children currently receive developmental screening (from whom and when) and if evidence-based tools are being utilized.
- 3) Outline the processes used for assuring evidence-based tools are consistently utilized across settings and sharing results of a developmental screen (who shares them and how).
- 4) Identify action steps to improve the delivery of and communication of results of developmental screenings.
- 5) Develop common messages that are shared with families to promote continued healthy development for children who are developmentally progressing well.
- 6) Identify how children who are not developmentally progressing well receive supports and services. What supports and services are available? How does a family know about these services and supports? How are referrals shared between programs? What improvements can be made to assure children receive necessary services?

- 7) Determine how to measure the impact of their systems building activities. How is data about developmental screening captured amongst providers? If it is not, how can better data be captured?

The leadership of this initiative will receive support from the Regional Children and Youth with Special Health Care Needs Centers as they work with individual medical providers to implement developmental screening in their practice setting.

This model aligns with the proposed healthy birth outcome racial disparity goals of a) Strong community coalitions promoting buy-in, coordination, strategic direction, resources and accountability and b) re-norming and developing supportive social networks for healthy practices.

The proposed framework includes funding opportunities to promote and evaluate system building activities around each of the priorities identified in the Maternal and Child Health Needs Assessment process based on health promotion and grounded in the evidence-based model of Bright Futures.

6. Priorities and Measures

A variety of measures will be utilized to determine annual progress made on each of the eight priorities.

In order to more accurately measure progress on priorities and to supplement the existing National Performance Measures, some of the current state performance measures have been changed. Three State Performance Measures remain the same, seven of the previous measures have been retired and four new measures have been developed. The following chart demonstrates the changes to the State Performance Measures:

2005-2010 STATE PERFORMANCE MEASURES	STATUS	2011-2015 STATE PERFORMANCE MEASURES
Percent of eligible women enrolled in the Wisconsin Medicaid Family Planning Waiver during the year.	Continued	Existing: Percent of eligible women enrolled in the Wisconsin Medicaid Family Planning Waiver during the year.
Percent of Medicaid and BadgerCare recipients, ages 3-20, who received any dental service during the reporting year.	Retired	New: Percent of women having a live birth who reported having an unintended or unwanted pregnancy.
Percent of children, ages 6 months-5 years, who have age-appropriate social & emotional developmental levels.	Retired	New: Percent of African-American women having a live birth who experience depressive symptoms after pregnancy.
Rate per 1,000 of substantiated reports of child maltreatment to Wisconsin children, ages 0-17, during the year.	Continued	Existing: Rate per 1,000 of substantiated reports of child maltreatment to WI children, ages 0-17, during the year.

2005-2010 STATE PERFORMANCE MEASURES	STATUS	2011-2015 STATE PERFORMANCE MEASURES
Percent of children who receive coordinated, ongoing comprehensive care within a medical home.	Continued	Existing: Percent of children who receive coordinated, ongoing comprehensive care within a medical home.
Percent of children less than 12 years of age who receive one physical exam a year.	Retired	New: Replaced with: Percent of children age 10 months to 5 years who received a standardized screening for developmental or behavioral problems
Percent of women who use tobacco during pregnancy.	Retired	New: Percent of children under 1 year of age enrolled in WI's Birth to 3 Program
Percent of children, ages 2-4, who are obese or overweight.	Retired	
Ratio of the black infant mortality rate to the white infant mortality rate.	Retired	
Death rate per 100,000 among youth, ages 15-19, due to motor vehicle crashes.	Retired	

In addition to Wisconsin's seven state developed measures one new outcome measure has been identified. The maternal mortality rate is the additional outcome measure Wisconsin will monitor in addition to the six federal outcome measures. [Appendix J: Connecting the Dots](#) Priorities and Measurements, crosswalks the State's priorities, National Performance Measures (NPMs), State Performance Measures (SPMs), Outcome Measures, Health Status Indicators, HW2020 Focus Areas, and HW2020 applicable measures. Each of the priorities and the corresponding measures are as follows:

- a) Reduce **health disparities** for women, infants, and children, including those with special health care needs

Wisconsin's racial and ethnic minority communities continue to endure striking inequities in health. Social, environmental, cultural, and economic factors, including poverty, education, use of health care, and quality of health care exert considerable influence on the health of mothers, children, and families. In addition, children and youth with special health care needs experience differences in health outcomes compared to other children.

This priority focuses on promoting activities and policies that reduce health disparities for women, infants, and children, including children with special health care needs. By identifying and addressing differences in health outcomes, the Wisconsin Maternal and Child Health Program expects efforts to promote health equity and reduce disparities will result in social environments and public policies that lead to changes in:

NPM #04: 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.

SPM #01: Percent of African-American women having a live birth who experience depressive symptoms after pregnancy.

HSI 8a and HSI 8b: Numbers of children's deaths by race and ethnicity.

Outcome Measure: The ratio of black infant mortality rate to white infant mortality rate.

Additional Measures: Disparity Ratios for infant mortality, low birth weight (<2,500 grams), prematurity and timing of entry into Women, Infants & Children (WIC) Program, and Racial and ethnic disparities in teen birth rates.

b) Increase the number of women, children, and families who receive preventive and treatment health services within a **medical home**

Receipt of preventive and treatment services within a medical home model leads to better health outcomes. Services such as primary care, prenatal care, well-child and well-women care are most effective if provided by a medical home that knows its patients and patient populations; partners with and learns from patients and families; connects with other community-based organizations; and offers safe, efficient care while coordinating with other medical providers such as reproductive and mental health providers. (Wisconsin promotes the right of all men and women to receive sensitive and personal health related services from a separate medical home including reproductive/sexual health and mental health as part of the larger patient centered care approach described in the context of the "medical home" concept.)

This priority focuses on promoting activities and policies that support the development of medical homes and contributes to the overall health of women, children, and families. By emphasizing this comprehensive approach to coordinated care, the Wisconsin Maternal and Child Health Program expects efforts to promote medical homes will result in health care environments and public policies that lead to changes in:

NPM #03: Percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home.

SPM #02: Percent of children who have a medical home.

Additional Measures: The number of certified medical home practices in the state according to NCQA.

c) Increase the number of children and youth with special health care needs and their families who access **necessary services and supports**

Families of children and youth with special health care needs who require health care and community supports continue to identify barriers to receiving coordinated and comprehensive resources and supports for their child including medical, mental health, and dental care services. Although Wisconsin has a variety of services that enhance the opportunities that allow children

with disabilities to stay in their homes and their families to become connected to the community, there remain many children who are receiving fragmented and inadequate health care services and community supports.

This priority focuses on promoting activities and policies to support infants, children, and adolescents with disabilities and special health care needs access to systems of care throughout their lifetime. By identifying and addressing challenges faced by families such as lack of understanding by professionals, lack of specialized providers and inadequate funding, the Wisconsin Maternal and Child Health Program expects efforts to promote comprehensive coordinated services and supports will result in social environments and public policies that lead to changes in:

NPM #02: 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.

NPM #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.

NPM #06: Percent 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.

d) Increase the number of women, men, and families who have knowledge of and skills to promote **optimal infant and child health, development, and growth**

Optimum infant, child, and adolescent health, development and growth lays the foundation for health and success across the lifespan. This priority focuses on promoting activities and policies that support healthy physical growth and development to ensure the birth of healthy infants and the nurturing and care of children and adolescents at home, early care and education, and health care settings.

By emphasizing the connection between early health status and development milestones with life-long health through a life course model, the Wisconsin Maternal and Child Health Program expects efforts to promote optimal infant, child, and adolescent health; growth and development will result in social environments and public policies that lead to changes in:

NPM #11: Percentage of mothers who breastfeed their infants at 6 months of age.

SPM #03: Percent of children age 10 months to 5 years who received a standardized screening for developmental or behavioral problems.

Outcome Measure: The infant mortality rate.

Outcome Measure: Neonatal mortality rate.

Outcome Measure: Post-neonatal mortality rate.

Outcome Measure: Perinatal mortality rate.

Outcome Measure: Child death rate.

Additional Measures: Proportion of parents reporting that a health provider assessed their child's learning, development, communication or social behavior.

- e) Increase the number of women, children, and families who have **optimal mental health and healthy relationships**

Optimum mental health and healthy relationships provide the foundation for success across the lifespan and are essential to overall health. Helping children and adolescents develop healthy relationship skills early can contribute to their social-emotional development and help them interact positively with others as they grow. Children who grow up in healthy relationships respect others. They can talk honestly and freely to supportive people and share decisions. They trust and support each other and respect each other's independence.

This priority focuses on promoting activities and policies that support the development of healthy relationships and contribute to optimum mental health and social-emotional development. By emphasizing a public health approach to mental health, the Wisconsin Maternal and Child Health Program expects efforts to promote optimal mental health and healthy relationships will result in social environments and public policies that lead to changes in:

NPM #16: Rate per 100,000 of suicide deaths among youths aged 15 through 19.

SPM #04: Rate per 1,000 of substantiated reports of child maltreatment.

Additional Measures: Percent of children who have depression, anxiety or emotional problems; Percent of CSHCN and non-CSHCN who received mental health treatment in the past year; Incidence of intimate violence and hate crimes.

- f) Increase the number of women, men, and families who have knowledge of and skills to promote **optimal reproductive health and pregnancy planning**

Because almost half of pregnancies in Wisconsin are not planned, many women are not aware they are pregnant until after the critical period of time (4-10 weeks after conception) has passed. As such, planning for the possibility of pregnancy or preconception care is recognized as a critical component of health care for women of reproductive age. The main goal of preconception care is to provide health promotion, screening and interventions for women of reproductive age to reduce risk factors that might affect future pregnancies.

This priority focuses on promoting reproductive and sexual health. By encouraging adolescents to delay sexual activity, promoting access to reproductive health and family planning services for sexually active women of childbearing age and postpartum women, and promoting the adoption of healthy behaviors by women of childbearing age, the Wisconsin Maternal and Child Health Program expects efforts to promote optimal reproductive health and pregnancy planning will result in social environments and public policies that lead to changes in:

NPM #08: Rate of Birth (per 1,000) for teenagers aged 15 - 17 years of age.

NPM #15: Percent of moms who smoke in the last three months of pregnancy.

NPM #17: Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

NPM #18: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

SPM #05: Percent of eligible women enrolled in the Wisconsin Medicaid Family Planning Waiver during the year.

SPM #06: Percent of women having a live birth who reported having an unintended or unwanted pregnancy.

Outcome Measure: (State Identified) Maternal Mortality rate.

Additional Measures: Percent of births that are to women with avoidable risks for poor birth outcomes; Percent of sexually active high school students who reported that they or their partner had used a condom during last sexual intercourse; Unintended pregnancy rates.

g) Increase the number of women, children, and families who receive **preventive screenings, early identification, and intervention**

Identification of health risks and concerns as early as possible in the lifespan, during developmentally sensitive periods yields the greatest benefits for optimal health. Many risk factors that can be identified and influenced in childhood and adolescence are directly connected to chronic diseases later in life.

This priority focuses on increasing access to preventive screening and treatment services for mothers, children, and families. By supporting and implementing interventions that target risks and concerns as early as possible, the Wisconsin Maternal and Child Health Program expects efforts to promote preventive screenings at an individual and community level will result in social environments and public policies that lead to changes in:

NPM #01: 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.

NPM #12: Percent of newborns who have been screened for hearing before hospital discharge.

SPM #07: Percent of children under 1 year of age enrolled in Wisconsin's Birth to 3 Program.

h) Increase the number of women, children, and families who live in a **safe and healthy community**

Communities exert considerable influence on the health of mothers, children, and families. The immediate surrounding of a person, where he or she lives, plays an important role in influencing individual behaviors as well as contributing to the overall health of an individual.

This priority focuses on helping communities reduce injuries, prevent violence against children and promote healthy physical and built environments. By supporting and implementing interventions that support injury prevention, emphasize safety and improve the quality of the environment, the Wisconsin Maternal and Child Health Program expects efforts to promote safe and healthy communities will result in social environments and public policies that lead to changes in:

NPM #10: Rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.

HSI 3a: Death rate among children aged 14 years and younger due to unintentional injuries.

HSI 4a: Rate of all nonfatal injuries among children aged 14 years and younger.

The Wisconsin Maternal and Child Health Program will engage in collaborative activities with DHS partners to impact the following National Performance Measurements not identified above in the 2011-2015 priorities:

NPM #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. (Primary Partner: Immunization Program)

NPM #09: Percent of third grade children who have received protective sealants on at least one permanent molar tooth. (Primary Partner: Oral Health Program)

NPM #13: Percent of children without health insurance. (Primary Partner: Division of Access and Accountability)

NPM #14: Percent of children, ages 2-5 years, receiving WIC services that have a BMI at or above the 85th percentile. (Primary Partner: Nutrition & Physical Activity Program)

Appendices

- A. Utilization Review of Previous Needs Assessment by Local Health MCH Staff**
- B. MCH Expert Team Members**
- C. MCH Advisory Committee Invitees**
- D. Summary of Emerging Issues and Unmet Needs, 2008**
- E. Progress on Previous MCH Priorities**
- F. MCH Block Grant Measures by Life Stage**
- G. WI MCH Program Logic Model**
- H. 10 Essential Services and Public MCH Program Functions**
- I. Federal and State Requirements of the WI MCH Program**
- J. Connecting the Dots Priorities and Measurements**

**Utilization Review of Previous Needs Assessment by Local Health MCH Staff
Summary of Qualitative Results Gathered at the Five Regional MCH Forums, Fall 2008**

- 1) What knowledge do you feel could be gained from the MCH Needs Assessment that would be most helpful to you as a local partner?
- 2) If and how have you used the information in the MCH Needs Assessment "Report" from 2006? Specifically the Data Detail Sheets on priorities.
- 3) How will you use information gathered through the MCH Needs Assessment process to guide your community health improvement planning?

Some of the ways the Data Detail Sheets from the previous MCH Needs Assessment have been used are:

Responses: Overall, the Data Detail sheets are unfamiliar to participants. Responses ranged from "I do not know what they are" to "the Health Officer may use them but I have no idea". A question posed many times was "Where do I find the Data Detail Sheets?"

Recommendation: Assure data gathered and utilized in the Needs Assessment Process is accessible and easily available for partners.

Action Taken: Guiding Principle was added: "Transform any data gathered or analyzed into useful information for programs and partners".

Some of the ways the MCH Statewide Priorities identified through the Needs Assessment have been used in community health improvement planning are:

Responses: Overall, there was not a connection identified to the community health improvement planning. Local priorities drive programming and are not connected to State priorities. Only one concrete way was mentioned which indicated cooperative meetings regarding dental programming for children with adjacent communities occurred because it was identified as a statewide priority and a MCH priority.

Recommendation: Assure all partners feel part of and see their role in addressing the MCH Priorities.

Action Taken: Guiding Principle was added: "Convey responsibility of all partners to address priorities for the MCH/CYSHCN population."

The information from the upcoming MCH Statewide Needs Assessment that will be most helpful is:

A variety of responses were received with no clear themes emerging. Responses included:

- Information that gets filtered down to nurses in the field
- Patterns between statewide priorities and priorities identified in the local needs assessment
- An easily usable Assessment that is posted on the internet with an executive summary
- Specific information on preconception care and use of folic acid, prenatal dental care, birth control education for teens and smoking cessation programs (prenatal versus postnatal)
- The dollars are what drive programming and do not always follow the highest priorities – funded mandates should parallel priorities.
- A clear plan of how the priorities identified will be addressed at a state and local level.

Recommendation: Assure all partners see the connection of Statewide and Local MCH Priorities.

Action Taken: Guiding Principle was added: "Conduct strategic planning within the Framework of HW2020 with a commitment to identifying and addressing disparities within the MCH/CYSHCN populations."

MCH Expert Review Team

Family Health Section

Revised October 2008

Family Health Section Office

Linda Hale – Room 351
Family Health Section Chief
(608) 267-7174 Linda.Hale@wisconsin.gov

- Oversee in conjunction with program experts:
- Title V MCH/CYSHCN Block Grant
 - Early Screening Programs (Universal Newborn Hearing Screening, Universal Blood Screening)
 - Congenital Disorders/Genetics
 - Injury Prevention (CDC Falls Prevention Research Grant with UW Medical School and UWHC Rehab Medicine, Statewide Falls Initiative, Statewide Suicide Prevention Initiative, Sexual Assault Prevention, Public Health Injury Surveillance and Prevention Program, N/WVDRS, CASEPOINT)
 - Organ and Tissue Donor Program
 - SSDI and SPHERE data system
 - Birth Defects Prevention
 - CYSHCN Health Promotion
 - Transitions/Medical Home
 - Family Health/Infant/Child Health
 - Preconceptual, Prenatal, Perinatal, and Maternal Health
 - Reproductive Health/Abstinence

Michelle Gainey – Room 243 / 351
SPHERE IS Business Automation Spec
(608) 267-9165 Michelle.Gainey@wisconsin.gov

- Assist with SPHERE (Secure Public Health Electronic Record Environment) technical assistance and consultation needs of local projects and State MCH staff
- Assist the SPHERE Statewide Coordinator in the development and maintenance of the software portion of the SPHERE System
- Monitor and follow up on calls to MCH SPHERE System Help
- Serve as liaison for SPHERE to the Immunization Program, WIC Data System, WE-TRAC, Birth Defects Surveillance Data System, and Lead Programs with respect to data

Tami Horzewski – Room 233
Congenital Disorders Program Consultant
(608) 266-8904 Tami.Horzewski@wisconsin.gov

- Review, negotiate, approve, and monitor contract objectives for the Congenital Disorders Program
- Coordinate the Newborn Screening Advisory Group meetings to include agenda planning, notification of meetings, coordination of meeting location, and meals
- Provide statewide education and training regarding newborn screening
- Develop and update educational materials related to newborn screening
- Establish and maintain relationships with statewide and regional agencies such as Wisconsin Association for Perinatal Care and March of Dimes

- Provide newborn screening expertise to public health programs such as early hearing detection and intervention and birth defects surveillance and prevention
- Stay apprised of state and federal legislative issues related to newborn screening
- Collaborate and coordinate activities between newborn screening programs, e.g. WI Sound Beginnings, WE-TRAC, Birth Defect Registry, WI Genetics Program
- Establish long-term follow up and evaluation of children identified as having one of the congenital disorders detected by the WI Screening Program
- Coordinate day to day activities between the Bureau and the Screening Laboratory
- Coordinate product purchase and distribution

Susan Kratz – Room 351

SPHERE State Administrator

(608) 266-3890 Susan.Kratz@wisconsin.gov

- SPHERE (Secure Public Health Electronic Record Environment) data system development
- Oversee and coordinate the continued development and enhancement of SPHERE
- SPHERE is used for collecting data and providing measurements related to Maternal and Child Health, Injury Prevention, PNCC, Family Planning/Reproductive Health, and Children and Youth with Special Health Care Needs
- Represents BCHP on the Public Health Information Network (PHIN) activities

Loraine Lucinski – Room 351

SSDI Program Director

(608) 267-9190 Loraine.Lucinski@wisconsin.gov

- Coordinates Wisconsin's State Systems Development Initiative (SSDI)--a federal grant funded to improve the ability of WI maternal and child health programs to access needed data
- Promotes ongoing communication regarding data systems and potential data sharing or linking
- Works closely with Secure Public Health Electronic Record Environment (SPHERE) and other Public Health Information Network (PHIN) applications
- Coordinated the 5 year Title V Needs Assessment (2005)

Jayne Vargas – Room 351

Family Health Section Grants Coordinator

(608) 266-0220 Jayne.Vargas@wisconsin.gov

- Coordinate, format, edit, and submit all electronic and hard copy grants for FHS programs
- Coordinate annual federal Title V Block Grant document including formatting, editing, preparing for electronic submission, and getting it printed for the public and other agencies
- Co-Sponsorships Agreements / Membership Dues
- MCH Program Advisory Committee Coordinator
- Personnel files, i.e., PDs, PPDs

Michelle Kempf-Weibel – Room 233

Statewide Genetics Consultant

(608) 267-7148 Michelle.Kempfweibel@wisconsin.gov

- Coordinates MCH Title V Statewide Genetic Services Program
- Provide guidance for Region V HRSA Grant
- Provides leadership for the implementation of the Genetic Services Plan for Wisconsin
- Coordinates Congenital Disorders Program (Newborn Blood Screening--NBS)
- Resource for health care professionals and consumers regarding state genetic issues

FH / Early Screening Team

Megan O'Hern – Room 351

WE-TRAC Project Manager

(608) 267-9473

Megan.Ohern@wisconsin.gov

- Serve as point of contact and system monitor for users, stakeholders, partners, and others for the Wisconsin Early Hearing Detection and Intervention (EHDI) tracking system, called WE-TRAC (WI EHDI Tracking Referral and Coordination)
- Collaborates with the WI State Laboratory of Hygiene Newborn Screening Program and the UW-Division of Information Technology
- Works with Wisconsin Sound Beginnings and NICH-Q
- Provides technical support and training for WE-TRAC end-user application
- Coordinates hearing screening followup activities to hospitals
- Work with WI State Lab of Hygiene (WSLH) NBS to provide guidance to hospitals on blood card hearing screening completion and advise WSLH on entry and follow-up protocol

Elizabeth Seeliger – Room 351

Wisconsin Sound Beginnings (WSB) Program Director / Audiologist

(608) 267-9191

Elizabeth.Seeliger@wisconsin.gov

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- Develop data, tracking, and referral system (WE-TRAC).
- Educational resources for hospitals, audiologists, and other providers
- Best practices guide for providers and an interactive notebook for parents
- Assist in planning for the annual conference for families of deaf and hard of hearing children and Parent Summit
- Spearhead the initiative to enable WI homebirth midwives to provide Universal Newborn Hearing Screening (UNHS)
- Serve on the board of directors for the WI Chapter and National Organization of Families for Hands & Voices
- Coordinates WI's NICH-Q grant and program

Ravi Shah – Room 351

WI Sound Beginnings Follow-Through Coordinator

(608) 261-7654

Ravi.Shah@wisconsin.gov

- Assist in maintenance of the WE-TRAC surveillance system
- Coordinate WE-TRAC on-site trainings
- Develop and maintain the WE-TRAC user guide and the Guide-By-Your-Side physician directory

FH / Injury Prevention Team

Brianna Kopp – Room 233

Public Health Injury Surveillance and Prevention Program Coordinator

(608) 267-6716

Brianna.Kopp@wisconsin.gov

- Coordinate and administer the CDC Public Health Injury Surveillance and Prevention Program grant
- Staff the Statewide Injury Coordinating Committee
- Strengthen organizational focus related to the prevention and control as well as surveillance of injuries across the lifespan

Susan LaFlash – Room 233
Sexual Assault Prevention Coordinator
(608) 266-7457 Susan.LaFlash@wisconsin.gov

- Coordinates and administers CDC Rape Prevention Education grant funds
- Monitors education and training provided to professionals working with sexual assault victims.
- Works with WI Coalition Against Sexual Assault (WCASA) to assure sexual violence education, training, referral and access is available statewide
- Coordinating the development of a comprehensive statewide plan to end sexual violence

Rebecca Turpin – Room 233
State Injury Prevention Coordinator
(608) 266-3008 Rebecca.Turpin@wisconsin.gov

- Maintain state injury prevention program that collects data, provides surveillance, education and promotion of evidence based injury prevention, and control related programs and activities
- Assist local health departments and community agencies by serving as focal point for injury prevention expertise and guidance and by providing leadership for effective local program development and evaluation
- Promote and ensure sustainability of injury prevention activities and programs in WI
- Provide direction for integration of injury prevention into other public health related venues

Maternal and Child Health Unit

Katie Gillespie– Room 351
Maternal and Perinatal Nurse Consultant
(608) 266-1538 Kate.Gillespie@wisconsin.gov

Coordinates programs to improve birth outcomes and address disparities:

- Healthy Babies in Wisconsin initiative
 - Steering Committee
 - Ongoing Action Teams
- Prenatal Care Coordination Program
 - Technical assistant and training for providers
- Maternal Mortality Review Program
 - Preparation and facilitation of Case Review Team Meetings
- Milwaukee Fetal and Infant Mortality Review Program
- Perinatal Depression Task Force
- Public Health/Homebirth Workgroup
- Contract monitor for Infant Death Center of WI and WI Assoc for Perinatal Care

Peggy Helm-Quest – Room 351
CYSHCN Health Promotion Consultant / Birth Defects Program Consultant
(608) 267-2945 Peggy.HelmQuest@wisconsin.gov

Children with Special Health Care Needs Program:

- Integration of the CYSHCN National outcome measures throughout the Bureau including CYSHCN WAPC integration with MCH statewides

Wisconsin Birth Defects Prevention and Surveillance Program:

- Staff to the Council on Birth Defect Prevention and Surveillance Outreach

Children's Mental Health and Behavioral Health:

- Bureau lead on mental health

- Infant and young child mental health promotion
- Mental health screening, foster care, and Birth to 3
- Autism and other behavioral health consultant
- Children’s Health Alliance of WI statewide contract administrator

Millie Jones – Room 351
 Reproductive / Family Health Consultant
 (608) 266-2684 Millie.Jones@wisconsin.gov

- Consultant promoting optimal and comprehensive health across the lifespan for women of reproductive age—children, adolescents, and women
- Resource on maternal and child health issues
- Building collaborations and partnerships with existing women health networks

Terry Kruse – Room 351
 MCH Unit Supervisor
 (608) 267-9662 Terry.Kruse@wisconsin.gov

- Supervise the MCH, Family Planning, and CYSHCN Programs and staff

Kate Kvale – Room 351
 MCH Epidemiologist
 (608) 267-3727 Katherine.Kvale@wisconsin.gov

- Title V Block Grant Application/Report
- Healthy Birth Outcomes Initiative
- Special assignments/projects that are data related
- Project Director for Pregnancy Risk Assessment Monitoring System (PRAMS)
- Milwaukee Fetal and Infant Mortality Review (FIMR)

Susan Latton – Room 351
 Medical Home Coordinator
latton@charter.net

- Wisconsin Medical Home Tool Kit
- Wisconsin Medical Home Summit in collaboration with Waisman Center
- Wisconsin Medical Home Summit Project

Laurie Lindquist – Room 351
 MCH Program Associate
 (608) 267-2204 Laurie.Lindquist@wisconsin.gov

- Program support to the CYSHCN Program staff, and other staff as needed
- Resource for printing, setting up of WISlines and conference calls, ordering of supplies, timesheets, DOHAAS, travel embursements, etc.

Elizabeth Oftedahl – Room 351
 CYSHCN Epidemiologist
 (608) 261-9304 Elizabeth.Oftedahl@wisconsin.gov

- Children with Special Health Care Needs data
- Wisconsin Birth Defects Registry
- Autism Project with the Waisman Center

Eden Schafer – Room 218
CYSHCN Nurse Consultant
(608) 267-0329 Eden.Schafer@wisconsin.gov

- Serve as a resource for CYSHCN Transitions
- Provide contract monitoring support to CYSHCN Medical Director for WISC-I
- Resource for CYSHCN families
- Working on gathering and preparing Emergency Preparedness guidelines for vulnerable/special populations that the FHS works with
- Member of the Wisconsin Brain Injury Advisory Council
- Member of WAPC Infant and Family Committee

Ann Stueck – Room 351
Infant and Child Health Nurse Consultant
(608) 266-3504 Ann.Stueck@wisconsin.gov

- Resource for statewide child death review process
- Consultant and contract administrator for Early Childhood Comprehensive System's grant
- Consultant for hand held technology to support early screening of children
- Interim support for Family Foundations and Empowering Families of Milwaukee Projects
- Consultant and contract administrator for UW Extension training for home visitors

Mike Vaughn – Room 351
Family Planning / Reproductive Health Consultant
(608) 266-3959 Michael.Vaughn@wisconsin.gov

- Statewide Wisconsin Family Planning Program
- Emergency contraception initiative
- Infertility prevention initiative
- EIDP Program
- Statewide access to contraception
- Cervical cancer screening in family planning programs
- STD testing and treatment in family planning programs
- Pregnancy testing
- Preventive (women's) health screening in family planning programs

Amy Whitehead – Room 218
CYSHCN Statewide Coordinator
(608) 267-3861 Amy.Whitehead@wisconsin.gov

- Provide technical assistance and training to the five Regional CYSHCN Centers related to their GAC objectives
- Assist the CYSHCN Medical Director in the implementation of Regional CYSHCN Center and WISC-I grants and contracts
- Enhance and strengthen linkages between Regional CYSHCN Centers, children services partners, and national CYSHCN initiatives on the local, regional, and state levels
- Seek opportunities to promote and sustain the CYSHCN Program
- Utilize this position to enhance the collaboration between the University Center for Excellence in Developmental Disabilities (Waisman Center) and the State CYSHCN Program through outreach, service, and research

MCH Advisory Committee Invitees

Last	First	Title	Agency
Ahlers	Therese	MS, MPA, Director	WI Alliance for Infant Mental Health
Bailo	Beth	Prevention Specialist	WI Coalition Against Sexual Assault
Becker	Anne	Student	UW School of Medicine and Public Health
Benton	Anna	MCH Division Manager	Milwaukee Health Department
Benton	Linda		GLITC Tribal Health Clinic
Blood	Gabrielle		DCF / Child Care Section
Brummel	Eva		WAPC / McConnell Hall
Buedel	Ann	Research Analyst	DHS / DPH / BHIP
Cohen	Rebecca	Planner/Analyst	DHS / DMHSAS
Conway	Ann	Executive Director	WAPC / McConnell Hall
Davis	Hugh		Wisconsin Family Ties
DeSteffen	Cynthia	RN	Portage County Health Department
Dobberke	Lisa	Counseling Supervisor	Children's Service Society of Wisconsin
Dougherty	Becky	RN, BSN	Portage County Health Department
Ebert	Ann		WAPC / McConnell Hall
Eide	Yvonne	Nursing Consultant	DHS / DPH / Southern Region
Eithun	Kim		DCF
Endres	Kathleen	Executive Vice Chair	Dental Hygiene Assoc of WI
Enters	Terri	Conference Coordinator	WI Alliance for Infant Mental Health
Erving	Patricia	Parent	Parent Representative
Feder	Elizabeth	Health Policy Analyst	UW Population Health Institute
FitzGerald	Charlanne		UW School of Medicine & Public Health
Fleischfresser	Sharon		DHS / DPH / BCHP
Freeman	Mary Ellen	Practice Nurse	Children's Hosp of WI- Cystic Fibrosis Prog
Froemming	Jyothi	Intern	Family Voices of Wisconsin
Gabel	Kari	CIRS	MCH Hotline c/o Gundersen Lutheran
Gallagher	Rachel		DPI
Gerlach	Mary Jo	PH Nurse Supervisor	Milwaukee Health Department
Giampietro	Philip	MD, PhD	Waisman Center- UW Medical School
Giese	Lieske	Regional Office Director	DHS / DPH / Western Region
Gillespie	Katie		DHS / DPH / BCHP
Gilmore	Claude	Youth Policy Director	DHS / DPH / BCHP
Gothard	Mary		DHS / DPH / BCHP
Gowan	Kristin	Resource Specialist	Waisman Center
Halatek	Lynn	Volunteer Parent Leader	Wisconsin FACETS
Hale	Linda	Section Chief	DHS / DPH / BCHP

Last	First	Title	Agency
Halverson	Teresa	Resource Specialist	MCH Hotline c/o Gundersen Lutheran
Hammel	Jennifer	Director	Children's Hospital and Health System
Harris	Anne	Clinical Asst Professor	Waisman Center Clinical Services
Harris	Robert	Regional Office Director	DHS / DPH / Southeastern Region
Harvieux	Anne		
Helm-Quest	Peggy	CYSHCN Health Promotion Consult	DHS / DPH / BCHP
Hibray	Dennis	Regional Office Director	DHS / DPH / Northeastern Region
Horzewski	Tami	Congenital Disorders Coord	DHS / DPH / BCHP
Hvizdak	Anne		Dental Hygiene Assoc of WI
Johnson	Cynthia		Kenosha County Dept of Health
Jones	David Allen	Independent Consultant	Wisconsin Seizure Control Network
Jones	Millie		DHS / DPH / BCHP
Katcher	Murray	State MCH Director	DHS / DPH / BCHP
Katz	Barbara	Co-Director	Family Voices of Wisconsin
Kempf-Weibel	Michelle	Clinical Genetic Consult	DHS / DPH / BCHP
Kettner	Sue		Family Planning Health Services, Inc
Kratz	Susan	SPHERE Coordinator	DHS / DPH / BCHP
Kruse	Terry	MCH Unit Supervisor	DHS / DPH / BCHP
Kryfke	Lynn	Manager	Managed Health Services
Kurka Reimer	Jeanie	Executive Director	WI Coalition Against Sexual Assault
Kvale	Kate		DHS / DPH / BCHP
Laszewski	Audrey	Project Director	Performance Works
Lawrence	James	Health Education Consultant	DHS / DPH / Northern Region
Liebenthal	Diane	Program Supervisor	Sheboygan Co HHS / DPH
Lucinski	Loraine		DHS / DPH / BCHP
Maaneb deMacedo	Merta	Research Coordinator	Parent Representative
Marshall	Curtis		
McAllister	Leslie		DCF
McCarthy	Millie	RN Maternal/Child Nurse	Gerald L Ignace Indian Health Center, Inc
Medeiros	Anne		Department of Children and Families
Mickelson	Sherry	Student Intern	Alverno College
Moore-Lightfoot	Gail	Parent	Gail's Child Supervision Services
Morgan	Rachel	Program Coordinator, RN, BSN	Black Health Coalition of WI
Nash	Karen	Community Services Coordinator	Childrens Hospital of WI - Infant Death Center
Nenide	Lana		WI Alliance for Infant Mental Health
Oftedahl	Liz	CYSHCN Epidemiologist	DHS / DPH / BCHP
Olejnickzak	Amy Beth	MPH Student	Wisconsin Alliance for Women's Health
Olson	Dan	Pediatric Resident	

Appendix C

Last	First	Title	Agency
Onheiber	Patrice	Disparities in Birth Outcomes Director	DHS / DPH / BCHP
Ordinans	Karen	Executive Director	Childrens Health Alliance of WI
Paradowski	Jill	PH Nursing Supervisor	
Pfeffer	Pam	Director	March of Dimes
Poehlman	Sandra	Nutrition Consultant	DHS / DPH / Southeastern Region
Radowicz	Jill	PH Nurse Supervisor	Milwaukee Health Department
Rahl	Kitty	Director of Nursing	Eau Claire City/Co Health Dept
Renner	Lynn	Outreach Coordinator	Family Voices of Wisconsin
Rohan	Angela	Epidemiology Fellow	DHS / DPH / BCHP
Rosecky	Mary	PH Nurse, Health Educ	Dodge Co Human Services & Health Dept
Schafer	Eden	CYSHCN Program Consultant	DHS / DPH / BCHP
Schmelzer	Margaret	Director PH Nursing & Health Policy	DHS / DPH
Selkurt	Joanne	Pediatrician, MD	Gundersen Lutheran Whitehall
Siemers	Sheri		DHS / DPH / Southern Region
Spitzer-Resnick	Jeff		Disability Rights Wisconsin
Ssempijja	Sebastian		Sebastian Family Psychology Practice
Stattelman-Scanlan	Daniel		Public Health Madison & Dane Co
Steimle	Meg	Outreach Specialist	Children's Hospital of WI
Stueck	Ann		DHS / DPH / BCHP
Timmers	Terri	Regional Office Director	DHS / DPH / Northern Region
Uttech	Susan	Bureau Director	DHS / DPH / BCHP
Van Vooren	Kara	Info & Referral Spec	Children's Hosp of WI- Fox Valley
Vargas	Jayne	Coordinator	DHS / DPH / BCHP
Walter	Linda	Health Officer	Washington County Health Department
Walter	Wendy	Parent Representative	Parent Representative
Weborg	Cindy	Manager	GLITC
Weik	LuAnn	Senior Genetic Assoc	Children's Hosp of WI- Genetics Center
Whitehead	Amy	CYSHCN Coordinator	DHS / DPH / BCHP
Wymore	Kevin		DHS / DPH / BHIP
Yaccarino	Karen	Parent	Parent Representative
Yankaway	Shalonda		Black Health Coalition of WI
Young	Mary	Regional Office Director	DHS / DPH / Southern Region
Zemke	Molly	Outreach Specialist	First Breath Program- WI Women's Health
Zetzsche	Lindsey	Clinical Genetic Counselor	Waisman Center- UW Medical School

Summary of Emerging Issues & Unmet Needs Impacting Health of Families, Women, and Children

Overview

The Wisconsin Maternal & Child Health Program partners with local health departments, non-profit agencies and community organizations through the provision of funding, guidance and technical assistance to promote positive health outcomes for families, women, and children across Wisconsin.

As part of a strategic planning process, all of these partners were provided an opportunity to share the unmet needs and emerging issues of the families, women, and children served in their community.

Analysis of the responses indicate all of the determinants and risk factors identified in the previous needs assessment conducted in 2005 continue to be impacting the health of families, women, and children. These include the following:

- a. High rates of infant mortality, low birth weight, and prematurity, especially in minority populations
- b. Lack of access to health care services; i.e. Primary Care, Early Prenatal Care, Mental Health Care and Dental Care
- c. High rate of teenage pregnancy
- d. High rate of unintended pregnancy
- e. Lack of mental health screening for children and pregnant women
- f. High rate of suicide among adolescents
- g. High rate of prenatal and postpartum depression in women
- h. Lack of affordable health insurance
- i. High rate of tobacco use, especially among pregnant women and adolescents
- j. High rate of unintentional injuries among children
- k. High rate of intentional injuries and violence, especially among pregnant women and children
- l. Lack of physical activity and exercise
- m. High rate of obesity
- n. High rate of dental caries, especially in children

Multiple partners identified three issues which were not apparent in the previously identified determinants and risk factors. These emerging issues include:

- a. Alcohol use, especially among pregnant women
- b. Economic and poverty-related impacts on health
- c. Inadequate long term support services for CYSHCN

Background

As a recipient of the federal Title V Maternal and Child Health Block Grant, each state including Wisconsin is required to complete a statewide assessment of needs of the maternal & child population, including children with special health care needs every five years. The previous needs assessment, which was last completed in Federal Fiscal Year (FFY) 2004-05, resulted in the identification of ten priorities for the maternal, child and adolescent health population.

The current needs assessment process being conducted in Federal Fiscal Year (FFY) 2009-10 will need to be completed for inclusion in the federal application which will be submitted July 15, 2010 and will serve as a guide for the Department of Health Services staff, local health departments and community partners for the 5 year span beginning January 2011 through December 2015.

Methodology

Approximately 110 entities receive funding through the Title V Maternal and Child Health Block Grant administered by the Wisconsin Maternal & Child Health Program. As part of the contractual relationship with each funded partner, a report is required to be submitted at the end of the calendar year which includes both a data report and a narrative report.

The 2008 MCH End of Year Report included three specific narrative questions designed to solicit input from partners regarding the connection of their activities and community health improvement plans to the previously identified needs and the unmet needs and emerging issues the families they serve are experiencing. The three questions were:

- 1) Provide a description of how all of your MCH programmatic activities advance one or more of the State's MCH Priorities.
- 2) What MCH related priorities were identified in your most recent community needs assessment process? Which of these are you currently or planning to work on in the upcoming year, two years, and five years?
- 3) Based on your experiences over the past year, what do you feel are the most important unmet needs and emerging issues impacting the health of mothers and children in your jurisdiction?

The responses to these questions were synthesized utilizing an **inductive content analysis process** to discover core meanings.

Content analysis is defined as “any qualitative data reduction and sense-making effort that takes a volume of qualitative material and attempts to identify core consistencies and meanings.”

Deductive content analysis is a process of analyzing text of interview transcripts, diaries, documents, and notes, according to an existing framework. In contrast, **inductive content analysis** refers to the process of analyzing text to discover core meanings emerging from the data. The core meanings found through this content analysis process are referred to as patterns or themes and can be used to identify and distinguish descriptive categories of similar responses. These descriptive categories, once identified, can then be used to make interpretations by others.

Results

A total of (86) eighty-six responses were received from a variety of partners which were included in the inductive content analysis.

- (73) Seventy-three responses were received from local health departments
- (5) Five responses from each of the five Regional Children and Youth with Special Health Care Needs (CYSHCN) Centers
- (1) One response from Wisconsin Family Voices
- (1) One response from the Great Lakes Inter-tribal Council, CYSHCN Program
- (1) One response from the Great Lakes Inter-tribal Council, Honoring Our Children Program
- (5) Five responses from each funded statewide project including the Children's Health Alliance of Wisconsin, the Wisconsin Genetics Services System, Infant Death Center, Wisconsin Association of Perinatal Care, and Parent to Parent of Wisconsin.

The descriptive categories identified through the content analysis were:

- Infant mortality, low birth weight, and prematurity, especially in minority populations
- Lack of access to health care services; i.e. Primary Care, Early Prenatal Care, Mental Health Care and Dental Care
- Teenage pregnancy
- Unintended pregnancy
- Mental health screening for children and pregnant women
- Suicide among adolescents
- Prenatal and postpartum depression in women
- Affordable health insurance
- Tobacco use, especially among pregnant women and adolescents
- Unintentional injuries among children
- Intentional injuries and violence, especially among pregnant women and children
- Physical activity and exercise
- Obesity and nutrition
- Dental caries, especially in children
- Alcohol use
- Economic challenges
- Lack of funding for long term supports resulting in waiting lists for CYSHCN

CYSHCN Unmet Needs from 2008 End of Year Reports

Southern Regional Center for CYSHCN

Based on the documentation in SPHERE and conversations with families the following were consistently unmet needs:

- Waiting lists resulting from inadequate funding for children eligible for long term supports
- Dental care providers who accept Medicaid, with skills to treat CSHCN and general lack of pediatric providers in rural areas. Lack of awareness by parents and physicians about the need for dental exams beginning at age one.
- Mental health providers who accept Medicaid, with skills to treat CSHCN and general lack of pediatric providers in rural areas.
- Community-based recreational opportunities for CSHCN particularly in the summer
- Childcare for children with challenging behaviors or SHCN and lack of trained childcare professionals
- Access to Medicaid or comprehensive health care for children with SHCN, but who do not meet eligibility for Medicaid through disability
- Families continue to struggle with school partnerships and look for tools to assist and empower themselves
- What to do while on a waiting list for services particularly when families get the message that early intervention is critical to their child's success

Northern Regional Center for CYSHCN

The most important unmet needs and emerging issues impacting children and families in northern Wisconsin continue to be:

- The lack of qualified providers, especially those that provide specialty services and/or accept Medicaid payment including dentists and mental health providers in the rural counties
- The limited funding for waiver programs or other services for children's long term support services
- The lack of health care coverage for mental health and neurodevelopmental treatment services
- The growing need for nutritional services and financial support for children with special dietary needs
- Lack of public or reliable personal transportation resource to access needed health care and treatment services that are often more than one hour away from a child's home

Southeastern Regional Center for CYSHCN

A small workgroup met in 2008 to focus on accurately tracking unmet needs for CYSHCNs across the state. Outcomes from this group resulted in recommendations to SPHERE administrators to revise the “referred to” section of SPHERE. Unmet needs remain consistent with previous years and include mental health, child care, dental, autism-related services and respite. Next steps include working with Family Voices to provide anecdotal stories related to BadgerCare+ and home health care services.

Western Regional Center for CYSHCN

Lack of easy access to medical coverage, alcohol awareness and the effects of alcohol on the developing brain, increasing poverty and job loss, higher tobacco use by 19-21 year olds including pregnant females

Northeastern Regional Center for CYSHCN

- 1) The increased numbers of autism spectrum disorders. The new Connections grant will allow us an opportunity to review current resources and determine needs.
- 2) Mental Health issues for young children continue to be an area of need.
- 3) Increased understanding of early child development and coordination of screening programs throughout the community will impact early identification and future health outcomes of children.

Parent to Parent

Isolation In the midst of services, service providers, healthcare providers and family, parents still feel extremely isolated because of lack of a “similar other” – another parent who has firsthand knowledge of the feelings and realities that come with having a child with special needs. The ripple effect of providing social support to parents of children with special needs moves beyond the mother and child, but can affect the outcome of lives.

Family Voices

Through our needs identification over the past year, we have determined the following issues to be of top concern to families who have children and youth with special health care needs:

- Lack of health insurance to youth after the age of 18 who have significant medical needs but lack the criteria to meet level of care for long term supports;
- Inadequate access to appropriate mental health providers;
- Current system inability to pay parents for nursing care they provide to their child;
- Families are still asking how they learn, in a timely way, about programs and services that are available to help their children.

Great Lakes Inter-Tribal Council

Lack of providers: physicians, dentists, and mental health workers; lack of transportation for high risk pregnancies, lack of funding to maintain staff.

Summarized by Loraine Lucinski, MPH 02/27/09

Wisconsin's Maternal & Child Health Progress on 10 Priority Needs 2005-2010



April 2009

Disparities in Birth Outcomes

Rationale

In Wisconsin in 2003, the Black infant mortality rate was 15.3 deaths per 1,000 live births, nearly 3 times the rate of 5.3 for White infants. The White infant mortality rate is declining steadily with a near 50% reduction over the past 20 years. In contrast, the Black infant mortality rate has varied slightly but has not declined during this period. Comparing Wisconsin's Black infant mortality rates relative to other states, for the period 1979-1981, Wisconsin ranked 3rd best. However great strides in infant mortality reduction made by other states, compared to a lack of improvement in Wisconsin has led to sharp drops in Wisconsin's rank relative to other states. For the period 1999-2001, Wisconsin's rank dropped to 32 among 34 states with a sufficient number of Black births. The infant mortality disparity of Blacks as compared to Whites ranked Milwaukee as the 4th worst among 16 U.S. cities (Big Cities Health Inventory, 2003). Analysis of 3-year average infant mortality rates for Wisconsin's American Indian population identifies a disturbing trend with rates increasing from 8.4 in 1998 -2000 to 12.9 from 2002-2003.

Measurement

Disparities in birth outcomes are related to National Performance Measure #15, #17, and #18 by addressing very low birth weight and early prenatal care. Wisconsin's continuing State Performance Measure #9 addresses the ratio of the Black infant mortality rate to White infant mortality rate.

Progress

Five year trends for each of the Performance Measures show that there has not been significant improvements made in the key indicators measuring contributions to disparities in birth outcomes. This includes little to no improvement in decreasing the percentage of mothers who smoke; improving the percentage of pregnant women receiving prenatal care in the first trimester; or improving the percentage of low birth weight infants delivered at facilities for high risk deliveries. Overall, the outcome of reducing the ratio of the black infant mortality rate to the white infant mortality rate continues to fluctuate and does not show significant improvement.

MCH Priority: Disparities in Birth Outcomes		2003	2004	2005	2006	2007
SPM 9	Ratio of the black infant mortality rate to the white infant mortality rate.	2.9	4.3	2.7	3.5	2.72
NPM 15	Percent of moms who smoke in the last three months of pregnancy.	***	***	14%	14.90%	14.9%
NPM 17	Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.	80.2	77.4	80.6	74.8	75.8
NPM 18	Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.	84.7	85.1	85	83.8	82.84

Wisconsin's Maternal & Child Health Progress on 10 Priority Needs 2005-2010



Contraceptive Services

Rationale

This priority takes into account the concerns voiced by many during the needs assessment process regarding unintended pregnancy, teen births, and abstinence from sexual activity. Women are defined as "in need of contraceptive services and supplies" during a given year if they are ages 13-44 and meet three criteria: 1) they are sexually active, that is, they have ever had intercourse; 2) they are fecund, meaning that neither they nor their partner have been contraceptively sterilized, and they do not believe that they are infected for any other reason; and 3) during at least part of the year, they are neither intentionally pregnant nor trying to become pregnant. Women are defined as "in need of publicly-funded contraceptive services and supplies" if they meet the above criteria and have a family income under 250% of the federal poverty level (estimated to be less than \$42,625 for a family of four). All women younger than 20 who need contraceptive services and supplies are assumed to need publicly supported care, either because their personal incomes are below 250% of poverty or because of their heightened need--to preserve confidentiality--for obtaining care that not depend on their family's resources or private insurance.

640,420 women ages 13-44 are estimated to be in need of contraceptive services and supplies in Wisconsin. Ninety-three percent of females aged 15-44 years at risk of unintended pregnancy used contraception in 1995. Approximately 17% of the estimated need for public support family planning services has been met through the Medicaid Family Planning Waiver through December 31, 2004.

Measurement

This priority aligns with National Performance Measure #8 which examines rate of teen births. Wisconsin's new State Performance Measure #1 attempts to examine the access and utilization of contraceptive services by monitoring the percent of eligible women enrolled in the Wisconsin Medicaid Family Planning Waiver during the year.

Progress

Five year trends for each of the Performance Measures show that although the percentage of women enrolled in the Family Planning Waiver has been steady over the past three years, there have not been significant improvements in increasing the number of eligible women enrolled in the Family Planning Waiver.

The key indicator measuring contraceptive use by adolescents is the rate of births to 15-17 year olds which has remained relatively constant over the past five years and does not show any significant improvement.

MCH Priority: Contraceptive Services		2003	2004	2005	2006	2007
NPM 8	Rate of Birth (per 1,000) for teenagers aged 15 - 17 years of age.	15.5	14.9	14.9	15.6	15.6
SPM 1	Percent of eligible women enrolled in the Wisconsin Medicaid Family Planning Waiver during the year.	***	17.3	22.7	22.2	21.2

Wisconsin's Maternal & Child Health Progress on 10 Priority Needs 2005-2010



Mental Health For All Population Groups

Rationale

According to the 2000 National Survey of Early Childhood Health, parents of children 4-35 months of age most frequently have concerns about how their child behaves (48%), how their child talks and makes speech sounds (45%), the child's emotional well-being (42%), and how their child gets along with others (41%). Infant mental health focuses on several complementary issues: 1) promoting a healthy bond between the child and caregivers; 2) assessing and promoting healthy social and emotional development; 3) developing intervention services for children at risk of poor developmental outcomes because of family issues such as domestic violence and substance abuse; and 4) provisions for specialized treatment for children and families who need intensive help because of postpartum depression or other diagnosed mental illness of the parent, abuse and neglect, or a diagnosed emotional or behavioral disorder.

Measurement

Mental health as a priority need links with the National Performance Measure #16 that focuses on deaths from suicide among youth.

Wisconsin's new State Performance Measure (SPM) #3 will monitor the percent of children, ages 6 months - 5 years, who have age appropriate social and emotional developmental levels. (It is important to note that we recognize the importance of women's mental health, postpartum depression, the stigma associated with a mental illness diagnosis, and adolescent indicators of need, however, our SPM focus is on young children.)

Progress

Five year trends for each of the Performance Measures show that suicide rates among 15 – 19 year olds have been slowly but steadily declining while the percentage of children who have age appropriate social and emotional developmental levels is increasing. Both of these indicators indicate positive movement in a positive direction.

MCH Priority: Mental Health for All Population Groups		2003	2004	2005	2006	2007
SPM 3	Percent of children, ages 6 months-5 years, who have age-appropriate social & emotional developmental levels.	***	***	22.2	82.9	94.3
NPM 16	Rate (per 100,000) of suicide deaths among youths aged 15 through 19.	***	9.5	11	8.4	7.71

Wisconsin's Maternal & Child Health Progress on 10 Priority Needs 2005-2010



Medical Home For All Children

Rationale

A child with a medical home does not use a hospital emergency room as their primary place of care. According to the Wisconsin Family Health Survey in 2003, 2.5 % of Hispanic children and 14.7% of African American children used a hospital emergency room as their primary place of care compared to less than 1% of White children. National SLAITS data indicate that: children without a medical home are twice as likely to experience delayed or forgone care; non-White children are significantly less likely to have a medical home; and poor children and children whose special health care needs have a significant adverse impact on their activity levels are more than twice as likely not to have a medical home and have unmet health care needs.

Measurement

This priority need is an outgrowth of the National Performance Measure (NPM) #3 which focuses on children with special health care needs. During the needs assessment process it became evident that medical home was an important concept for all children. Wisconsin's new State Performance Measure #5 reads the same as the NPM except for the population target including all children.

Progress

Five year trends for each of the Performance Measures do not demonstrate any significant improvement in the percentage of children, including children with special health care needs who have a medical home.

MCH Priority: Medical Home for All Children		2003	2004	2005	2006	2007
NPM 3	Percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home.	***	57.1	57.1	57.1	54.6
SPM 5	Percent of children who receive coordinated, ongoing comprehensive care within a medical home.	***	51.2	51.2	52.5	52.5

Wisconsin's Maternal & Child Health Progress on 10 Priority Needs 2005-2010



Dental Health

Rationale

Both Governor Jim Doyle, in his KidsFirst Initiative, and the state health plan, Healthiest Wisconsin 2010, identify oral health as a critical need. The National Survey of CSHCN reported that 83.1% of Wisconsin CSHCN required dental services and 92.6% received all needed dental services. 7.4% did not receive all needed dental services, which translates to 13,000 children with unmet oral health needs each year. The Wisconsin Family Health Survey revealed that 4.3% of CSHCN, or 12,800 children, did not receive needed dental care. The two primary reasons given were they couldn't afford dental care or had inadequate insurance.

In Wisconsin, 30.8% of children have at least one primary or permanent tooth with an untreated cavity. Compared to White children, a significantly higher proportion of minority children had caries experience and untreated decay. Twenty-five percent of the White children screened had untreated decay compared to 50% of African American children, and 45% of Asian children, and 64% of American Indian children. In addition, children who attend lower income schools have significantly more untreated decay (44.5%) compared to children in both middle (31.7%) and higher income schools (16.6%).

Measurement

The dental health priority has shifted focus to access and accessibility. The National Performance Measure #9 concentrates on delivery of protective sealants whereas Wisconsin's new State Performance Measure #2 will observe the percent of Wisconsin Medicaid and Badger Care recipients, ages 3-20, who received any dental services during the year.

Progress

Five year trends for each of the Performance Measures demonstrate that access to dental health services is declining for the population of children who are served by the Medicaid and Badger Care Programs while the number of children receiving preventive dental health services has remained stagnant. Overall, dental health continues to be a need for children, especially those who receive Medicaid.

MCH Priority: Dental Health		2003	2004	2005	2006	2007
NPM 9	Percent of third grade children who have received protective sealants on at least one permanent molar tooth.	***	47	47	47	47
SPM 2	Percent of Medicaid and Badger Care recipients, ages 3-20, who received any dental service during the reporting year.	***	30.2	30.2	25.8	22.4

Wisconsin's Maternal & Child Health Progress on 10 Priority Needs 2005-2010



Health Insurance and Access to Health Care

Rationale

There is a strong relationship between health insurance coverage and access to health care. During the needs assessment process, our stakeholders had difficulty looking at one need without the other; thus, we combined them into one priority. Wisconsin ranks high in the proportion of people who have health insurance. However, state data indicate that the maternal and child health population are less likely to be insured for the entire year.

Measurement

The National Performance Measure #13 requires data on percent of children without health insurance. The Wisconsin new State Performance Measure #6 monitors the movement to achieve this need by measuring the percent of children less than 12 years of age who receive one physical exam a year.

Progress

Although some improvements are noted, the overall percent of children without health insurance continues to slightly increase while the percent of families who have adequate insurance to pay for the needs of their child with special needs slightly decreased.

The percent of children who receive one physical examination a year has not shown improvements over the past couple of years after a high point in 2005 demonstrating that although 96% of children may have health insurance, access to preventive care examinations remains difficult for more than 23% of the children in the State.

MCH Priority: Health Insurance and Access to Health Care		2003	2004	2005	2006	2007
NPM 13	Percent of children without health insurance.	***	2.2	2.9	3.8	3.8
NPM 4	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.	***	66.6	66.6	66.6	63
SPM 6	Percent of children less than 12 years of age who receive one physical exam a year.	***	75.70%	83%	77.10%	77.10%

Wisconsin's Maternal & Child Health Progress on 10 Priority Needs 2005-2010



Smoking and Tobacco Use

Rationale

Smoking during pregnancy is a major risk factor for infant mortality, low birthweight, prematurity, stillbirth, and miscarriage. Overall in 2003, 9,769 or 14% of pregnant women in Wisconsin reported smoking during pregnancy; this rate is higher than the national rate of 11.0%. In terms of racial differences, American Indian women continue to report the highest percentage of smoking during pregnancy, nearly 3 times as high as the overall state percentage.

Measurement

There is not a National Performance Measure for tobacco use. The Wisconsin State Performance Measure #7 will continue to look at percent of women who use tobacco during pregnancy.

Progress

To compare the rates of smoking among pregnant women, one should look at the trends in smoking of other populations. The overall percent of adult smokers was 24.2 in 2000 and has steadily declined each year to the 2007 percentage of 19.6. The percent of students who smoked a whole cigarette before the age of 13 years old has declined from 22.2% in 2000 to only 11.5% in 2007. Finally, the percentage of students who report smoking daily has declined from 24.9% in 2001 to 14.2% in 2007. Each of these indicators (the percent of adults smoking, the % of adolescents smoking and the % of initiation of smoking by adolescents have steadily declined. When comparing these trends to pregnant women, one can see that the same trend is not apparent with this population. There appears to be no decline in the percentage of women who report smoking during pregnancy.

MCH Priority: Smoking and Tobacco Use		2003	2004	2005	2006	2007
SPM 7	Percent of women who use tobacco during pregnancy.		14	13.4	14.9	14.9
NPM 15	Percent of moms who smoke in the last three months of pregnancy.		Data Not Available			

Wisconsin's Maternal & Child Health Progress on 10 Priority Needs 2005-2010



Intentional Childhood Injuries

Rationale

Discussions during the needs assessment process resulted in dividing injury into intentional and unintentional injuries. In 2002, there were 42,698 total reports of child abuse and neglect with substantiations in Wisconsin. The largest number of substantiated reports are for children between the ages of 12 and 14. Between 2000 and 2002, there were slightly more reports and substantiations for female children than males.

Measurement

The National Performance Measure #16 relates to the priority as it addresses deaths from suicide among older teens. However, Wisconsin's new State Performance Measure #4 focuses on child abuse, neglect and maltreatment issues. We will monitor the number of substantiated reports of child maltreatment to Wisconsin children, ages 0-17, during the year.

Progress

The two key indicators to measure intentional injury demonstrate a decline over the past four reporting years in both the rate of child abuse and rate of adolescent suicide in Wisconsin.

MCH Priority: Intentional Childhood Injuries		2003	2004	2005	2006	2007
SPM 4	Rate per 1,000 of substantiated reports of child maltreatment to Wisconsin children, ages 0 -17, during the year.	***	6.1	6	5.5	5.0
NPM 16	Rate (per 100,000) of suicide deaths among youths aged 15 through 19.	***	9.5	11	8.4	7.71

Wisconsin's Maternal & Child Health Progress on 10 Priority Needs 2005-2010



Unintentional Childhood Injuries

Rationale

In Wisconsin, there are almost two times the number of unintentional injuries and deaths than intentional or violent injuries and deaths in this 0-21 age group. More than 2,100 children, teenagers, and young adults up to 21 years of age died from injuries and more than 37,300 were hospitalized from 1998-2002. Of these deaths, 916 died from injuries related to motor vehicles. The leading injury hospitalization for children ages 0-21 were motor vehicle related and fall injuries totaling 4,054 out of more than 37,300 hospitalizations.

Measurement

The priority need for unintentional childhood injuries relates with the National Performance Measure #10 and the new State Performance Measure #10 both addressing death from motor vehicle crashes but for different age groups; 14 and under; and 15- 19, respectively.

Progress

The indicators of death by motor vehicle crashes show little improvement as the rates fluctuate each year without demonstrating consistent progress.

MCH Priority: Unintentional Childhood Injuries		2003	2004	2005	2006	2007
SPM 10	Death rate per 100,000 among youth, ages 15-19, due to motor vehicle crashes.	***	23.5	25.7	24.5	23.12
NPM 10	Rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.	3.6	2.5	2.8	1.8	2.48

Wisconsin's Maternal & Child Health Progress on 10 Priority Needs 2005-2010



Overweight and At Risk for Overweight

Rationale

The concern about overweight and at risk for overweight was clear during the needs assessment process and surfaced as a priority need for Wisconsin. The prevalence of overweight in Wisconsin children from birth to age 5 is 12.2%. Overweight and at-risk-for-overweight has increased among all racial and ethnic groups. The prevalence of at-risk-for-overweight for children aged 2 to 5 or older increased from 13.8% in 1994 to 15.9% in 2003. In 2003, the highest rates for overweight and at-risk-for-overweight were among American Indian (19.2% and 20.0%), Asian (19.3% and 17.8%), and Hispanic (17.8% and 17.6%). Rates for Whites were slightly lower at 11.8% and 15.9%, and Blacks were at 10.1% and 13.6%.

Measurement

The National Performance Measure #11 which relates to breastfeeding is the closest measure to this priority need. The Wisconsin's continuing State Performance Measure #8 looks closely at the percent of children, 2-4 years who are obese or overweight.

Progress

The percentage of mothers who breastfeed their infants to 6 months of age has shown very slight improvement but continues to be about ¼ of mothers. The trends demonstrate the percent of preschool age children who are obese has remained relatively constant around 13% while the percent of children who receive WIC and have a high BMI did not demonstrate any decline.

MCH Priority: Overweight and At Risk for Overweight		2003	2004	2005	2006	2007
NPM 11	Percent of mothers who breastfeed their infants at 6 months of age	***	***	24.2	24.2	26.6
NPM 14	Percent of children, ages 2-5, receiving WIC services that have a BMI at or above the 85th percentile	***	***	13.3	29.2	29.2
SPM 8	Percent of children, ages 2-4 who are obese or overweight at or above the 95th percentile	***	13.3	12.9	12.9	13.1

Healthy People at Every Stage of Life
Maternal and Child Health Federally Reported Measures

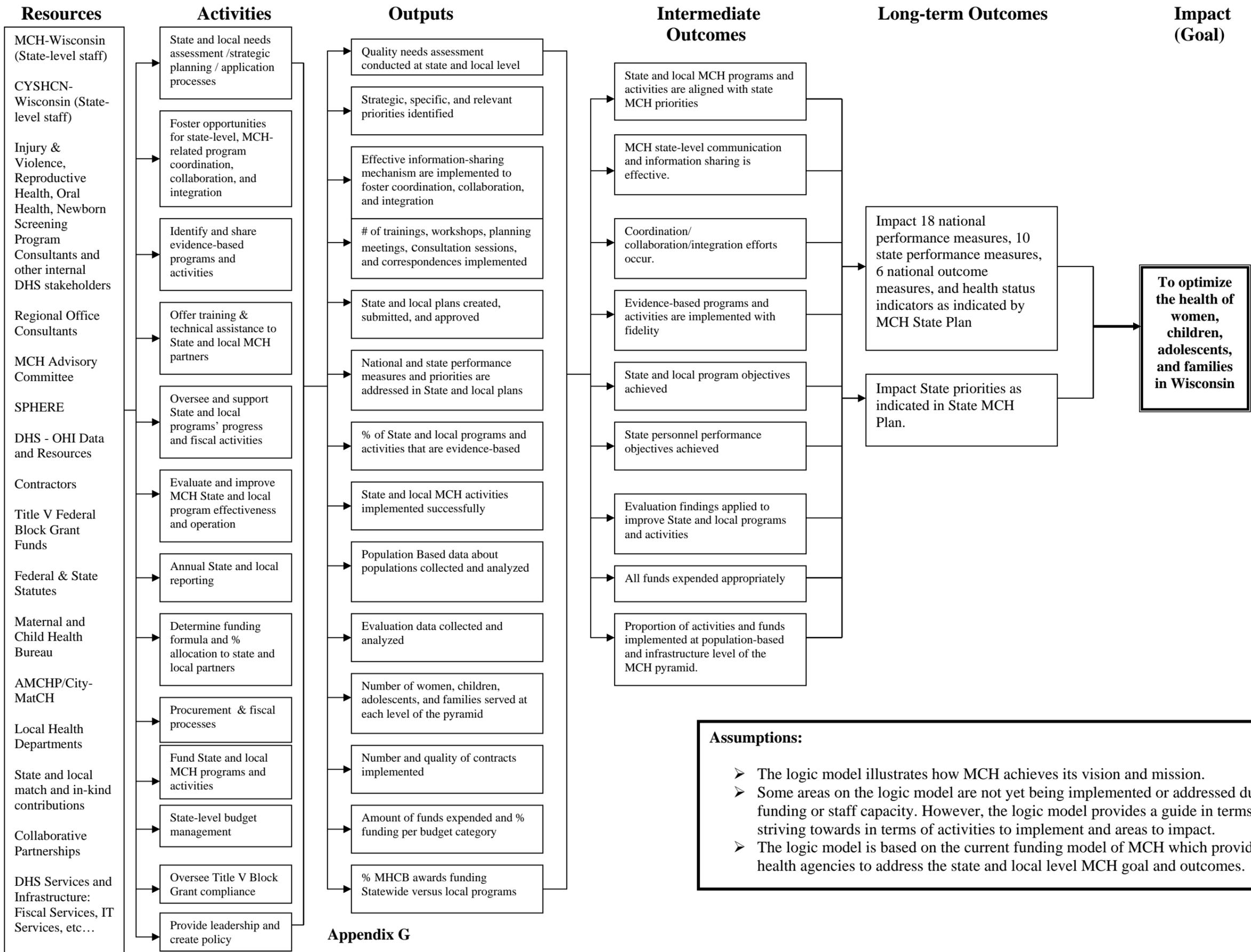
Reference	Measurement	2008	2007	2006	2005	2004	2003	2002	5 Year Trend
Start Strong - Newborn and Infant (Up to one year of age)									
HSCI 2	The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.	97.50%	96.40%	97.70%	97.50%	97.10%	95.40%	95.30%	↑
HSCI 3	The percent State Children's Health Insurance Program (SCHIP) enrollees whose ages is less than one year during the reporting year who received at least one periodic screen.	92.50%	95.40%	94.50%	95.20%	93.80%	91.20%	91.70%	↑
HSCI 5a	(MA Population/Non-MA Population/All) Percent of low birth weight (<2,500 grams)		2007 - xxx		2006 - 9 / 5.1 / 6.8		2005 - 9.1 / 5.2 / 6.9		↔
HSCI 5b	(MA Population/Non-MA Population/All) Infants deaths per 1,000 live births.		2007 - xxx		2006 - 8.6 / 4.8 / 6.5		2005 -7.8 / 4.5 / 5.9		↔
HSC I5c	(MA Population/Non-MA Population/All) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.		2007 - xxx		2006-75.4 / 90.2/ 83.7		2005-76.6 /91.5/ 84.9		↔
HSI 1a	The percent of live births weighing less than 2,500 grams.		6.99	6.8	7	7	6.8	6.6	↔
HSI 1b	The percent of live singleton birth weighing less than 2,500 grams.		5.5	5.4	5.4	5.5	6.7	5.2	↔
HSI 2a	The percent of live births weighing less than 1,500 grams.		1.2	1.2	1.3	1.2	1.3	1.3	↔
HSI 2b	The percent of live singleton births weighing less than 1,500 grams.		0.9	1	1	0.9	1	1	↔
NPM 1	Percent of newborns who received timely follow-up to definitive diagnosis & clinical management for conditions mandated by their State-sponsored NBS programs.		100%	100%	100%	100%	100%	100%	↔
NPM 11	Percentage of mothers who breastfeed their infants at 6 months of age.	27.10%	26.60%	26.00%	25.00%	25.00%	xxx	xxx	↑
NPM 12	Percentage of newborns who have been screened for hearing before hospital discharge.		97.90%	94.50%	95.60%	94.50%	94.50%	93.80%	↑
NPM 17	Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.	75.80%	74.80%	74.80%	80.60%	77.40%	80.20%	77.70%	↔
OM 1	The infant mortality rate per 1,000 live births.		6.45	6.4	6.6	6.0	6.5	6.9	↔
OM 2	The ratio of the black infant mortality rate to the white infant mortality rate.		2.72	3.5	2.7	4.3	2.9	3.3	↔
OM 3	The neonatal mortality rate per 1,000 live births.		4.01	4.3	4.5	4.0	4.4	4.7	↔
OM 4	The postneonatal rate per 1,000 live births.		2.43	2.1	2.1	2.0	2.1	2.1	↔
OM 5	The perinatal mortality rate per 1,000 live birth plus fetal deaths.		7.1	7.1	6.4	5.7	6.4	6.8	↔
SPM 9	Ratio of the black infant mortality rate to the white infant mortality rate.		2.72	3.5	2.7	4.3	2.9	3.3	↔
Grow Safe and Strong- Early Childhood (1-5 years of age)									
NPM 7	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.	79.40%	86.80%	82.30%	83%	83%	82.60%	77.40%	↑
NPM 14	Percent of children, ages 2-5 years, receiving WIC services that have a BMI at or above the 85th percentile.	29.90%	29.20%	29.30%	29%	xxx	xxx	xxx	↔

Reference	Measurement	2008	2007	2006	2005	2004	2003	2002	5 Year Trend
SPM 3	Percent of children, ages 6 months-5 years, who have age-appropriate social & emotional developmental levels.		94.30%	82.90%	22.20%	xxx	xxx	xxx	
SPM 8	Percent of children, ages 2-4, who are obese or overweight.	13.60%	13.10%	13.00%	12.90%	13.30%	13.00%	11.80%	
HSCI 1	The rate of children hospitalized for asthma (ICD-0 Codes: 493.0-493.9) per 10,000 less than 5 years of age.		24.5	27	27	26.9	29.5	25.7	
Grow Safe and Strong - School Age (6-14 years of age)									
NPM 9	Percent of third grade children who have received protective sealants on at least one permanent molar tooth.	47%	47%	47%	47%	47%	47%	47%	
HSCI 7b	The percent of EPSDT-eligible children aged 6-9 who have received any dental services during the year.		17.9	32.4	32.6	34	53.1	50.1	
Achieve Healthy Independence (Over 14 years of age)									
NPM 8	Rate of Birth (per 1,000) for teenagers aged 15 - 17 years of age.	16.1	15.6	15.6	14.9	14.9	15.5	16	
NPM 6	Percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life, including adult health care, work & independence	44.50%	44.50%	44.50%	5.80%	5.80%	5.80%	5.80%	
NPM 16	Rate (per 100,000) of suicide deaths among youths aged 15 through 19.		7.71	8.4	11	9.5	11.2	10.5	
SPM 10	Death rate per 100,000 among youth, ages 15-19, due to motor vehicle crashes.		23.12	24.5	25.7	23.5	28.8	28.1	
HSI 3c	The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.		24.94	25.7	26.3	25.5	30	28	
HSI 4c	The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.		149.28	149.3	146.7	149.5	182.5	207.6	
HSI 5a	The rate per 1,000 women aged 15-19 years with a reported case of chlamydia	29.9	28.6	28.2	28	27.8	25.6	25.2	
Live a Healthy, Productive & Satisfying Life - Reproductive Years									
NPM 15	Percent of moms who smoke in the last three months of pregnancy.		14.90%	14.90%	14.00%	xxx	xxx	xxx	
NPM 18	Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.		82.84%	83.80%	85%	85.10%	84.70%	84.20%	
SPM 1	Percent of eligible women enrolled in the WI Medicaid Family Planning Waiver during the year.			22.20%	22.70%	17.30%	xxx	xxx	
SPM 7	Percent of women who use tobacco during pregnancy.		14.90%	14.90%	13.40%	14.00%	14.00%	xxx	
HSI 5b	The rate per 1,000 women aged 20 -44 with a reported case of chlamydia.	9.63	7.4	7.4	9.1	8.5	7.6	7.1	
HSCI 4	The percent of women (15-44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80% on the Kotelchuck Index.		84.1	84.1	85.2	85.2	85.2	78.4	
HSCI 5d	(MA Population/Non-MA Population/All) Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index]).								

Reference	Measurement	2008	2007	2006	2005	2004	2003	2002	5 Year Trend
Indicators and Measures for Children Across Life Span (indicated with *****)									
HSCI 7a	Percent of Medicaid-eligible children who have received a service paid by the Medicaid Program****.	93.40%	94.3	93.9	93.6	83.6	93.4	93.3	↔
HSCI 8	The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State CYSHCN Program****.		100%	100%	100%	100%	100%	100%	↔
HSI 3a	The death rate per 100,000 due to unintentional injuries among children aged 14 yrs & younger.		9.48	7.4	9.7	7.2	8.1	8.5	↔
HSI 3b	The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.		2.48	1.8	2.8	2.9	3.6	3.8	↓
HSI 4a	The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger****.		254.74	256.1	293.3	293.2	296	352.1	↓
HSI 4b	The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger****.		21.26	23.2	26	29.7	27.3	37	↓
NPM 10	Rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.****		2.48	1.8	2.8	2.5	3.6	3.5	↓
NPM 13	Percent of children without health insurance.****		3.80%	3.80%	2.90%	2.20%	2.00%	2.60%	↑
NPM 2	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****.		65.30%	65.30%	66.60%	66.60%	66.60%	66.60%	↓
NPM 3	Percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home****.		54.60%	54.60%	57.10%	57.10%	57.10%	57.10%	↓
NPM 4	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****.		63%	63%	66.60%	66.60%	66.60%	66.60%	↓
NPM 5	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****.		90%	90%	80.70%	80.70%	80.70%	80.70%	↑
OM 6	The child death rate per 100,000 children aged 1 through 14****.		18.34	15.3	20.3	17.9	19.9	20.4	↓
SPM 2	Percent of Medicaid and BadgerCare recipients, ages 3-20, who received any dental service during the reporting year****.		22.40%	25.80%	30.20%	30.20%	xxx	xxx	↓
SPM 4	Rate per 1,000 of substantiated reports of child maltreatment to Wisconsin children, ages 0 - 17, during the year.****		5.5	5.5	6	6.1	5.7	xxx	↔
SPM 5	Percent of children who receive coordinated, ongoing comprehensive care within a medical home****.		52.50%	52.50%	51.20%	51.20%	51.20%	xxx	↔
SPM 6	Percent of children less than 12 years of age who receive one physical exam a year.****		77.10%	77.10%	83.00%	75.70%	72.60%	xxx	↑

Wisconsin Maternal and Child Health (MCH) Program Administration LOGIC MODEL

7/2009



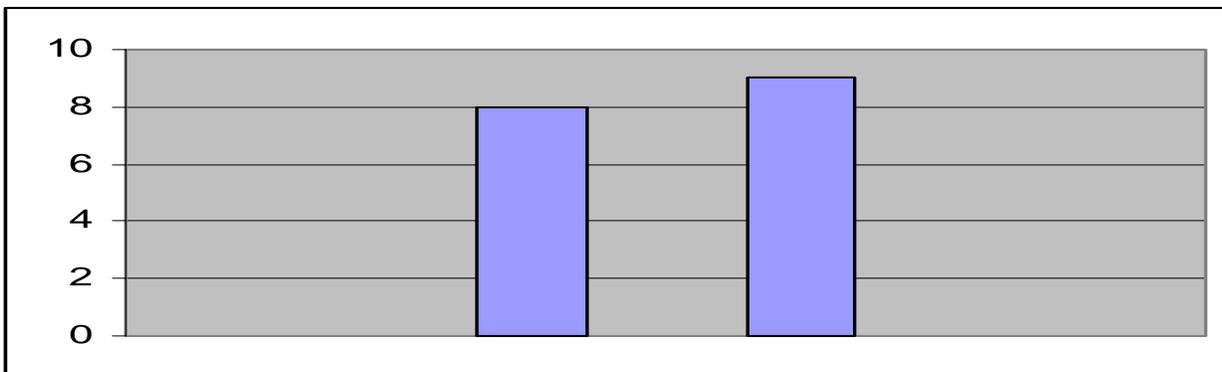
Appendix G

Appendix G

10 MCH Essential Services and Public MCH Program Functions*

1. Assess and monitor maternal and child health status to identify and address problems.

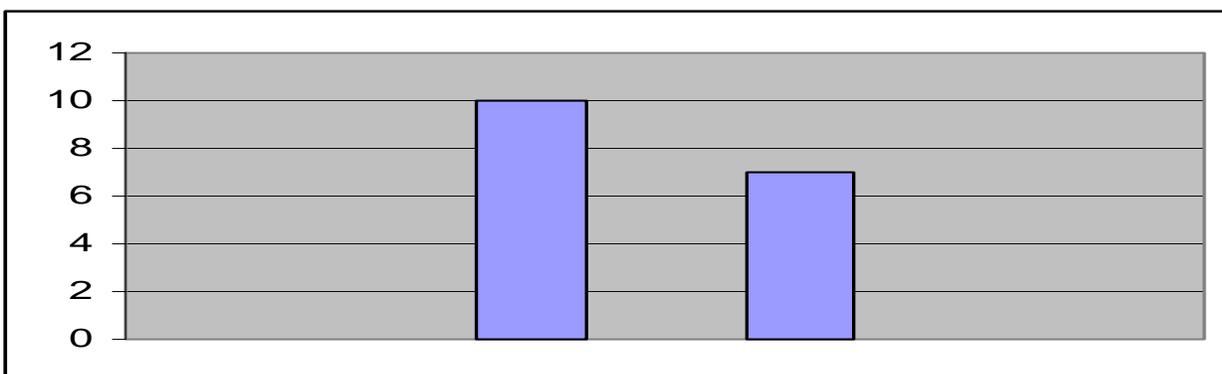
- A. Develop frameworks, methodologies, and tools for standardized MCH data in public and private sectors.
- B. Implement population-specific accountability for MCH components of data systems.
- C. Prepare and report on the descriptive epidemiology of MCH through trend analysis.



Minimally Adequate (0)	Partially Adequate (8)	Substantially Adequate (9)	Fully Adequate (0)
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2. Diagnose and investigate health problems and hazards affecting women, children, and youth.

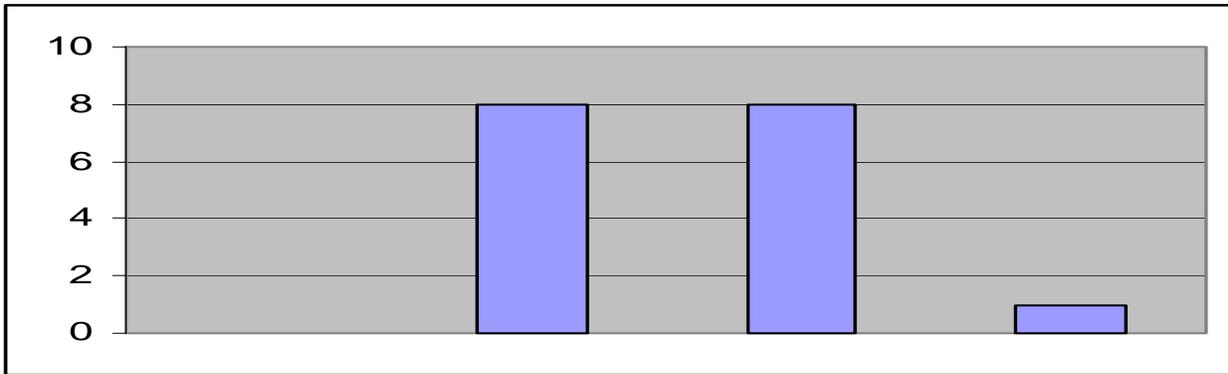
- A. Conduct population surveys and publish reports on risk conditions and behaviors.
- B. Identify environmental hazards and prepare reports on risk conditions and behaviors.
- C. Provide e leadership in maternal, fetal/infant, and child fatality reviews.



Minimally Adequate (0)	Partially Adequate (10)	Substantially Adequate (7)	Fully Adequate (0)
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3. Inform and educate the public and families about maternal and child health issues.

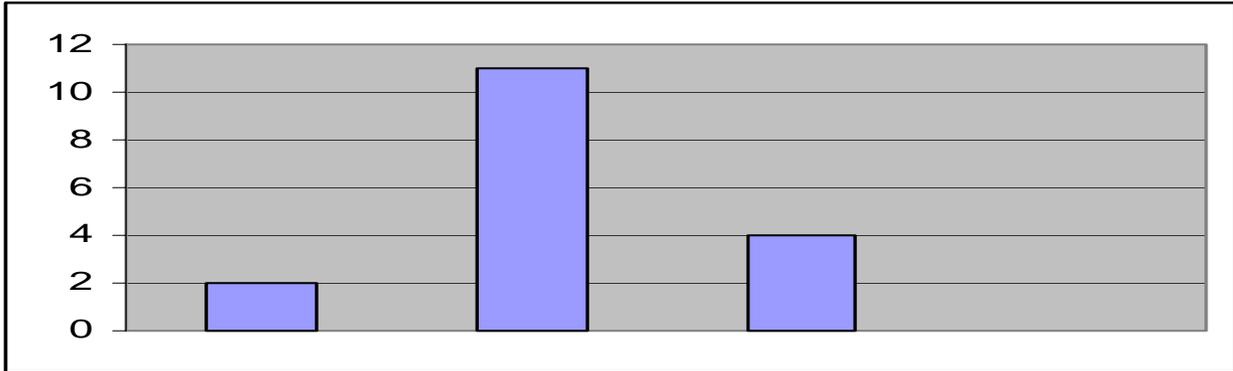
- A. Provide MCH expertise and resources for informational activities such as hotlines, print materials, and media campaigns, to address MCH problems such as teen suicide, inadequate prenatal care, accidental poisoning, child abuse and domestic violence, HIV/AIDS, DUI, helmet use, etc.
- B. Provide MCH expertise and resources to support development of culturally appropriate health education materials/programs for use by health plans/networks, MCOs, local public health and community-based providers.
- C. Implement, and/or support, health plan/provider network health education services to address special MCH problems—such as injury/violence, vaccine-preventable illness, underutilization of primary/preventive care, child abuse, domestic violence—delivered in community settings (e.g., schools, child care sites, worksites).
- D. Provide families, the general public, and benefit coordinators reports on health plan, provider network, and public health provider process and outcome data related to MCH populations based on independent assessments.



Minimally Adequate (0)	Partially Adequate (8)	Substantially Adequate (8)	Fully Adequate (1)
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4. Mobilize community partnerships between policymakers, health care providers, families, the general public, and others to identify and solve maternal and child health problems.

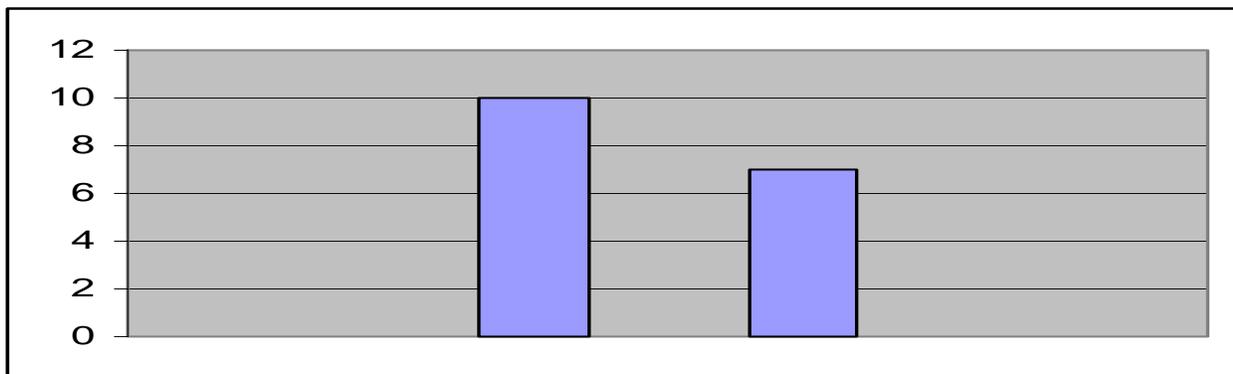
- A. Provide needs assessment and other information on MCH status and needs to policymakers, all health delivery systems, and the general public.
- B. Support/promote public advocacy for policies, legislation, and resources to assure universal access to age-, culture-, and condition-appropriate health services.



Minimally Adequate (2)	Partially Adequate (11)	Substantially Adequate (4)	Fully Adequate (0)
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5. Provide leadership for priority-setting, planning, and policy development to support community efforts to assure the health of women, children, youth and their families.

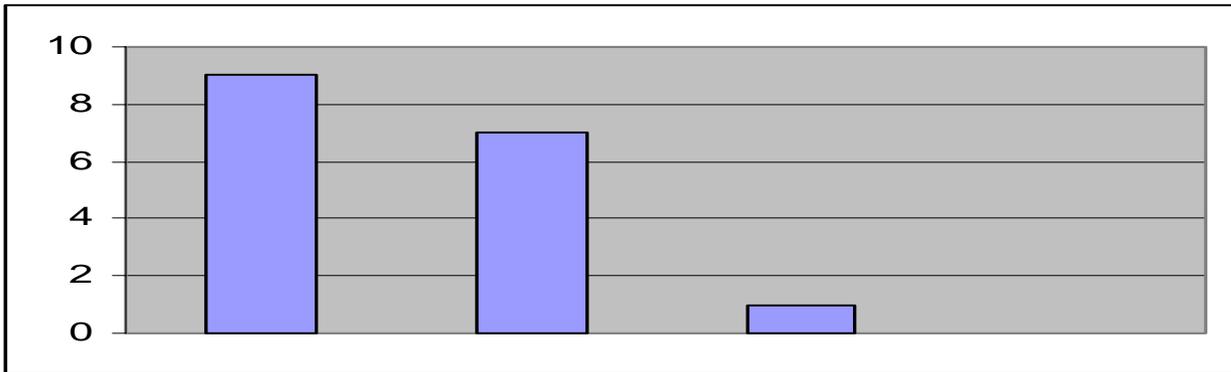
- A. Develop and promote the MCH agenda using the Year 2000 National Health objectives or other benchmarks.
- B. Provide infrastructure, communication structures and vehicles for collaborative partnerships in development of MCH needs assessments, policies, services, and programs.
- C. Provide MCH expertise to, and participate in the planning and service development efforts of, other private and public groups and create incentives to promote compatible, integrated service system initiatives.



Minimally Adequate (0)	Partially Adequate (10)	Substantially Adequate (7)	Fully Adequate (0)
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6. Promote and enforce legal requirements that protect the health and safety of women, children and youth, and ensure public accountability for their well-being.

- A. Ensure coordinated legislative mandates, regulation, and policies across family and child-serving programs.
- B. Provide MCH expertise in the development of a legislative and regulatory base for universal coverage, medical care (benefits), and insurer/health plan and public health standards.
- C. Ensure legislative base for MCH-related governance, MCH practice and facility standards, uniform MCH data collection and analysis systems, public health reporting, environmental protections, outcomes and access monitoring, quality assurance/improvement, and professional education and provider recruitment.
- D. Provide MCH expertise/leadership in the development, promulgation, regular review and updating of standards, guidelines, regulations, and public program contract specifications.
- E. Participate in certification, monitoring and quality improvement efforts of health plans and public providers with respect to MCH standards and regulations.
- F. Provide MCH expertise in professional licensure and certification processes.
- G. Monitor MCO marketing and enrollment practices.
- H. Provide MCH expertise and resources to support ombudsman services.

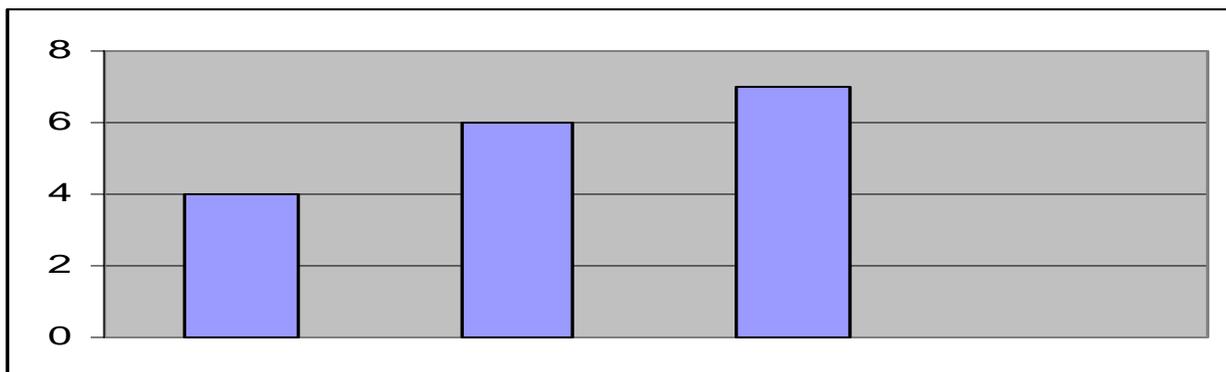


Minimally Adequate (9)	Partially Adequate (7)	Substantially Adequate (1)	Fully Adequate (0)
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7. Link women, children and youth to health and other community and family services, and assure access to comprehensive, quality systems of care.

- A. Provide a range of universally available outreach interventions (including home visiting), with targeted efforts for hard-to-reach MCH populations.
- B. Provide for culturally and linguistically appropriate staff, materials, and communications for MCH populations/issues, and for scheduling, transportation, and other access-enabling services.
- C. Develop and disseminate information/materials on health services availability and financing resources.
- D. Monitor health plan, facility, and public provider enrollment practices with respect to simplified forms, orientation of new enrollees, enrollment screening for chronic conditions/special needs, etc.
- E. Assist health plans/provider networks and other child/family-serving systems (e.g., education, social services) in identifying at-risk or hard-to-reach individuals and in using effective methods to serve them.

- F. Provide/arrange/administer women’s health, child health, adolescent health, Children with Special Health Care Needs (CSHCN) specialty services not otherwise available through health plans.
- G. Implement universal screening programs—such as for genetic disorders/metabolic deficiencies in newborns, sickle cell anemia, sensory impairments, breast and cervical cancer—and provide follow-up services.
- H. Direct and coordinate health services programming for women, children and adolescents in detention settings, mental health facilities and foster care, and for families participating in welfare waiver programs that intersect with health services.
- I. Provide MCH expertise for prior authorization for out-of-plan specialty services for special populations (e.g., CSHCN).
- J. Administer/implement review processes for pediatric admissions to long-term care facilities and CSHCN home- and community-based services.
- K. Develop model contracts to provide managed care enrollees access to specialized women’s health services, pediatric centers of excellence and office/clinic-based pediatric subspecialists and to community- site health services, (school-based health clinics, WIC, Head Start, etc).
- L. Provide expertise in the development of pediatric risk adjustment methodology and payment mechanisms.
- M. Identify alternative/additional resources to expand the fiscal capacity of the health and social services systems by providing MCH expertise to insurance commissions and public health care financing agencies, pooling categorical grant funding, and pursuing private sector resources.

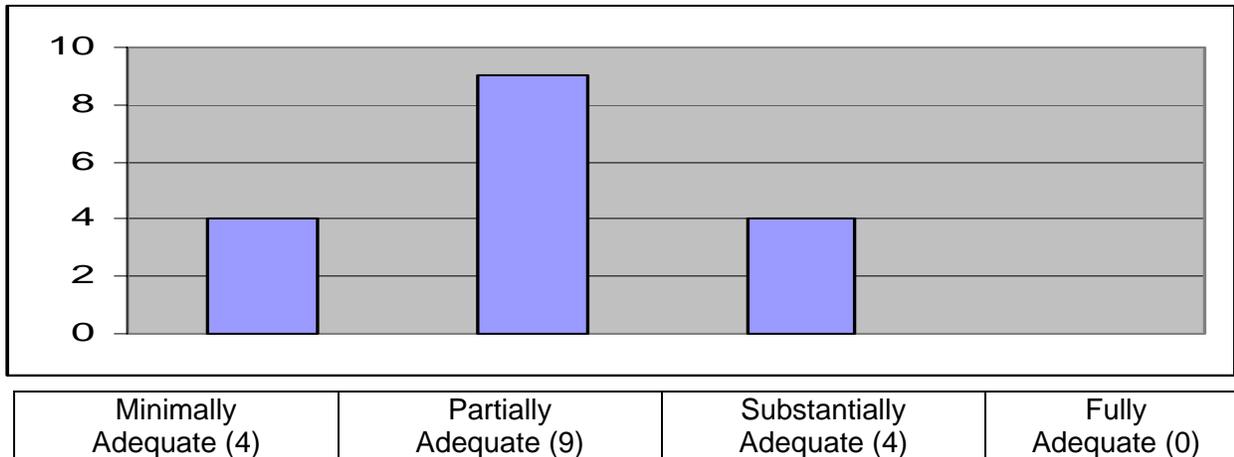


Minimally Adequate (4)	Partially Adequate (6)	Substantially Adequate (7)	Fully Adequate (0)
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8. Assure the capacity and competency of the public health and personal health workforce to effectively and efficiently address maternal and child health needs.

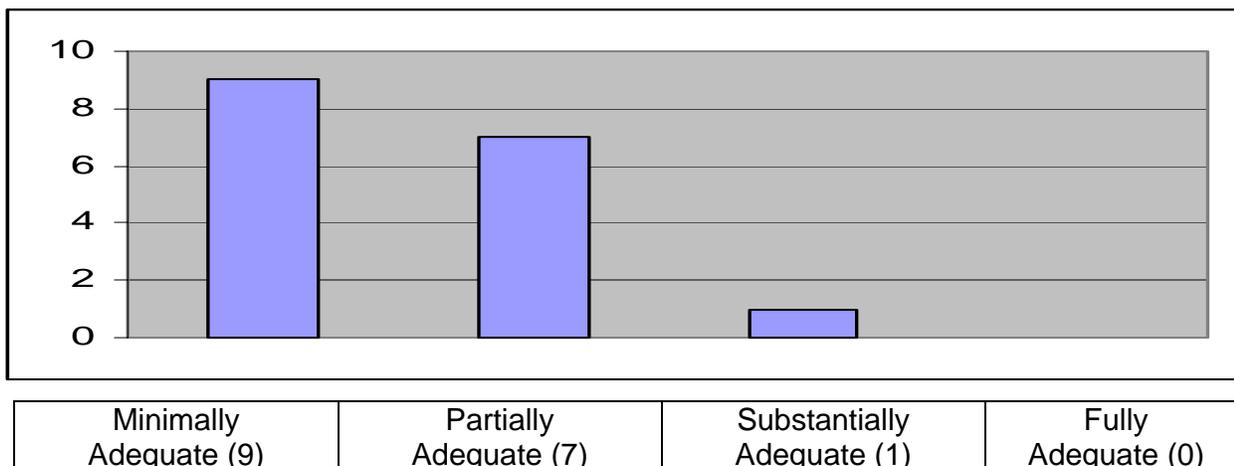
- A. Provide infrastructure and technical capacity and public health leadership skills to perform MCH systems access, integration, and assurance functions.
- B. Establish competencies, and provide resources for training MCH professionals, especially for public MCH program personnel, school health nurses and school-based health center providers, care coordinators/ case managers, home visitors, home health aides, respite workers, and community outreach workers.
- C. Provide expertise, consultation, and resources to professional organizations in support of continuing education for health professionals, and especially regarding emerging MCH problems and interventions.

- D. Support health plans/networks in assuring appropriate access and care through providing review and update of benefit packages, information on public health areas of concern, standards, and interventions, plan/provider participation in public planning processes and population-based interventions, technical assistance, and financial incentives for meeting MCH-specific outcome objectives.
- E. Analyze labor force information with respect to health professionals specific to the care of women and children (e.g. primary care practitioners, pediatric specialists, nutritionists, dentists, social workers, CNMs, PNP's, FFNP's, CHNs/PHNs)
- F. Provide consultation/assistance in administration of laboratory capacity related to newborn screening, identification of rare genetic diseases, breast and cervical cancer, STDs, and blood lead levels.



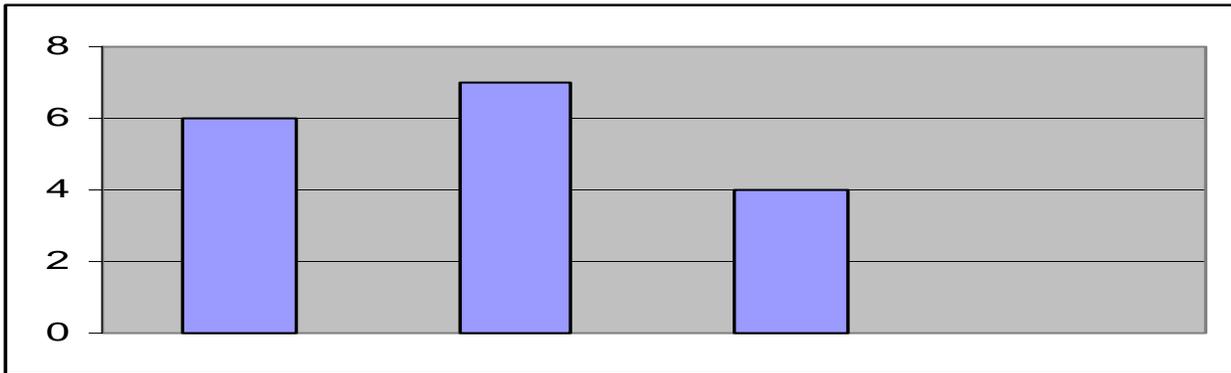
9. Evaluate the effectiveness, accessibility, and quality of personal health and population-based maternal and child health services.

- A. Conduct comparative analyses of health care delivery systems to determine effectiveness of interventions and to formulate responsive policies, standards, and programs.
- B. Survey and develop profiles of knowledge, attitudes and practices of private and public MCH providers.
- C. Identify and report on access barriers in communities related to transportation, language, culture, education, and information available to the public.
- D. Collect and analyze information on community/constituents' perceptions of health problems and needs.



10. Support research and demonstrations to gain new insights and innovative solutions to maternal and child health-related problems.

- A. Conduct special studies (e.g., PATCH) to improve understanding of longstanding and emerging (e.g., violence, AIDS) health problems for MCH populations.
- B. Provide MCH expertise and resources to promote “best practice” models, and to support demonstrations and research on integrated services for women, children, adolescents, and families.



Minimally Adequate (6)	Partially Adequate (7)	Substantially Adequate (4)	Fully Adequate (0)
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* Total Number of Votes equals 17 for each Essential Service

FEDERAL AND STATE REQUIREMENTS OF THE WISCONSIN MCH PROGRAM

Monitor how the structures, relationships, resources, workforce, funding that exist in our State are working to improve the health of families. Specifically, monitor:

Quality of health care:

- #1: The rate of children hospitalized for asthma. (Ambulatory Sensitive Condition)
- #2: The percent of Medicaid enrollees under 1 year of age who received at least one initial periodic screen. (Adequacy of Primary Care)
- #3: The percent of (SCHIP) enrollees under 1 year of age who received at least one periodic screen. (Adequacy of Primary Care)
- #4: The percent of women with a live birth during the reporting year who had 80 percent or more of the expected prenatal visits. (Prenatal Care)

Health care services provided through the State Medicaid/SCHIP Program:

- #5: Comparison of Medicaid and Non-Medicaid births on percent of low birth weight, infant deaths, first trimester prenatal care, adequate prenatal care.
- #6: Percent of poverty level for eligibility in the State's Medicaid and SCHIP programs for infant (0-1), children, Medicaid and pregnant women.
- #7a: Percent of Medicaid-eligible children, aged 1-21, who have received a service paid by the Medicaid program.
- #7b: The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.

Infrastructure of the State MCH Program:

- #8: The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State (CSHCN) Program.
- #9a: The ability of the State to assure MCH Program access to policy and program relevant information.
- #9b: The ability of the States to monitor tobacco use by children and youth.

Monitor to determine if activities (budgets, program focus, establish five-year targets, evaluation, etc.) to improve/ increase/ reduce/ decrease need to be implemented...

Low Birth Weight

Fatal and Nonfatal Unintentional Injuries

Sexually Transmitted Diseases

Service Enrollment Numbers of children enrolled in State programs such as WIC, TANF and SCHIP by race and ethnicity

Monitor Demographic Information

Conduct activities to ...

Provide information to women about **family planning & adoption** services

Conduct **outreach to low-income pregnant women**

Develop & update state plan for **community-based family planning programs**

Establish & maintain **birth defects registry**

Provide **information and follow-up counseling** for parents of victims of **SIDS**

Assure use of prophylactic agent to prevent **infant blindness**

Conduct activities (budgets, program focus, establish five-year targets, evaluation, etc.) to improve/ increase/ reduce/ decrease...

Newborn Health

- #11: Percentage of mothers who **breastfeed** their infants at 6 months of age.
- #12: Percentage of newborns who have been **screened for hearing** before hospital discharge.
- #17: Percent of very low birth weight infants delivered at **facilities for high-risk deliveries** and neonates.
- OM: Infant Death (With Comparison of Black and White Rates)

Child Health

- #7: 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.
- #14: Percent of children, ages 2-5 years, receiving WIC services that have a **BMI** at or above the 85th percentile.
- #9: Percent of third grade children who have received **protective sealants** on at least one permanent molar tooth.

Adolescent Health

- #8: Rate of **Birth (per 1,000) for teenagers** aged 15 through 17.
- #16: Rate (per 100,000) of **suicide deaths among youths** aged 15 through 19.

All Children

- #10: Rate of **deaths to children aged 14 years and younger** caused by **motor vehicle crashes** per 100,000 children
- #13: Percent of children without **health insurance**.
- OM: Child Death

Pregnant Mothers

- #15: Percent of **moms who smoke** in the last three months of **pregnancy**.
- #18: Percent of infants born to pregnant women receiving **prenatal care beginning in the first trimester**.

CYSHCN

6 core measurements of **newborn screening, parent satisfaction, community services, insurance, medical home, and transition to adult services**.

Connecting the Dots: Priorities and Measurements
 Wisconsin Maternal & Child Health Program
 2011-2015

Maternal & Child Health Priority	Title V National Performance Measure(s)	Title V State Performance Measure(s)	Title V State Health Status or Outcome Measure (if applicable)	Healthy Wisconsin 2020 Focus Area(s) and Objectives	Healthy Wisconsin 2020 Related Measurements
Reduce health disparities for women, infants, children and families, including those with special health care needs	NPM #4 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.	SPM #1 Percent of African-American women having a live birth who experience depressive symptoms after pregnancy (PRAMS)	HSI 8a. and HSI 8b. Numbers of children's deaths by race and ethnicity OM The ratio of black infant mortality rate to white infant mortality rate.	Health Disparities and Healthy Growth and Development By 2020, reduce the racial & ethnic disparities in poor birth outcomes, including infant mortality Reproductive and Sexual Health By 2020, reduce the disparities in reproductive and sexual health experienced among populations of differing races, ethnicities, etc...	Disparity Ratios for infant mortality, low birth weight (<2,500 grams), prematurity and timing of entry into Women, Infants & Children (WIC) Program Racial and ethnic disparities in teen birth rates
Increase the number of women, children and families who receive preventive and treatment health services within a medical home	NPM #3 Percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home.	SPM #2 Percent of children who have a medical home (NCHS)		Access to High-Quality Health Services Obj.#1 By 2020, assure all residents have access to comprehensive, patient-centered health services that are safe, effective, affordable, timely, coordinated & navigable	The # of certified medical home practices in the state according to NCQA

Maternal & Child Health Priority	Title V National Performance Measure(s)	Title V State Performance Measure(s)	Title V State Health Status or Outcome Measure (if applicable)	Healthy Wisconsin 2020 Focus Area(s) and Objectives	Healthy Wisconsin 2020 Related Measurements
<p>Increase the number of children and youth with special health care needs and families who access needed services and supports</p>	<p>NPM #5 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.</p> <p>NPM #2 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.</p> <p>NPM #6 Percent 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.</p>				

Maternal & Child Health Priority	Title V National Performance Measure(s)	Title V State Performance Measure(s)	Title V State Health Status or Outcome Measure (if applicable)	Healthy Wisconsin 2020 Focus Area(s) and Objectives	Healthy Wisconsin 2020 Related Measurements
Increase the number of women, men and families who have knowledge of and skills to promote optimal infant and child health, development and growth	NPM #11 Percent of mothers who breastfeed their infants at 6 months of age.	SPM #3 Percent of children age 10 months to 5 years who received a standardized screening for developmental or behavioral problems (NCHS)	OM Infant mortality rate. OM Neonatal mortality rate. OM Post-neonatal mortality rate. OM Perinatal mortality rate. OM Child death rate.	Healthy Growth and Development Obj#1 By 2020, increase the proportion of children who receive periodic developmental screening and individualized intervention	Proportion of parents reporting that a health provider assessed their child's learning, development, communication or social behavior Number of children who received services from the Birth to 3 Program during the first year of life
Increase the number of women, children and families who have optimal mental health and healthy relationships	NPM #16 Rate (per 100,000) of suicide deaths among youths aged 15 through 19.	SPM #4 Rate per 1,000 of substantiated reports of child maltreatment (DCF) SPM #1 Percentage of African-American women having a live birth who experience depressive symptoms after pregnancy (PRAMS)		Mental Health By 2020, reduce the rate of depression, anxiety and emotional problems among children with special health care needs Reproductive and Sexual Health By 2020, establish a norm of sexual health and reproductive justice across the life span as fundamental to the health of the public	Percent of children who have depression, anxiety or emotional problems Percent of CSHCN and non-CSHCN who received mental health treatment in the past year Incidence of intimate violence and hate crimes

Maternal & Child Health Priority	Title V National Performance Measure(s)	Title V State Performance Measure(s)	Title V State Health Status or Outcome Measure (if applicable)	Healthy Wisconsin 2020 Focus Area(s) and Objectives	Healthy Wisconsin 2020 Related Measurements
<p>Increase the number of women, men and families who have knowledge of and skills to promote optimal reproductive health and pregnancy planning</p>	<p>NPM #8 Rate of Birth (per 1,000) for teenagers aged 15-17 years of age.</p> <p>NPM #15 percent of moms who smoke in the last three months of pregnancy.</p> <p>NPM #17 Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.</p> <p>NPM #18 Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester</p>	<p>SPM #5 Percent of eligible women enrolled in the Wisconsin Medicaid Family Planning Waiver during the year (DHS)</p> <p>SPM #6 Percentage of women having a live birth who reported having an unintended or unwanted pregnancy (PRAMS)</p>	<p>OM Maternal Mortality rate.</p>	<p>Healthy Growth and Development By 2020, provide pre-conception & inter-conception care to Wisconsin women in population groups disproportionately affected by poor birth outcomes</p> <p>Reproductive and Sexual Health By 2020, establish a norm of sexual health and reproductive justice across the life span as fundamental to the health of the public</p>	<p>Rates of avoidable infant and fetal death</p> <p>Percentage of births that are to women with avoidable risks for poor birth outcomes</p> <p>Percentage of sexually active high school students who reported that they or their partner had used a condom during last sexual intercourse</p> <p>Unintended pregnancy rates</p>

Maternal & Child Health Priority	Title V National Performance Measure(s)	Title V State Performance Measure(s)	Title V State Health Status or Outcome Measure (if applicable)	Healthy Wisconsin 2020 Focus Area(s) and Objectives	Healthy Wisconsin 2020 Related Measurements
<p>Increase the number of women, children and families who receive preventive screenings, early identification and intervention</p>	<p>NPM #1 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.</p> <p>NPM #12 Percent of newborns who have been screened for hearing before hospital discharge.</p>	<p>SPM #7 Percent of children under 1 year of age enrolled in Wisconsin's Birth to 3 Program (DHS)</p> <p>SPM #3 Percent of children age 10 months to 5 years who received a standardized screening for developmental or behavioral problems (NCHS)</p>		<p>Healthy Growth and Development Obj#1 By 2020, increase the proportion of children who receive periodic developmental screening and individualized intervention</p>	<p>Proportion of parents reporting a health provider's assessment of child's learning, development, communication or social behavior</p>
<p>Increase the number of women, children and families who live in a safe and healthy community</p>	<p>NPM #10 Rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children</p>		<p>HSI 3a. The death rate among children aged 14 years and younger due to unintentional injuries.</p> <p>HSI 4a. The rate of all nonfatal injuries among children aged 14 years and younger.</p>	<p>Injury and Violence Prevention Reduce the leading causes of injury & violence through policies and programs that create safe environments</p>	

Connecting the Dots
Wisconsin Maternal & Child Health Program
2011 - 2015

The Title V MCH Program will engage in collaborative activities with DHS partners to impact the following National Performance Measurements not identified above in the 2011 - 2015 priorities...

- NPM #7** 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
(Primary Partner: Immunization Program)
- NPM #9** Percent of third grade children who have received protective sealants on at least one permanent molar tooth
(Primary Partner: Oral Health Program)
- NPM#13** Percent of children without health insurance
(Primary Partner: Division of Access and Accountability)
- NPM#14** Percent of children, ages 2-5 years, receiving WIC services that have a BMI at or above the 85th percentile
(Primary Partner: Nutrition & Physical Activity Program)

Appendix J