C. National Performance Measures

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	95	124	117	119	106
Denominator	95	124	117	119	106
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	100	100	100	100	100

Notes - 2007
Source: Numerator: NBS program, State Lab of Hygiene, Wisconsin, 2007. The number of infants that were confirmed with a condition through newborn screening and who receive appropriate follow-up care.
Denominator: NBS program, State Lab of Hygiene, Wisconsin, 2008. The number of screened through NBS and confirmed with a condition.
Wisconsin screens for 47 congenital disorders. Every newborn with an abnormal NBS result is tracked by the NBS Program to a normal result or appropriate clinical care.

Notes - 2006
Source: Numerator: NBS program, State Lab of Hygiene, Wisconsin, 2007. The number of infants that were confirmed with a condition through newborn screening and who receive appropriate follow-up care.
Denominator: NBS program, State Lab of Hygiene, Wisconsin, 2007. The number of screened through NBS and confirmed with a condition.
Wisconsin screens for 47 congenital disorders. Every newborn with an abnormal NBS result is tracked by the NBS Program to a normal result or appropriate clinical care.

Notes - 2005
Source: Numerator: NBS program, State Lab of Hygiene, Wisconsin, 2005. The number of infants that were confirmed with a condition through newborn screening and who receive appropriate follow-up care.
Denominator: NBS program, State Lab of Hygiene, Wisconsin, 2005. The number of screened through NBS and confirmed with a condition.
Wisconsin screens for 47 congenital disorders. Every newborn with an abnormal NBS result is tracked by the NBS Program to a normal result or appropriate clinical care.

a. Last Year's Accomplishments

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

In 2007, 70,666 infants were screened for 47 different congenital disorders. 106 infants were confirmed with a condition screened for by the NBS Program and 100% were referred for appropriate follow-up care.

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

The Department provided necessary diagnostic services, special dietary treatment as prescribed by a physician and follow-up counseling for the patient and his or her family through contracts with specialty clinics and local agencies. Five cystic fibrosis centers, three metabolic clinics, one sickle cell comprehensive care center, one genetics center, and a local health department receive these contracts.

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

The Education Subcommittee of the NBS Advisory Group explored mechanisms to increase provider knowledge and awareness of the screening process. Based on recommendations of the subcommittee, a two-part webcast series was developed and presented live in September, 2007. The series was heavily promoted and a large number of providers viewed one or both webcasts. The series is now archived and available for viewing. Topics of the webcast included a history of NBS in Wisconsin, how to properly draw and prepare a sample, the role of the primary care provider, and how to talk to parents about the screen. The subcommittee also initiated quarterly newsletters to birth hospital coordinators with regular updates and reminders about newborn screening.

The Wisconsin NBS Program continues to participate in the HRSA "Region 4 Genetics Collaborative" grant with Wisconsin representatives in all workgroups. The regional collaborative allows states to share expertise in new technologies and best practice models to maximize available newborn screening resources.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Newborn Screening			X	
2. Diagnostic Services	X			
3. Development of Educational Materials		X		

b. Current Activities

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

The Wisconsin NBS Program currently screens all infants for 47 congenital disorders. In 2008, on the recommendations of the NBS Advisory Group, the Program discontinued screening for malonic acidemia and initiated screening for Severe Combined Immunodeficiency (SCID). Wisconsin is the first NBS Program in the nation to screen for SCID. Mechanisms for effective confirmatory testing and follow-up are also in place. An Immunodeficiency Subcommittee of the Newborn Screening Advisory Group has been established and will meet for the first time in the first half of 2008.

In March 2008, a Newborn Screening Coordinator was hired to coordinate Congenital Disorders Programming at the Division of Public Health, a role previously assumed by the State Genetics Coordinator. The NBS Coordinator will work with contracted agencies to promote and improve the NBS Program.

The NBS Program is working with the Wisconsin Hearing Screening Program, Vital Records, and the Birth Defects Surveillance System to link newborn screening data with other birth data. An infant's newborn screening card number will be included on the birth certificate and, in the future, will be used to link the results to other data.

c. Plan for the Coming Year

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

In 2009, all infants born in Wisconsin will continue to be screened at birth for a minimum of 47 congenital disorders.

The NBS Advisory Group and its Cystic Fibrosis, Metabolic, Hemoglobinopathy, Endocrine, Immunodeficiency, and Education subcommittees will meet at least biannually to advise the Department regarding emerging issues and technology in NBS.

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

The Department will implement a paper-based tracking system for NBS dietary services in preparation for a web-based system. Tracked services will include the provision of dietary formulas and medical food products to children with conditions screened for by NBS by dietitians at contracted specialty centers.

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

The NBS Advisory Group Education subcommittee will educate the public and medical providers about Severe Combined Immunodeficiency (SCID) and its addition to the newborn screening panel. The subcommittee will continue to improve communication with the NBS program and hospitals through e-newsletters and other means as the NBS laboratory moves to 7-day-a-week operations. The subcommittee will develop a module for childbirth educators about newborn screening to be presented to parents-to-be during childbirth education classes.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	67.6	68.6	69.6	70	70.5
Annual Indicator	66.6	66.6	66.6	65.3	65.3
Numerator	47,819	47,819	47,819	132,074	132,074
Denominator	71,816	71,816	71,816	202,257	202,257
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	71	71.5	72	72.5	71

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

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

In 2007, the following services were provided: 87 families were matched through the WI Parent to Parent Program; 73 families received health education through Family Voices of WI (FVW); and 1,585 families received individual information and assistance through the five Regional CYSHCN Centers and their subcontracted agencies, which provided three primary methods for enhancing the capacity of parents to be decision makers, partners and leaders and offer parents an avenue to develop an informal network of support. For the first time, non-English speaking families were trained to be Parent to Parent support parents and efforts to identify match parents began. In collaboration with the MCB Integrated Services grant (WISC-I), 120 families with complex health benefits challenges received intensive health benefits counseling from ABC for Health, a non-profit health advocacy firm in Madison.

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

In 2007, the CYSHCN Program contracted with FVW to provide: a newsletter, which is distributed both electronically and hard copy, three times per year; technical assistance to Regional Centers; policy updates; and health benefits training targeting CYSHCN from under-represented populations. The outreach to underserved populations resulted in non-English speaking families receiving both Parent to Parent and Family Voices trainings and materials in Spanish.

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

Parents continued to be utilized in a variety of advisory capacities including: the MCH and CYSHCN Programs and FVW co-facilitated both the strategic planning for Wisconsin's Medical Home Spread and a listening session for parents at the annual Circles of Life Conference. Each Regional Center and Family Voices support parents to be linked to councils at the local, regional or state levels. At the listening session we learned that while only 25-33% of the attendees were aware of the Regional CYSHCN Centers, parents who had used the centers or Parent to Parent found these services valuable. The staff at the Regional Centers, Family Voices and Parent to Parent all serve on a range of councils and committees to advance the performance measure to address families as partners in decision-making at all levels. In 2007 the Regional Center directors delineated the collective council representation and identified parent representation, duplication, gaps and made plans for refinement.

CYSHCN program staff provided input at a National gathering, "Family Perspectives on Autism Service Guidelines for the Medical Home", to forward the Autism Service Guidelines and system requirements that were developed by a multi-disciplinary expert work group and were presented to the federal Interagency Autism Coordinating Committee. The guidelines address the core principles of an integrated and coordinated service system for autism services within and through the medical home. This meeting considered what it will take to influence national policy for improvement of systems of care for individuals with Autism Spectrum Disorders. The Autism Service Guidelines articulate best practice for serving children with ASD and their families in medical home primary care practices, working in collaboration and with the support of other professionals and professional organizations, government, health, education, and social services.

4. Family Partnerships--Infrastructure Building Services--CYSHCN

In 2007, parents of CYSHCN were part of the staff of the State CYSHCN Program, all five Regional Centers, Parent to Parent and Family Voices, making parents integral to the ongoing decision-making, program implementation and evaluation. CYSHCN partners have formed a

Collaborators Network which communicates regularly to share resources, problem solve difficult issues and identify unmet needs in the state. A subgroup of the Network consists of staff providing information and referral (I & R) services to families and this group began monthly teleconferences and a listserv in 2007 to increase the level of communication. Family Voices tracks policies that impact families and was effective in bringing the needs of CYSHCN on waiting lists to the attention of policy makers resulting in new funding for long term care.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Family Support Services		X		
2. Coordination with Family Leadership and Support			X	
3. Participation of Families on Advisory Committees to the MCH and CYSHCN Program				X
4. Family Partnerships				X

b. Current Activities

1. Family Support Services--Enabling Services--CYSHCN

In 2008, families receive parent matching, training and information and assistance. In April, WISC-I's intensive health benefits counseling with families ended, yet ABC for Health continues to provide general supports to the Network.

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

In 2008, the CYSHCN Program contracts with FV to provide: a newsletter three times per year; listserv; policy updates; and health benefits training for under-represented populations including Great Lakes Inter-Tribal Council's (GLITC) parents.

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

Parents continue to be utilized in a variety of advisory capacities through Regional Centers and Family Voices who link parents to committees, with an emphasis on outreach to underserved parents. A new Regional Center brochure was developed with family input at every step.

4. Family Partnerships--Infrastructure Building Services--CYSHCN

In 2008, parents continue to be part of the staffing at all levels of the CYSHCN Program. The CYSHCN Collaborators Network met at GLITC to learn more about Indian Health Services and Tribal cultures, and the implications for parents as decision makers. Family Voices tracks policies that impact families and was effective in bringing the needs of CYSHCN on waiting lists to the attention of policy makers.

c. Plan for the Coming Year

1. Family Support Services--Enabling Services--CYSHCN

In 2009, families will continue to be matched through the WI Parent to Parent Program, receive health education through FVW and will be offered information and assistance through the five Regional Centers. ABC for Health will continue to provide general supports to the CYSHCN Collaborators Network around the complexity of health insurance eligibility and benefits.

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

In 2009, the CYSHCN Program will continue to contract with FVW and dove-tail these activities with those of the Family to Family Health Information Network grant that FVW has through

MCHB. FV will provide the following: a newsletter three times per year; health benefits training targeting CYSHCN from under-represented populations; unmet needs collection, analysis and dissemination; and assistance in Regional Center transition to adult health care trainings. FVW will continue to build a parent network as it addresses the above activities. The outreach to underserved populations continues to target Southeast Asian, African American, Hispanic, and Native American families.

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

Parents will continue to be utilized in a variety of advisory capacities through Regional Centers and Family Voices who support parents to be linked to a council or committee at a local, regional or state level. The staff at the Regional Centers, Family Voices and Parent to Parent will continue to serve on a range of councils and committees to advance the CYSHCN NPO on parents as decision makers.

4. Family Partnerships--Infrastructure Building Services--CYSHCN

In 2009, parents will continue to be part of the staffing at all levels of the CYSHCN Program. The CYSHCN Collaborators Network will meet annually and by conference call so that the CYSHCN system for building parents as partners can be coordinated across programs. The I & R group continues to benefit from regular contact so that the staff understand the ever changing health benefits system and can educate families about community resources and insurance eligibility and benefits. Family Voices will continue to track unmet needs in collaboration with the CYSHCN partners so that family needs are articulated on a policy level.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	58.1	59.1	60.1	60.5	61
Annual Indicator	57.1	57.1	57.1	54.6	54.6
Numerator	98,758	98,758	98,758	110,432	110,432
Denominator	173,017	173,017	173,017	202,257	202,257
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	55	57	58	59	60

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments
1. Medical Home Education and Training--Population-Based Services--CYSHCN

In conjunction with the Wisconsin Integrated Systems for Communities Initiative (WISC-I) grant, the CYSHCN Program held the third annual Medical Home Summit on November 15, 2007 with 138 registered participants. The plenary panel on care coordination, facilitated by a Regional Center, gave participants concrete strategies for change. The panel on Wisconsin-specific initiatives, facilitated by Family Voices of WI (FVW), addressed: children's long term care; local community health centers; electronic health records; and the role of state legislators. Sectionals on developmental screening, outcomes/financing, transition from pediatrics to adult health care, partnership building and links to community care were all addressed with state leaders in these areas.

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

As part of Spread, dissemination of the concepts of Medical Home continued to be integrated in the Wisconsin Sound Beginnings (Early Hearing Detection and Intervention) and Congenital Disorders (blood spot newborn screening) Programs. The Medical Home Toolkit has been disseminated using a variety of methods, including face-to-face presentations at primary practice offices. The Toolkit had approximately 1,500 visits/month in 2007. The Medical Home Local Capacity Building grants, administered by each Regional CYSHCN Center, were in the second year of the first cycle. As part of the WISC-I grant, five medical home quality improvement mini-grants were awarded to primary practice teams in three regions of the state. The pre and post Medical Home Short Index showed improvements in key areas. Distribution has included the Tips for Families/Providers brochures through CYSHCN Collaborators network.

3. Medical Home and Community Supports--Infrastructure Building Services--CYSHCN

The Regional CYSHCN Centers continued to develop relationships with individual primary care providers in their region to assist with community connections, information and referrals. The state CYSHCN Program continued its collaborative activities with the National Medical Home Autism Initiative, the Division of Health Care Financing and the two pediatric tertiary care facilities in Wisconsin. Statewide spread planning continued with FVW. The Medical Home Tertiary Care Transition Learning Collaborative, supported through the WISC-I grant, partnered with other CYSHCN initiatives as it brought together interdisciplinary teams to hear from youth, parents and medical providers about transitioning from pediatrics to adult health care. Product development and data collection were continued from the previous year.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Medical Home Education and Training			X	
2. Medical Home Outreach			X	
3. Medical Home and Community Supports				X

b. Current Activities
1. Medical Home Education and Training--Population-Based Services--CYSHCN

In 2008, the CYSHCN Program will continue Medical Home Toolkit improvements adding new resources from local grantees and learning collaborative participants. FVW and Regional Centers will continue to integrate Medical Home concepts and strategies into their information-sharing and training.

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

The Medical Home Local Capacity Building grants, administered by each Regional Center, are in the first year of the second cycle. The annual grantee meeting will focus on cultural competency as integral to Medical Home. Key Medical Home spread activities, which began with WISC-I (which ended in April) will be continued through Regional Centers and the Practice Group on Health.

3. Medical Home and Community Supports--Infrastructure Building Services--CYSHCN

The Regional CYSHCN Centers will reach out to new individual providers in their regions to assist with community connections, information and referrals. Partnerships strengthened through WISC-I will continue to develop as the Regional Centers assume responsibility for follow-up with the learning collaborative with tertiary care specialty clinics. The CYSHCN Program and the National Medical Home Autism Initiative partner to share information, support practice sites, and participate in state and regional planning.

c. Plan for the Coming Year

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

The CYSHCN Program will continue to implement improvements to its Medical Home Toolkit to include new resources and in response to product evaluation data. Family Voices and Regional Centers will continue to integrate Medical Home concepts and strategies into their information-sharing and training.

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

The Medical Home Local Capacity Building grants, administered by each Regional Center, will be in the second year of the second cycle. The annual grantee meeting will further strengthen Medical Home spread and quality improvement strategies. Regional Centers will promote early screening and identification to their grantees and link them to training and materials if needed.

3. Medical Home and Community Supports--Infrastructure Building Services--CYSHCN

The CYSHCN State Program and its contracted agencies will continue to promote Medical Home spread and offer technical assistance supports through work with key partners on the local, regional and state levels. Promotion will include targeting children's hospitals and pediatric units within hospitals, primary care practices, local health departments, state and community partners, and parents who have CYSHCN. The CYSHCN Program will continue to facilitate discussion with Health Care Access and Accountability and the two pediatric tertiary care facilities in Wisconsin to explore the spread of reimbursement for care coordination for children with complex medical needs.

The Regional CYSHCN Centers, in collaboration with Birth to Three and physician champions will implement a training in each region that targets primary care medical providers to adopt early screen practices, validated tools and links to community resources.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	66.6	67.6	68.6	69	69.5
Annual Indicator	66.6	66.6	66.6	63.0	63.0

	2008	2009	2010	2011	2012
Numerator	117,664	117,664	117,664	127,442	127,442
Denominator	176,641	176,641	176,641	202,257	202,257
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	64	65	66	67	68

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

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

In collaboration with funding through Wisconsin Integrated Systems for Communities Initiative (WISC-I) grant, the five Regional CYSHCN Centers completed a Health Benefits Self-Assessment. Training needs were identified and addressed by ABC for Health through monthly conference calls and webcasts.

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

Three of the five Regional CYSHCN Centers co-facilitated Health Watch Committees with a focus on oral and mental health.

3. Access to Dental Care Services--Infrastructure Building Services--CYSHCN

Regional Oral Health Consultants continued to provide oral health prevention programs in the (5) DPH public health regions. Working within local communities the consultants utilized an interdisciplinary approach to case management and treatment services focusing on CYSHCN. 'Smile Abilities' was a presence at the Circles of Life Conference providing information and support to families.

4. Mental Health Services for CYSHCN--Infrastructure Building Services--CYSHCN

The CYSHCN Health Promotion Consultant serves on the DHFS Infant Mental Health Leadership Team which lends guidance to the Wisconsin Alliance for Infant Mental Health initiative on implementing the Wisconsin Infant and Early Childhood Mental Health Plan. DHFS created an Infant Mental Health Leadership Team to address the infant mental health goal in the Governor's Kids First Initiative supporting the Infant Mental Health and Early Childhood Plan for Wisconsin. As part of that plan that addresses access to services, the following initiatives were begun in 2007: development of a service plan for children with a DC:0-3R diagnoses; implementation of a mental health screen for children in the child protective services system; development and

implementation of provider training on early child development; and the provision of technical assistance regarding raising emotionally attached children to early childhood community groups.

5. Family Education and Training--Enabling Services--CYSHCN

The CYSHCN Program contracted with Family Voices of Wisconsin (FVW) to implement health benefits and community supports training for parents in each of the five DPH regions. The trainers were parents of CYSHCN.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Health Benefits Services		X		
2. Access to Health Insurance				X
3. Access to Dental Care Services				X
4. Mental Health Services for CYSHCN				X
5. Family Education and Training		X		

b. Current Activities

1. Health Benefits Services--Enabling--CYSHCN

The Regional CYSHCN Center staff completed the Health Benefits post self-assessment. ABC for Health is reviewing the information and will continue training and technical assistance on the Badger Care Plus system.

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

The Regional Centers continued one of their core services in assisting families to secure health insurance through information, referral and follow-up.

3. Access to Dental Care Services--Infrastructure Building Services--CYSHCN

Expansion continued for the HRSA funded Wisconsin Community-based System of Oral Health for CYSHCN. Through collaboration with the regional CYSHCN centers, public/private schools, and Head Start, the Regional Oral Health Consultants provide case management, education, and treatment follow up for at least 25 families.

4. Mental Health Services for CYSHCN--Infrastructure Building Services--CYSHCN

The "2007 Annual Report and Fact Sheet for the Dept. Infant Mental Health Leadership Team" was competed and forwarded to the Governor. This Team's charge is to identify ways that DHFS can weave infant mental health practices and principles into the Departments' programs and services.

5. Family Education and Training--Enabling Services--CYSHCN

Parent trainers of FVW continue to offer family members training regarding health insurance and community supports with the support of the CYSHCN Regional Centers.

c. Plan for the Coming Year

1. Health Benefits Services--Enabling Services--CYSHCN

ABC for Health is reviewing results of the post self-assessment and will the provide analysis. The CYSHCN Program and Medicaid are planning a web cast training on BadgerCare Plus. ABC for Health will continue its web casts and case study calls through the WISC-I grant period and questions regarding complex legal issues will be referred to ABC for Health.

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

The Regional Centers will continue one of their core services in assisting families to secure health insurance through information, referral and follow-up. Two of the Regional Centers maintain a local Health Watch Committee and two attend local meetings, to identify and address health related needs for CYSHCN. The Southeast Region has a focus on the BadgerCare Plus Program.

3. Access to Dental Care Services--Infrastructure Building Services--CYSHCN

The Department, in collaboration with the Children's Health Alliance of Wisconsin (CHAW), received funding through HRSA for the Wisconsin Community-based System of Oral Health for Children with Special Health Care Needs. Seven Regional Oral Health Consultants will be placed within the (5) DPH regions. They will work directly with the regional CSYHCN centers providing technical assistance, program development, case management and prevention services to CYSHCN and their families. The grant will allow for the hands on training of dental health personnel to reduce a major barriers to care for CYSHCN.

4. Mental Health Services for CYSHCN--Infrastructure Building Services--CYSHCN

The Wisconsin Infant Mental Health Leadership Team selected the following goals for 2008-2010 to address the service needs of children to include: standardization of screening objectives across diverse divisions and systems of care; integration of children's mental health and primary health care services; full implementation of DC:0-3R in Wisconsin; and training and technical assistance on DC:0-3R.

In addition, the Children's Committee of the Wisconsin Mental Health Council will be addressing the shortage of child and adolescent psychiatrists including parity issues. With 8.2 psychiatrists per 100,000 youths, Wisconsin is near the national average for psychiatrists however, it is below the 14.4 needed for optimum patient care. Nearly 90,000 school-age children in Wisconsin have a mental illness. Only 15.6% of these children received public mental health services in 2005. In addition, the Wisconsin Autism Developmental Disability Monitoring (ADDM) Network Project reported that 5.2 per 1,000 children in Wisconsin have an Autism Diagnosis and are in need of mental health services.

5. Family Education and Training--Enabling Services--CYSHCN

Parent trainers of FVW will continue to offer family members training regarding health insurance and community supports with the support of the Regional Centers.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	81.7	82.7	83.7	84	84.5
Annual Indicator	80.7	80.7	80.7	90.0	90.0
Numerator	57,768	57,768	57,768	182,031	182,031
Denominator	71,620	71,620	71,620	202,257	202,257
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and					

2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.

Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	91	91	92	92	93

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

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

Individuals, families, and providers who contact the five Regional CYSHCN Centers and their subcontracted agencies received direct assistance, referrals to other professionals, or other interventions by Center and local staff. In 2007, according to the data entered in the MCH Secure Public Health Electronic Record Environment (SPHERE), there were 4,542 CYSHCN-funded contacts and services provided, with 1,585 individual/household interventions and 2,817 brief contacts. "Brief contacts" include consultations that are face-to-face, on the telephone, and/or in writing.

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

This year the Northeast Regional CYSHCN Center terminated their contract due to budgetary constraints and an RFP process was implemented to identify and secure a new vendor. Children's Hospital of Wisconsin-Fox Valley in Neenah was awarded the contract to begin January 1, 2008. This vendor brings a high level of content expertise, institutional commitment, and links to the community.

Partnerships at the local, regional and state levels were advanced through co-sponsored events, established cross-referral plans and identified target populations that are vulnerable to falling through the cracks. The CYSHCN and its Regional Centers have delineated the key committees and conferences where CYSHCN representation is critical and an outreach plan specifies responsibilities over the state.

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

Working in partnership with other funding sources, the WI Title V CYSHCN Program continued to plan and implement statewide training of nine WIC nutritionists who work with Regional Centers to improve nutritional services for CYSHCN.

Wisconsin was awarded a MCH Targeted Oral Health Service Systems Grant entitled "Wisconsin Community-based System of Oral Health for CYSHCN." This four year grant is administered through the Children's Health Alliance of Wisconsin.

Collaboration with the WISC-I grant led to establishment of the CYSHCN Collaborators Network comprised of the CYSHCN-funded entities; the five Regional Centers, Family Voices, Parent to Parent, First Step, GLITC, ABC for Health, the oral health coordinators and the WIC nutritionists. This group met regularly by phone and once a year face-to-face.

The Title V CYSHCN Program continues to work collaboratively with many partners to assure that that children and youth with special health care needs are identified early, receive coordinated care and that their families have access to the supports they need. These collaborative partnerships include: Parent to Parent; Family Voices of Wisconsin; Great Lakes Inter Tribal Council; ABC for Health; First Step; WI Chapter of the AAP and WAFP; early intervention ICC; Wisconsin Early Childhood Collaborating Partners; Department of Public Instruction's Wisconsin Statewide Parent-Educator Initiative; the Parent Training and Information Center- WI FACETS; statewide Wisconsin Asthma Coalition; Wisconsin Infant Mental Health Association; and the Circles of Life Planning Conference.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Access to Individual/Household Services		X		
2. Community Based and System Based Services			X	
3. Planning and Implementing Community Based Projects				X

b. Current Activities
1. Access to Individual/Household Services--Enabling Services--CYSHCN

In 2008, the five Regional Centers and their delegate agencies continue to provide information and assistance to families and providers. Local Health Departments (LHD) continue to have the option of providing these serves at a local level. Families are linked to trainings and parent support opportunities to meet their needs.

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

Regional CYSHCN Centers administer 12 Medical Home local community capacity grants allowing communities to build upon assets and develop local systems of care for CYSHCN.

In 2008, the new NE Regional Center has hired a Director, previously the Director of the National Autism Medical Home Initiative, who brings expertise in CYSHCN.

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

The Regional Centers have begun to meet with the regional oral health consultants from the Wisconsin Community-based System of Oral Health for CYSHCN. Centers continue to access their WIC-nutrition regional consultants and an all-day WIC pre-conference session in June will provide an opportunity for more dialogue on partnership.

Regional Centers continue to respond to local requests for training, outreach, and assistance. The Collaborators Network continues to share resources, problem-solve, and cross-refer.

c. Plan for the Coming Year
1. Access to Case Management, Consultation and Referral and Follow-Up Services--Direct Health Care Services--CYSHCN

In 2009, the five Regional CYSHCN Centers and their delegate agencies will continue to provide information and assistance to families and providers. Families will be linked to trainings and

parent support opportunities to meet their needs. The LHDs will again have the option to choose serving CYSHCN through Regional Center subcontracts and/or MCH Consolidated Contracting.

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

Regional Centers will continue to administer Medical Home local community capacity grants which will allow communities to build upon resources, develop local systems of care for CYSHCN and reach out to underserved populations. LHDs will have an option to select a systems objective to spread Medical Home through both the consolidated contracts and regional center subcontracts.

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

In partnership with other funding sources, the CYSHCN Program will plan and implement the following projects during 2009: continue to implement the Regional CYSHCN Center model; use the statewide GAC system to manage and monitor the objectives and fiscal operation of the CYSHCN Program; and provide technical assistance to recipients of local community capacity grants to monitor, evaluate and support the objectives of the grant. The Collaborators Network will continue to share resources, problem-solve, and cross-refer.

As an outcome of the annual all-staff 2008 CYSHCN Collaborators Network strategic planning meeting, the CYSHCN Program will follow-up on recommendations to increase our program's visibility, focus more attention on early identification and screening and broaden the stakeholder group that meets regularly. In 2009, plans will be explored to sponsor a key stakeholder leadership meeting whereby leaders from key agencies and community partners would come together to talk about and plan for our shared population of CYSHCN and how we can work together to support this population.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	6.8	7.8	7.8	8	7
Annual Indicator	5.8	5.8	5.8	44.5	44.5
Numerator	64,727	64,727	64,727	90,004	90,004
Denominator	1,116,374	1,116,374	1,116,374	202,257	202,257
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	50	52	54	55	56

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM #06 indicator for the 2005-

2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for NPM #06 and the 2005-2006 may be considered baseline data.

Notes - 2006
Data issues: 1) The data reported in 2006 are pre-populated with the data from 2005 for this performance measure. 2) We revised our objectives for 2007 - 2011 to realistically assess this measure; however, Wisconsin does not have state-specific data for this measure and we rely on SLAITS.

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

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

The Statewide Transition Consortium and Department of Public Instruction's (DPI) transition advisory group merged to form a Community of Practice on Transition (CoT). This model of shared work is national and builds on what had been in place. The primary outcome is that the DPI group had a strong educational focus and the CYSHCN-sponsored Consortium has a health focus and now all key stakeholders are at the same table to share resources, identify gaps and work together through practice groups to get work accomplished. Practice teams have been established around CYSHCN-specific topic areas and the CYSHCN Program assumes a lead role on the Practice Group on Health.

The Youth Advisory Committee, funded through the Wisconsin Integrated Systems for Communities Initiative (WISC-I) grant, finalized its work and provided feedback to the CYSHCN program on its materials and program activities.

A new round of Community Connectors mini-grants was started in 2007 and continued to build community supports for youth in transition.

The CYSHCN Program continued to utilize the WISC-I grant to support a Transition Tertiary Learning Collaborative and the teams continued to work on their products, which are posted on the Medical Home Toolkit.

2. Training and Outreach--Training Infrastructure Building Services and Outreach Population-Based Service--CYSHCN

Regional CYSHCN Centers worked with school nurses to share strategies for implementing health into the IEP, using a set of training materials that the Centers developed and disseminated.

3. Access to Transition Information--Enabling Services--CYSHCN

Quality transition information was disseminated to YSHCN, their families and providers, through the transition listserv, referral and follow-up services, and in partnership with the new Family Voices of Wisconsin's, Family-to-Family Health Information Center.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. State Partnership Building				X
2. Training (IB) and Outreach (PBS)			X	X
3. Access to Transition Information		X		

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

The CYSHCN Program continues to support the CoT in collaboration with DPI. The Regional Centers will continue to support transition activities at the local and regional level through their involvement in the CoT and practice teams on CYSHCN-specific areas. The CYSHCN Program leads the Practice Group on Health. While WISC-I ends in 2008, the CYSHCN Program will sustain integration initiatives through Regional Center contracts and state managed activities. The state will be on the steering group for the statewide CoT. The Medical Home Transition Learning Collaborative with youth, families, tertiary care providers, and administrators will come to a close and outcomes from their work on transition from pediatric to adult care services will be disseminated. The collaborations will be continued through regional and state partnerships.

2. Outreach and Training--Training Infrastructure Building Services and Outreach Population-Based Services--CYSHCN

A CoT workgroup is adapting the Pennsylvania health care checklist for use in WI. The original HRTW Transition to Adult Health Care training curriculum was reviewed by key stakeholders and will be revised in the coming year with support from additional funding sources.

3. Access to Transition Information--Enabling Services--CYSHCN

The CYSHCN Program will continue to disseminate quality information about transition.

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

The CYSHCN Program will continue to support the Community of Practice on Transition in collaboration with Department of Public Instruction. This collaborative group has representatives from over 40 state programs and community partners with transition-related interests. The state CYSHCN Program is part of the core leadership team for the CoT. The Regional CYSHCN Centers will continue to support transition activities at the local and regional level through their involvement in the CoT, with practice teams on CYSHCN-specific areas. In 2009, the CYSHCN Program will sponsor an annual CoT meeting with a focus on health. The Health care Checklist will be finalized, printed and disseminated to key stakeholders, including posting it on the WI Medical Home Toolkit and sharedwork.org websites.

2. Outreach and Training--Training Infrastructure Building Services and Outreach Population-Based Services--CYSHCN

The Transition to Adult Health Care curriculum will be printed and disseminated to further prepare YSHCN, their families and providers for the move from pediatrics to adult health care. The Regional CYSHCN Centers and Family Voices parent trainers will receive a train-the-trainer session on the revised Health Care Transition curriculum. Following this training, there will be opportunities for youth, parents, and providers to go to a training, receive targeted support in a clinical or one-to-one setting.

3. Access to Transition Information--Enabling Services--CYSHCN

The CYSHCN Program will continue to disseminate quality information about transition to YSHCN, their families and providers. This will occur through the transition listserv, referral and follow-up services at the Regional CYSHCN Centers and in partnership with the Family Voices of Wisconsin, Family-to-Family Health Information Center. One medical home local capacity grant supports youth and parent training and includes health care transition information. The

Wisconsin Medical Home Toolkit will continue to serve as a source of CYSHCN transition information and resources for medical providers.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	79	83	83.5	83.2	83.4
Annual Indicator	82.6	83.0	83.0	82.3	86.8
Numerator	727	730	730	724	764
Denominator	880	880	880	880	880
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	83.5	83.6	83.7	83.7	83.7

Notes - 2007
These data are from 2006 and entered as provisional. Data for 2007 will not be available until late 2008. The most recent (entered as 2007, but 2006 data) from the National Immunization Survey show that Wisconsin's immunization estimated coverage rates for 4 DTaP, 3 Polio, 1 MMR, 3 Hep b, and 3 hib among kids 19-35 months of age rose from 83.0% in 2005 to 86.8% in 2006. This increase may be due to acceptance and use of the Wisconsin Immunization Registry (WIR).

Notes - 2006
Data issues: The most recent data from the CDC is from the National Immunization Survey (www.cdc.gov/nip under "data and statistics" and represent calendar year 2005. The vaccine coverage estimates for 2005 among Wisconsin children who were 19 to 35 months of age with 4 DTaP, 3 Polio, 1 MMR, 3 Hep b, and 3 hib doses was 82.2%. This is a slight decline from last year's estimate. The NIS states: "Remember, NIS provides estimates that include a margin of error. That's because it is a sample survey. Even though the sample is quite large -- about 30,000 children (nationally), it is just one of many possible samples. A different sample would result in a different--but probably quite similar estimate. The drop could be due to chance."
Although the national goal for 2010 is 90%, we have kept our 2010 and 2011 objectives at the same level based on program expertise.

Notes - 2005
Data issues: Due to fiscal constraints, CDC's National Immunization Survey was not completed for SFY 2005 (7/1/04-6/30/05), therefore, we used 2004 data for 2005.
Although the national goal for 2010 is 90%, we have slightly revised our objectives to reflect 2004's data and program expertise.

a. Last Year's Accomplishments
1. Providing, Monitoring, and Assuring Immunizations--Direct Health Care Services--Children, including CYSHCN

Data required for this measure is provided annually by the State Immunization Program. The Immunization Program's template objectives for the local health departments for the past several

years have been to use the Wisconsin Immunization Registry (WIR), and establish population-based objectives to raise immunization levels of all preschool children with series complete immunization (4,3,1,3,3,1) by 24 months of age or the 4th booster dose of DTaP vaccine by 19 months of age. The latest full year's data from the NIS show that Wisconsin's immunization estimated coverage rates among kids 19-35 months of age rose from 82.2% in 2005 to 86.8% in 2006. Varicella is also included as part of the CDC standard for series completion but not included in above rate.

2. Coordination with WIC and the State Immunization Programs and Enrollment in the Wisconsin Immunization Registry (WIR)--Infrastructure Building Services--Pregnant women, mothers, infants, and children, including CYSHCN

The State Immunization Program continues to partner with the Title V MCH/CSHCN Program, LHDs, the WIC Program, the Medicaid Program, tribes, and CHCs. WIR plans to support and maintain WIC sites as registry program participants. A dramatic increase in Wisconsin rates may be due in part to acceptance and use of the Wisconsin Immunization Registry.

3. Tracking and Sharing Policy Changes or Clinical Practices by the State Immunization Program--Infrastructure Building Services--Pregnant women, mothers, infants, and children, including CYSHCN

National and international circumstances that result in subsequent policy changes or clinical practices are tracked by the State Immunization Program. Information updates were shared by the state Immunization Program with key partners as indicated at spring communicable disease seminars held in each of the five DPH regions.

4. Tracking Children at Age Two Enrolled in Medicaid--Population-Based Services--Children, including CYSHCN

The statewide tracking of Medicaid-enrolled children at age two with up-to-date immunizations continued. The goal remains at 90% to reflect the national goal for 2010.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Providing, Monitoring, and Assuring Immunizations	X			
2. Coordination with WIC and the State Immunization Programs and Enrollment in the Wisconsin Immunization Registry (WIR)				X
3. Tracking and Sharing Policy Changes or Clinical Practices by the State Immunization Program				X
4. Quality Improvement of Vaccines for Children Program				X

b. Current Activities

1. Providing, Monitoring, and Assuring Immunizations--Direct Health Care Services--Children, including CYSHCN

Title V funding continues to support LHDs primary prevention activities that include immunization monitoring and support compliance with State Immunization Program funds.

2. Coordination with WIC and the State Immunization Programs and Enrollment in the Wisconsin Immunization Registry (WIR)--Infrastructure Building Services--Pregnant women, mothers, infants, and children, including CYSHCN

The State Immunization Program will continue partnerships with the Title V MCH/CYSHCN Program, LHDs, WIC Program, the Medicaid Program, tribes, and CHCs. WIR will expand as policy changes dictate.

3. Tracking and Sharing Policy Changes or Clinical Practices by the State Immunization Program--Infrastructure Building Services--Pregnant women, mothers, infants and children, including CYSHCN

National and international circumstances that result in recommended changes in the immunization schedule are tracked by the State Immunization Program.

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

QI efforts for providers in 2008 occur through site visits by Immunization Program personnel to 25% of all Vaccine for Children sites in Wisconsin. One of the topics covered is provider participation with the WIR and the appropriate use of the reminder/recall function.

c. Plan for the Coming Year

1. Providing, Monitoring and Assuring Immunizations--Direct Health Care Services--Children, including CYSHCN

Title V, MCH program funding will continue to support LHDs' primary prevention activities that include immunization monitoring and support compliance with State Immunization Program funding requirements. Data required to enable MCH to monitor and report this measure will continue to be provided by the State Immunization Program.

2. Coordination with WIC and the State Immunization Programs and Enrollment in the Wisconsin Immunization Registry (WIR)--Infrastructure Building Services--Pregnant women, mothers, infants, and children, including CYSHCN

The State Immunization Program continues to partner with the Title V MCH/CYSHCN Program, LHDs, the WIC Program, the Medicaid Program, tribes, and CHCs.

3. Tracking and Sharing Policy Changes or Clinical Practices by the State Immunization Program--Infrastructure Building Services--Pregnant women, mothers, infants and children, including CYSHCN

National and international circumstances that result in recommended changes in the immunization schedule will continue to be tracked by the State Immunization Program during 2009 and policy sharing will occur as appropriate. Starting in the fall semester of 2008-2009 school year, new vaccine requirements go into effect. All students in grades K, 6 and 12 will be required to receive the 2nd dose of varicella vaccine and students in grades 6, 9 and 12 will be required to receive a dose of the adolescent Tdap vaccine. Finally, children entering licensed day care centers after September 1, 2008 will have to provide evidence of having received pneumococcal vaccine.

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

During 2009 quality improvement efforts for providers will be maintained through site visits by Immunization Program personnel to at least 25% of all Vaccine for Children sites in Wisconsin.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	15.7	15.4	15.1	14.8	14.7
Annual Indicator	15.5	14.9	14.9	15.6	15.6
Numerator	1,861	1,765	1,776	1,840	1,840
Denominator	119,722	118,370	119,124	118,012	118,012
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	14.9	14.8	14.7	14.6	14.5

Notes - 2007
Data issue: Data for 2007 will not be available from the Bureau of Health Information and Policy until 2009.

Notes - 2006
Data notes: There were 92 births to teen <15 years in Wisconsin in 2006. Source: Bureau of Health Information and Policy, Division of Public Health, Wisconsin Department of Health and Family Services. Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Wisconsin Interactive Statistics on Health (WISH), http://dhfs.wisconsin.gov/wish/, Birth Counts Module, accessed 04/7/2008.
Denominator: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Bureau of Health Information and Policy. Wisconsin Interactive Statistics on Health (WISH), http://dhfs.wisconsin.gov/wish/, Population Module, accessed 03/21/2007.

Notes - 2005
Source: Numerator: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Wisconsin Interactive Statistics on Health (WISH), http://dhfs.wisconsin.gov/wish/, Birth Counts Module, accessed 04/10/2007.
Denominator: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Bureau of Health Information and Policy. Wisconsin Interactive Statistics on Health (WISH), http://dhfs.wisconsin.gov/wish/, Population Module, accessed 03/21/2007.

a. Last Year's Accomplishments
1. Title V Abstinence Education--Population-Based Services--Adolescents

The Governor of Wisconsin decided not to reapply for Title V Abstinence Education funds beyond 6-30-07. This decision related to requirements for grantees to adhere to all 8 elements in the definition of abstinence education specified in Title V of the Social Security Act. The Abstinence Education Program Closeout was effective on December 21, 2007.

2. Milwaukee Adolescent Pregnancy Prevention (MAPP) Partnership--Enabling Services--Adolescents

DPH successfully completed an RFP and contract award for a new initiative entitled; The Milwaukee Adolescent Pregnant Prevention Partnership. This four agency Milwaukee collaborative is designed to increase the Family Planning Waiver Enrollment for African American teens ages 15 to 19.

3. Education and Outreach--Enabling Services--Adolescents

A Parent and Teen Resource Guide and Video was developed focusing on influential roles of parents.

4. Data--Infrastructure Building Services--Adolescents

The third edition of the Wisconsin Youth Sexual Behaviors Data Outcomes Report was published highlighting trend data for abstinence, HIV/STD and teen births.

5. State Adolescent Pregnancy Prevention Committee--Infrastructure Building Services--Adolescents

A Department of Health and Family Services-Division of Public Health STD Program staff became Co-Chair to the State Adolescent Pregnancy Prevention Committee.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Title V Abstinence Education			X	
2. Milwaukee Adolescent Pregnancy Prevention Partnership		X		
3. Education and Outreach		X		
4. Data				X
5. State Adolescent Pregnancy Prevention Committee				X

b. Current Activities
1. Education and Outreach--Enabling Services--Adolescents

A joint Department of Health and Family Services and Department of Workforce Development press release was developed to acknowledge National Teen Pregnancy Prevention Month. The release encourages teens across Wisconsin to make responsible decisions about their health and highlights Wisconsin's effort to reduce disparities in teen pregnancy.

2. Milwaukee Adolescent Pregnancy Prevention Partnership--Enabling Services--Adolescents

The Milwaukee Adolescent Pregnancy Prevention Partnership is planning and implementing strategies to engage African American youth from non-traditional and ethnically diverse communities to become delivers of evidence-based teen pregnancy and STD prevention messages. The DPH Youth Policy Director administers the MAPP contract.

3. Data--Infrastructure Building Services--Adolescents

Work is beginning on the fourth edition of the Wisconsin Youth Sexual Behaviors Data Outcomes Report highlighting trend data for abstinence, HIV/STD and teen births.

4. Adolescent Pregnancy Prevention Committee--Infrastructure Building Services--Adolescents

The State's Adolescent Pregnancy Prevention Committee meets quarterly.

c. Plan for the Coming Year
1. Data--Infrastructure Building Services--Adolescents

The fourth edition of the Wisconsin Youth Sexual Behaviors Data Outcomes Report will be published highlighting trend data for abstinence, HIV/STD, and teen births.

2. Milwaukee Adolescent Pregnancy Prevention Partnership--Enabling Services--Adolescents

The Milwaukee Adolescent Pregnancy Prevention Partnership grantee will make significant numerical and qualitative inroads in increasing the Medicaid Family Planning Waiver as well as establish clear communication and coordination mechanism with Milwaukee organizations charged with responsibilities of teen pregnancy prevention, teen parenting and adolescent reproductive health services and advocacy.

3. Education and Outreach--Enabling Services--Adolescents

A Teen Pregnancy Prevention Press Release for the 2009 National Pregnancy Prevention Month will be completed.

4. Adolescent Pregnancy Prevention Committee--Infrastructure Building Services--Adolescents

The State's Adolescent Pregnancy Prevention Committee will continue to meet quarterly.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	49	49.5	50	50	50
Annual Indicator	47.0	47.0	47.0	47.0	47.0
Numerator	34,134	34,134	34,134	34,134	34,134
Denominator	72,626	72,626	72,626	72,626	72,626
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	50	50	50	50	50

Notes - 2007
Source: Numerator: calculated by taking 2001's indicator, the Wisconsin Division of Public Health "Make Your Smile Count" survey of third grade children, 2001-2002. Denominator: the number of third grade children enrolled in public and private schools. We are currently conducting another third grade survey, therefore, for next year we will have updated information/data.

Notes - 2006
Source: Numerator: calculated by taking 2001's indicator, the most recent Wisconsin Division of Public Health" Make Your Smile Count" survey of third grade children, 2001-2002. Denominator: the number of third grade children enrolled in public and private schools. Future data are dependent on funding for an additional survey.

Notes - 2005
Source: Numerator: calculated by taking 2001's indicator, the most recent Wisconsin Division of Public Health "Make Your Smile Count" survey of third grade children, 2001-02. Denominator: the number of third grade children enrolled in public and private schools. Future data are dependent on funding for another survey.

a. Last Year's Accomplishments

1. Healthy Smiles for Wisconsin Seal-A-Smile Sealant Program--Direct Health Care Services--Children

In 2006/07 Maternal Child Health Block Grant funds were provided to 4 local agencies to provide dental sealants in school-based/community settings to all eligible children with non-carious, erupted first or second molars. Approximately 385 children were assessed and had sealants placed.

The Department contracted with Children's Health Alliance of Wisconsin (CHAW), the Title V grantee for statewide child health system building, to manage Health Smiles for Wisconsin: Seal-A-Smile initiative.

In 2006/07 21 community or school-based programs hosted 174 Seal-A-Smile (SAS) events. SAS screened 8,522 children and delivered sealants to 5,602 children. The program documented that 374 children with special health care needs were served. In addition to placing 15,287 sealants on permanent first molars, 6,724 children received topical fluoride treatments, 12,076 children received oral health education and 3,671 were referred for additional dental care. The SAS program average for sealant placement cost per child is $21.92, however the cost per cavity averted, according to the Center for Disease Control and Prevention health economists is $51.48.

2. Healthy Smiles for Wisconsin Oral Health Infrastructure Support--Infrastructure Building Services--Children--including CYSHCN

CHAW is actively involved in improving dental access and care through the Healthy Smiles for Wisconsin initiative. CHAW conducted regional meetings for Seal-A-Smile grantees. The CDC refined SEALS, a data collection software program and published Wisconsin's data.

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

Technical assistance was provided for 21 state-funded sealant programs through CHAW's Oral Health Project Manager. The Wisconsin state Chief Dental Officer and Public Health Dental Hygienist monitored the CHAW contracts to manage the CDC Disease Prevention Grant in School-Aged Children and the Healthy Smiles for Wisconsin Seal-A-Smile grants.

Over $190,000 in state GPR and HRSA Workforce grant funds were distributed to initiate 21 funded programs.

The Healthy Smiles for Wisconsin Coalition continued to promote oral health prevention through a steering committee, policy development committee and prevention/clinical care committee.

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

County oral health surveys were conducted in 3 counties for use in community needs assessments.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Healthy Smiles for Wisconsin Seal-A-Smile Sealant Program	X			
2. Healthy Smiles for Wisconsin Oral Health Infrastructure Support				X
3. Technical Assistance		X		
4. Oral Health Surveillance			X	

b. Current Activities

1. Healthy Smiles for Wisconsin Seal-A-Smile Program--Direct Health Care Services--Children, including CYSHCN

In 2007/08 Maternal Child Health Block Grant funding was provided to 2 local agencies to provide oral health assessment and sealants to eligible children. It is projected that 225 children will be served.

The Department is contracting with CHAW to manage the Healthy Smiles for Wisconsin Seal-A-Smile initiative in 2007/08. There are 21 community or school-based programs as a result of the Wisconsin Seal-A-Smile program.

The department wrote and received additional funding through a HRSA funded Workforce grant, at just over $95,000.

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

The Department is contracting with Children's Health Alliance of Wisconsin (CHAW), the Title V grantee for statewide child health system building, to manage Health Smiles for Wisconsin: Seal-A-Smile initiative.

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

Technical Assistance is being provided to 21 state-funded sealant programs in cooperation with CHAW Oral Health Project Manager.

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

The Department is currently conducting the "Make Your Smile Count" Oral Health Survey of third grade students.

c. Plan for the Coming Year

1. Healthy Smiles for Wisconsin Seal-A-Smile Program--Direct Health Care Services--Children, including CYSHCN.

In 2009 the Department anticipates continued funding to at least 20 community and school-based programs through the GPR and HRSA funded Seal-A-Smile project. The Department will contract with CHAW, the Title V grantee for statewide child health system building, to manage Healthy Smiles for Wisconsin: Seal-A-Smile initiative in 2008/09. There are currently 21 school-based or community sealant projects.

The Department will be working with CHAW on the goals and objectives of the HRSA funded "Wisconsin Community-Based System of Oral Health for Children with Special Health Care Needs" specifically targeting school based opportunities to reach CYSHCN.

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

The Department will contract with CHAW, the title V grantee for statewide child health system building, will be actively involved in improving dental access and care through the Healthy Smiles for Wisconsin: Seal-A-Smile initiative in 2008/09. CHAW will conduct regional grantee for Seal-A-Smile grantees. The purpose of these meetings is to streamline information and review best practices.

In 2009 the Department intends to continue to support the MCH sealant program template and will advocate to local agencies for their participation.

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

Technical assistance will be provided to approximately 21 state-funded dental sealant programs in cooperation with CHAW Oral Health Program Manager. The State Oral Health Consultant will monitor contracts to manage the CDC Oral Disease Prevention Grant in School-Aged Children and the Healthy Smiles for Wisconsin Seal-A-Smile grants.

Data on the number of children provided protective sealants and with untreated decay in primary and permanent teeth will be available through this program in June 2008.

The State Public Health Dental Hygienist and the Chief Dental Officer will continue to play an active role in the Wisconsin Oral Health Coalition. The coalition will consider policy development changes to facilitate improved access to preventive programs.

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

The Department will publish and disseminate data collected through the Make Your Smile Count Survey of third grade students. The data will be used to evaluate current programs and as a framework for the development of new preventive based programs.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	3.3	3.2	3.2	3.1	2.8
Annual Indicator	3.6	2.5	2.8	1.8	1.8
Numerator	39	27	30	19	19
Denominator	1,094,410	1,073,202	1,062,378	1,078,955	1,078,955
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	2.8	2.7	2.7	2.6	2.5

Notes - 2007
Data issue: Data for 2007 will not be available from the Bureau of Health Information and Policy until 2009.

Notes - 2006
Data issues: Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Bureau of Health Information. Wisconsin Interactive Statistics on Health (WISH), http://dhfs.wisconsin.gov/wish/, Injury Mortality Module, accessed 04/08/2008.

Notes - 2005
Data issues: Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Bureau of Health Information. Wisconsin Interactive Statistics on Health (WISH), http://dhfs.wisconsin.gov/wish/, Injury Mortality Module, accessed 05/11/2007.

a. Last Year's Accomplishments
1. Car Seat Safety Education and Fitting/Inspections--Enabling Services--Infants and children

In 2007, 33 LHDs conducted checks for proper installation and use of car seat restraints through the MCH performance-based contracts, and conducted over 3,800 CPS screenings using this funding. Of those screened, 82% of the children were not properly positioned in a seat prior to instruction. This was the most frequently selected objective by LHDs.

2. Community Education and Outreach--Population-Based Services--Infants and children

Education to support the proper use of child passenger safety seats continued in 2007. Staff from DPH provided technical assistance to LHDs for implementation and sustainability of CPS programs.

3. Enhancement and Expansion of Partnerships--Infrastructure Building Services--Infants and children

LHDs continue to utilize partnerships with DOT law enforcement agencies, local hospitals, EMS, and SAFE KIDS to support their efforts to provide education and services pertaining to child passenger safety. Money is also available from DOT for staff training and education and for purchasing car seats for low income families.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Car Seat Safety Education and Fitting/Inspections		X		
2. Community Education and Outreach			X	
3. Enhancement and Expansion of Partnerships				X

b. Current Activities
1. Car Seat Safety Education and Fitting/Inspections--Enabling Services--Infants and children

In 2008, 37 LHDs are conducting checks for proper installation and use of car seat restraints through the MCH performance-based contracts. This is the most commonly selected objective, with $334,184 in Title V dollars going toward this effort in Wisconsin. We are currently evaluating this objective to assure that it meets the needs of both LHDs and the MCH program.

2. Community Education and Outreach--Population-Based Services--Infants and children

Education to support the proper use of child passenger safety seats continues in 2008. The number of LHDs who selected this objective increased by 5 between 2007 and 2008. We strongly encourage partnership with local organizations, such as SAFE KIDS, hospitals, and fire departments, to support this activity and reduce duplication of efforts. LHDs have reported that successful local coalitions formed around CPS efforts have allowed them to take on other injury-related activities in their community.

3. Enhancement and Expansion of Partnerships--Infrastructure Building Services--Infants and children

LHDs continue to utilize partnerships with DOT law enforcement agencies, local hospitals, EMS, and SAFE KIDS to support their efforts to provide education and services pertaining to child passenger safety. Money is also available from DOT for staff training and education and for purchasing car seats for low income families.

c. Plan for the Coming Year

1. Car Seat Safety Education and Fitting/Inspections--Enabling Services--Infants and children

It is anticipated that LHDs and others will continue to provide child passenger and car seat safety outreach, seats, training, and education to families with young children. We hope to increase the number of LHDs that select child passenger safety template objectives through the performance-based contracting system. Based on the review completed in 2008, we will make necessary changes to enhance this objective from the perspective of the LHD and the MCH program.

2. Community Education and Outreach--Population-Based Services--Infants and children

We will continue to collaborate with DOT, which has been able to provide funding for safety seats for low income families in the past, and other state and local agencies to promote and provide outreach activities and public education. We will support LHDs in forming partnerships with local entities, and provide technical assistance in development of local programs.

3. Enhancement and Expansion of Partnerships--Infrastructure Building Services--Infants and children

As opportunities are identified, new partnerships will be developed and/or current ones strengthened to accomplish the work of the new projects and initiatives.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective				40	25
Annual Indicator			25.0	26.0	26.6
Numerator			2,810	3,309	3,622
Denominator			11,238	12,726	13,616
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	26	27	28	30	32

Notes - 2007
Source: 2007 Pediatric Nutrition Surveillance System (PedNSS), Centers for Disease Control and Prevention.

Notes - 2006
Source: According to PedNSS 2006, 77% Hispanic infants were ever breastfed compared to 63.9% white infants, 47.2% African American, 62.1% American Indian/Alaskan Native, 43.8% Asian/Pacific Islander and 59.4% multiple races; for breastfed at least 6 months, 35.1% Hispanic infants were breastfed, compared to 20.9% white infants, 10.3% African American, 18.9% American Indian/Alaskan Native, 14.4% Asian/Pacific Islander and 12.6% multiple races.
Data issue: The data for 2005 cannot be amended in the TVIS; the data entered for 2005 are incorrect and should be 2,519/10,409 = 24.2%. Source: 2005 Pediatric Nutrition Surveillance System report (PedNSS); received from CDC in mid-January 07.
The subsequent years' objectives were revised to reflect 2004 and 2005 data that indicated about 25% of mothers breastfed their infants at 6 months of age. The HP 2010 objective is 50%;

however, given current data and program knowledge, we feel that our objectives do not reflect current breastfeeding practices and have revised them downward.

Notes - 2005
Source: 2004 Pregnancy Nutrition Surveillance System report.
Data issue: Data for 2005 are not available from the Pediatric Nutrition Surveillance System until 2007. Our objectives reflect the Wisconsin Nutrition and Physical Activity State Plan's 2007 objective that 50% of mothers will breastfeed their infants at 6 months of age; Healthiest Wisconsin 2010's Adequate and Appropriate Nutrition priority also has this same objective.

a. Last Year's Accomplishments
Impact on National Outcome Measures: The advantages of breastfeeding are indisputable and include nutritional, immunological and psychological benefits to both infant and mother as well as benefits to the community as a whole.

1. Breastfeeding Education, Promotion and Support--Enabling Services--Pregnant and breastfeeding women

About 30% of the LHDs receive Title V funds through performance-based contracting for perinatal care coordination services, including breastfeeding promotion and support to achieve increased initiation and duration rates. LHDs also selected an objective of breastfeeding initiation and duration for more than one month outside the parameters of prenatal case management services. Breastfeeding education, promotion and support are included in the care for pregnant women and mothers and infants.

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

The State WIC Breastfeeding Coordinator manages the Breastfeeding Peer Counseling Program (BFPCP) and the WIC Breast Pump Program. In CY 2007, the WIC Program trained 18 new breastfeeding peer counselors who provided prenatal breastfeeding counseling and postpartum support in 26 local WIC projects statewide. Breastfeeding peer counseling improves initiation and duration rates of breastfeeding. In the initial run of the WIC Breastfeeding Reports, the State average 6 month breastfeeding duration rate was 24.2% compared to the BFPCP 6 month duration rate of 26.2%. The WIC Breast Pump Program provides breast pumps to WIC mothers that are not eligible for Medical Assistance.

The Title V funded agencies continue to coordinate breastfeeding activities with the WIC Program for pregnant women, mothers and infants. This includes referrals for care from WIC to the MCH program and from MCH to WIC.

3. Wisconsin Partnership for Activity & Nutrition--Population-Based Services--Pregnant and the general public

The WIC Breastfeeding Coordinator co-chaired the breastfeeding committee of the Wisconsin Partnership for Activity & Nutrition (WI PAN). A key obesity prevention focus area of WI PAN is the promotion and support of breastfeeding. The Breastfeeding Coordinator provided numerous presentations including conferences attended by Family Resource Centers, Head Start/Early Head Start, hospitals, Birth to Three, Even Start Family Literacy Schools, Early Childhood Centers, and County and Tribal Social Service Departments.

The WIC Breastfeeding Coordinator updated the Wisconsin Breastfeeding Resource Directory which assists the public and health care professionals in locating appropriate referral sources for breastfeeding mothers who need help.

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

The WIC Breastfeeding Coordinator sent out Governor's Proclamations, Action Ideas and Resources for Health Professionals for World Breastfeeding Week/Month to the 24 local breastfeeding coalitions in Wisconsin. The Wisconsin WIC Program and Milwaukee County Breastfeeding Coalition provided a three day training for community partners in the Milwaukee area, including breastfeeding peer counselors, hospitals and clinics, teen parenting programs, public health programs, La Leche League, breastfeeding coalitions and others.

The WIC Breastfeeding Coordinator presided as the proctor and network coordinator for the CDC bimonthly State Breastfeeding Coalition conference calls in 2007.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Breastfeeding Education, Promotion and Support		X		
2. Breastfeeding Peer Counseling and Breast Pump Distribution		X		
3. Wisconsin Partnership for Activity & Nutrition			X	
4. Collaboration and Partnerships - Local Breastfeeding Coalitions				X

b. Current Activities

1. Breastfeeding Education, Promotion and Support--Enabling Services--Pregnant and breastfeeding women

The 10 Steps to Breastfeeding Friendly Health Departments assists LHDs in their efforts to protect, promote and support breastfeeding. This objective was the 4th most selected objective negotiated through performance based contracting.

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

In CY 2008, the WIC Program trained 18 new peer counselors who provide prenatal breastfeeding counseling and postpartum support in 32 local projects. In the most recent WIC Breastfeeding report, the State average 6 month breastfeeding duration rate was 25.6% compared to the 6 month duration rate of 27.7% for those in the Peer Counseling Program.

3. Wisconsin Partnership for Activity & Nutrition--Population-Based Services--Pregnant and breastfeeding women

The Breastfeeding Committee of WI PAN is developing a module that will be used by breastfeeding coalitions and public health professionals to train childcare staff.

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

The Breastfeeding Committee of WI PAN will develop a survey to assess the needs of local breastfeeding coalitions in Wisconsin.

c. Plan for the Coming Year

1. Breastfeeding Education, Promotion and Support--Enabling Services--Pregnant and breastfeeding women

In CY 2009, the 10 Steps to Breastfeeding Friendly Health Departments objective will continue to be promoted to LHDs in their efforts to protect, promote and support breastfeeding. Self-

assessment tools and LHD reports that describe strategies and activities implemented by the health department that are required in the 10 Steps will be reviewed. LHDs that have completed required activities of all 10 Steps will be awarded "Breastfeeding Friendly" status.

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

In CY 2009, the State WIC Breastfeeding Coordinator will continue to manage the Breastfeeding Peer Counseling Program (BFPCP) and the WIC Breast Pump Program. In addition to the 3 day Loving Support Training for the new peer counselors, continuing education programs will be provided for experienced peer counselors.

3. Wisconsin Partnership for Activity & Nutrition--Population-Based Services--Pregnant and breastfeeding women

The WIC Breastfeeding Coordinator will continue to co-chair the breastfeeding committee of the Wisconsin Partnership for Activity & Nutrition (WI PAN). The Breastfeeding Committee will promote and distribute the "How to Support a Breastfeeding Mother -- A Guide for the Childcare Center" to breastfeeding coalitions and public health professionals to train childcare staff.

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

The Breastfeeding Committee of WI PAN will distribute and evaluate the survey developed in 2008 for the local breastfeeding coalitions. This survey will assess specific breastfeeding coalition needs, best means to address needs and optimal approaches for networking.

The WIC Breastfeeding Coordinator will continue to preside as the proctor and network coordinator for the CDC bimonthly State Breastfeeding Coalition conference calls in 2009.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	93	94	95	95	95
Annual Indicator	94.5	94.5	95.6	94.5	97.9
Numerator	64,921	65,528	65,780	66,675	69,932
Denominator	68,688	69,308	68,785	70,.519	71,444
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	96	96	97	97	97

Notes - 2007
Data on hearing screening are reported on one page of the newborn blood-spot card that goes to the Wisconsin State Lab of Hygiene (WSLH). The data are electronically messaged daily to the Wisconsin Early Hearing Detection and Intervention Tracking Referral and Coordination (WE-TRAC) system. Records for infants who show PASS/PASS results are archived; records for infants who REFER in one or both ears are queued for follow-up by the birth hospital. Reports

started being generated directly from the WE-TRAC system for 2007 data. This method has allowed issues that occurred in the past, such as duplicate records that were difficult to identify as duplicates and babies with delayed screening or not screened for valid reasons but accounted for, to be corrected. However, since the blood card can be separated and the page with hearing screening results submitted separately, there are still occasional instances of hearing screening reports not submitted in a timely manner.

Notes - 2006
Data on hearing screening are reported on one page of the newborn blood-spot card that goes to the Wisconsin State Lab of Hygiene (WSLH). The data are delivered as a space-delimited file at least once a month, converted to a SAS dataset, and used to compile monthly reports on hearing screening in Wisconsin. The hearing screening records are also sent directly to the Wisconsin Early Hearing Detection and Intervention Tracking Referral and Coordination (WE-TRAC) System.
Data issues: Hearing screening results are occasionally separated from the blood card, delaying accurate reporting. Alternatively, sometimes the blood screening is repeated, but not the hearing screening, therefore, there may be duplicate (inaccurate) reporting. In 2006 functionality was added to WE-TRAC to allow administrators to remove duplicate records from the WE-TRAC data set. Currently, we are developing reports that will allow us to take data from WE-TRAC rather than from the blood card file. This will allow for more accurate data, and will also allow us to include data on delayed inpatient screenings done for special care infants, and report on other “accounted for” babies, or babies that have a valid reason for not being screened. With these new reports and the rapid increase of hospitals reporting using WE-TRAC, we anticipate being able to use WE-TRAC data for future reporting.

Notes - 2005
Data on hearing screening are reported on one page of the newborn blood-spot card that goes to the Wisconsin State Lab of Hygiene (WSLH). The data are delivered as a space-delimited file at least once a month, converted to a SAS dataset, and used to compile monthly reports on hearing screening in Wisconsin. The hearing screening records are also sent directly to the Wisconsin Early Hearing Detection and Intervention Tracking Referral and Coordination (WE-TRAC) System.
Data issues: Hearing screening results are occasionally separated from the blood card, delaying accurate reporting. Alternatively, sometimes the blood screening is repeated, but not the hearing screening, therefore, there may be duplicate (inaccurate) reporting. In 2005, the processing logic used to handle SLH records was changed to greatly reduce the occurance of duplicate cases. In 2006, functionality was added to WE-TRAC to handle any remaining duplicate records. Also, a phased release system began in 2007. Data will be collected directly from facilities using WE-TRAC, which will place accurate testing and follow-up responsibility on the birth hospitals, lessening the possibility that hearing screening results (and follow-up services) will be lost or delayed.

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

Wisconsin Sound Beginnings made available print outreach materials related to early hearing detection and intervention (EHDI) such as "A Sound Beginning for Babies" and "Babies and Hearing Loss" series to providers and produced a captioned version of the EHDI Video in Spanish, English and Hmong. WSB sent out just in time packets of information to pediatric primary care providers and collaborated with the Wisconsin Educational Services Program for the Deaf and Hard of Hearing (WESP DHH) to produce a just in time packet for early intervention providers.

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

WSB continued to coordinate follow-up activities with the WSLH and worked to improve data quality through the targeted monitoring of hospital faxed data updates.

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

The Sixth Annual Statewide Parent Conference focused on Looking Ahead to a Bright Future. In attendance were 101 families with ten Spanish speaking families and one Hmong family. A pre-conference for professionals who work with d/hh kids drew 76 people.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Outreach/Public Education		X		
2. WSB/Congenital Disorders Program			X	
3. Support Services for Parents		X		
4. Birth-3 Technical Assistance Network				X
5. EHDI Workgroup				X
6. Reduce Lost to Follow-up				X

b. Current Activities

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

WSB is disseminating the EHDI Video to community partners and collaborating with the WESP DHH Program to disseminate the newly created just in time packet for early intervention providers for newly diagnosed children.

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

WSB continues to coordinate follow-up with the WSLH and works to improve data quality. We are working to eliminate delayed submission of hearing results on the blood card via a new feature in WE-TRAC and investigating the collection of risk factors for late onset hearing loss.

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

The 7th Annual Statewide Parent Conference and professional pre-conference is being planned.

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

We are investigating linking WE-TRAC to the new web-based Birth to 3 system. Also looking to determine current numbers of children with hearing loss receiving early intervention services.

5. EHDI Workgroup--Infrastructure Building Services--CYSHCN

This workgroup is undergoing a conversion to focus on quality improvement efforts and will be called the EHDI Quality Improvement Consortium.

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

Continue to develop and implement Guide By Your Side Follow-through Program and WE-TRAC reports.

c. Plan for the Coming Year

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

WSB will continue to market existing materials and will work to revise the Babies and Hearing Loss Notebook for Families. WSB will continue to collaborate with the WESP DHH Program to evaluate and improve just in time packets for early intervention providers when we receive notification of a newly diagnosed child.

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

WSB will continue to coordinate follow-up with the WSLH and work to improve data quality. Delayed or missing hearing screening results will be submitted through WE-TRAC. WSLH will begin collection of risk factors for late onset hearing loss on the newborn screening card. We will investigate inputting hearing screening results for clients without blood screen.

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

An Annual Statewide Parent Conference and professional pre-conference will be held and will focus on parent professional teamwork.

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

Babies identified as deaf or hard of hearing will be connected to Birth-3 via WE-TRAC and reports will be automatically generated to determine the current numbers of children with hearing loss referred to early intervention services.

5. EHDI Workgroup--Infrastructure Building Services--CYSHCN

The EHDI Quality Improvement Consortium will be convened.

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

A series of learning collaboratives that focus on the reduction of lost to follow-up will be conducted. A EHDI web-based toolkit will be designed as a resource to the learning collaboratives. The Guide By Your Side Follow-through Program and WE-TRAC system will continue to be developed, enhanced, and implemented.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	3	2.9	2	2	2.8
Annual Indicator	2.0	2.2	2.9	3.8	3.8
Numerator	26,000	28,000	38,100	48,000	48,000
Denominator	1,300,000	1,300,000	1,300,000	1,273,000	1,273,000
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	2.7	2.6	2.5	2.5	2.5

Notes - 2007

Data issue: Data for 2007 will not be available from the Bureau of Health Information and Policy until 2009.

Notes - 2006
Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Family Health Survey, 2006. Madison, Wisconsin: 2008.
Numerator: Weighted data. Denominator: Weighted data.
Data issues: 1) Estimated numbers have been rounded to the nearest 1,000. The annual Wisconsin Family Health Survey is a random digit dial telephone survey that collects and reports information about health status, problems, insurance coverage, and use of health care services among Wisconsin residents. The survey has questions about health-related limitations and chronic conditions for persons greater than age seventeen.

Notes - 2005
Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Family Health Survey, 2005. Madison, Wisconsin: 2007.
Numerator: Weighted data. Denominator: Weighted data.
Data issues: 1) Estimated numbers have been rounded to the nearest 1,000. The annual Wisconsin Family Health Survey is a random digit dial telephone survey that collects and reports information about health status, problems, insurance coverage, and use of health care services among Wisconsin residents. The survey has questions about health-related limitations and chronic conditions for persons greater than age seventeen. 2) Indicator: 2005 data indicate a slight increase in the percentage of children without health insurance in Wisconsin. 3) We have revised our objectives to reflect issues of survey methodology and the implications of enrollment in Medicaid and SCHIP (BadgerCare and BadgerCare Plus).

a. Last Year's Accomplishments
1. Medicaid Outreach Overview--Enabling Services--Children, including CYSHCN

Title V MCH Program staff monitored enrollment trends in Wisconsin Medicaid and in BadgerCare Plus, the Wisconsin CHIP Program. The combined number of persons eligible for BadgerCare and Family Medicaid increased 5% from 540,662 in 2006 to 574,341 in 2007; though the percent of children in the state without health insurance increased from 2.9% to 3.8%. This likely reflects the implementation by Medicaid of the need to have verification of citizenship and income. The MCH program supported Medicaid outreach activities for children at risk served by the CYSHCN Regional Centers in five locations throughout Wisconsin.

2. Governor's BadgerCare Plus Initiative--Enabling Services--Pregnant women, mothers, infants, and children, including CYSHCN

Legislation to implement BadgerCare Plus was passed in September 2007 in the SFY 07-09 budget and the program began enrolling families on February 1, 2008. Increasing numbers of families eligible to enroll will impact the Medicaid enrollment numbers. In January 2008, the WI Medicaid program awarded a total of $447,142 to 32 community-based organizations to reach out to Wisconsin families and enroll children in BadgerCare Plus starting February 1, 2008. These community partners will share information about the program's benefits and provide direct, confidential application assistance. In some cases, children will be able to receive immediate, express enrollment in BadgerCare Plus through these community partners.

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

The "Covering Kids" Program in Wisconsin (CKF-WI) is housed at the UW-Madison School of Human Ecology, working in partnership with UW-Extension and other partners throughout the state. It is a coalition of more than 65 organizations committed to reducing the number of uninsured children and families. CKF-WI was active throughout 2007 with funds from DHCF and

both Medical Schools of Wisconsin. CKF-WI is making sure those who are eligible for BadgerCare Plus know about and can easily enroll in the programs for which they qualify.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Medicaid Outreach Overview		X		
2. Governor's BadgerCare Plus Initiative		X		
3. "Covering Kids" Program		X		

b. Current Activities

1. Medicaid Outreach Overview--Enabling Services--Children, including CYSHCN

Title V, MCH program continues the activities of recent years in this area.

2. Governor's BadgerCare Plus Initiative--Enabling Services--Pregnant women, mothers, infants, and children, including CYSHCN

The Title V MCH/CYSHCN Program continues to provide assistance to Governor Doyle's expansion to the Wisconsin BadgerCare Plus Program that provides health insurance for all children in the state. The MCH program will have an opportunity to outreach to pregnant women, mothers, infants, children, and children and youth with special health care needs and their families to improve access to health care coverage and connect to community programs enrolling families.

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

In cooperation with UW-Extension, the Title V MCH/CYSHCN Program continues to provide support for state and local coalitions, funded through 2010. These activities will assist children and their families and build access to funding mechanisms through BadgerCare Plus for affordable, comprehensive health care coverage.

c. Plan for the Coming Year

1. Medicaid Outreach Overview--Enabling Services--Children, including CYSHCN

The Title V MCH/CYSHCN Program will maintain the activities of recent years in this area.

2. Governor's BadgerCare Plus Initiative--Enabling Services--Pregnant women, mothers, infants, and children, including CYSHCN

The Title V MCH/CYSHCN Program will continue to provide assistance to Governor Doyle's expansion to the Wisconsin BadgerCare Program that is to provide an opportunity for health insurance for all children in the state and improve access to health care coverage.

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

In cooperation with UW-Extension, the Title V MCH/CYSHCN Program will continue to provide support for state and local coalitions that are funded through 2010. These activities will assist children and their families and build access to funding mechanisms through BadgerCare Plus for affordable, comprehensive health care coverage.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				12.1	29
Annual Indicator			13.3	29.3	29.2
Numerator			6,893	15,137	15,078
Denominator			51,825	51,667	51,636
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	28	27	26	25	24

Notes - 2007
Source: 2007 Pediatric Nutrition Surveillance System (PedNSS), Centers for Disease Control and Prevention.

Notes - 2006
Source: 2006 Pediatric Nutrition Surveillance System (PedNSS), Centers for Disease Control and Prevention. The subsequent year's objectives were revised to reflect the correct data for 2005 and program knowledge about this population.

Notes - 2005
Data issues: Data for 2005 are not available from the Pediatric Nutrition Surveillance System until 2007.

a. Last Year's Accomplishments
1. Increased Knowledge of Healthy Behaviors--Enabling Services--Children over the age of 2, including CYSHCN and their families

Through performance based contracting (PBC), 21 LHDs worked to create environments that promote healthy eating, physical activity, and a healthy weight. The activities are linked to Healthiest Wisconsin 2010, the Nutrition and Physical Activity State Plan and local community health improvement plans. Many provided educational programs and opportunities in a variety of settings including: child care, worksite, schools, and community. One LHD sponsored a health promotion class for 70 students. Another distributed "Just Keep Moving" brochures to highlight opportunities for physical activity in the community. One tribal health department sponsored a "Team Up to Defeat Diabetes" conference for enrolled families, a "Heart Healthy" event where families learned about portion control, blood sugars, blood pressure, and tobacco cessation, and another event to help families think about hidden sugars and calories in beverages.

2. Community Campaigns--Population-Based Services--Children over the age of 2, including CYSHCN and their families

Through the PBC system, LHDs promoted nutrition and physical activity in their community through campaigns. These included a Fun Walk/Run with 72 participants, a Choosing Low-fat Milk Campaign, Safe Routes to School, Turn off TV Week, and community walking programs. One community fitness challenge with 41 groups participating identified that 50% of the participants self-reported an increase in physical activity as a result of the campaign.

3. Needs Assessments and Plans--Infrastructure Building Services--Children over the age of 2, including CYSHCN and their families

Through PBC, LHDs improved the nutrition and physical activity environment in their communities. Strategies implemented included community planning, walkability/bikeability surveys, fruit and vegetable audits, FIT WIC assessments, Safe Routes to School, starting school breakfast programs in 13 schools, school staff wellness, school wellness policies, community assessments, worksite wellness, breastfeeding support at work, work with farmers' markets to increase participation, and childcare curriculum. One LHD worked with several schools to improve their nutrition and physical activity environments. Some of the changes included: a summer nutrition education program, development of a nature trail with a Vita course for students, staff and parents, development of a walking program for students and parents, development of a Safer Routes to School Program and walking program for students with theme walks. Another LHD worked with the Milwaukee Public School and 50% (104 schools) completed a nutrition and physical activity school assessment and action plan.

4. Nutrition and Physical Activity Coalitions - Collaboration and Partnerships--Infrastructure Building Services--Children over the age of 2, including CYSHCN and their families

Partnerships are vital to preventing and managing overweight. There are 47 local coalitions who focused efforts on obesity prevention in 2007.

Key partnerships that were developed by the LHDs included: the nutrition and physical activity coalitions, schools, worksites, local hospitals, farmers and farmers' market managers, UW-Extension, Master Gardeners and Preservers, economic development corporation, WIC, childcare centers, city planner, faith-based organizations, parent groups, YMCA, and minority organizations.

In many examples the work funded by MCH and through the above partnerships has been able to leverage addition grant funds, in-kind services and support.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Increased Knowledge of Healthy Behaviors		X		
2. Community Campaigns			X	
3. Needs Assessments and Plans				X

b. Current Activities

1. Increased Knowledge of Healthy Behaviors--Enabling Services--Children over the age of 2, including CYSHCN and their families

Through performance based contracting (PBC), 29 LHDs are creating environments that promote breastfeeding, healthy eating, physical activity, and a healthy weight in all sectors. The activities are linked to Healthiest Wisconsin 2010 and the Nutrition and Physical Activity State Plan.

2. Community Campaigns--Population-Based Services--Children over the age of 2, including CYSHCN and their families

Through the PBC system, LHDs are promoting nutrition and physical activity in their community. These include a Fun Walk/Run, Safe Routes to School, Turn off TV Week and WE CAN.

3. Needs Assessments and Plans--Infrastructure Building Services--Children over the age of 2, including CYSHCN and their families

Through PBC, LHDs are improving the nutrition and physical activity environment and building the infrastructure. Strategies include: walkability surveys, childcare environment assessments,

Safe Routes to School, school wellness, community assessments, worksite wellness, work with farmers' markets, and childcare curriculum.

4. Nutrition and Physical Activity Coalitions - Collaboration and Partnerships--Infrastructure Building Services--Children over the age of 2, including CYSHCN and their families

Partnerships are vital to preventing obesity. There are 48 local coalitions who currently focus on nutrition, physical activity and obesity prevention.

c. Plan for the Coming Year

1. Increased Knowledge of Healthy Behaviors--Enabling Services--Children over the age of 2, including CYSHCN and their families

Through the performance based contracting system, LHD will be encouraged to choose a template objective that provides focused effort related to obesity prevention through increased breastfeeding, increased fruit and vegetable consumption, increased physical activity, decreased television time, decreased sugar-sweetened beverage consumption and decreased consumption of high energy dense foods. These activities will be linked to the Healthiest Wisconsin 2010 and the Wisconsin Nutrition and Physical Activity State Plan to prevent obesity and related chronic diseases.

2. Community Campaigns--Population-Based Services--Children over the age of 2, including CYSHCN and their families

Community-wide campaigns (such as Safe Routes to School, TV Turn Off Week, Governor's Challenge) may be planned as part of the work of LHDs, coalitions, and community-based organizations to implement the Wisconsin Nutrition and Physical Activity State Plan. Community-wide campaigns are implemented in conjunction with other strategies (such as policy change, environmental change or education) to increase the impact of the campaign.

3. Needs Assessments and Plans--Infrastructure Building Services--Children over the age of 2, including CYSHCN and their families

The Wisconsin Partnership for Activity and Nutrition (WI PAN) and the Nutrition and Physical Activity Program plans to develop resources to assist LHDs, coalitions, and community-based organizations to implement evidence-based strategies to prevent overweight and obesity, work with schools to apply for the Governor's School Health Award, implement a childcare intervention, and promote the Worksite Kit and Safe Routes to School. The Program and WI PAN will continue to promote the use of the State Plan as a "blueprint" for activities to prevent and manage overweight among children and their families.

4. Nutrition and Physical Activity Coalitions - Collaboration and Partnerships--Infrastructure Building Services--Children over the age of 2, including CYSHCN and their families

State and community partnerships are vital to preventing and managing childhood overweight. There are ~48 local coalitions who will focus on preventing overweight, improving nutrition and increasing physical activity. The coalitions focus on a variety of issues related to childhood overweight including family meals, being active as a family, safe neighborhoods, access to healthy food as well as food security and hunger. An annual survey will be conducted to capture current capacity to implement interventions, identify training and resource needs and highlight successes.

Key partners include: the WIC Program, MCH Programs, DPI programs (Team Nutrition), the Child and Adult Care Feeding Program, Dept. of Transportation, Dept. of Agriculture, UW-Extension, Minority Health Program, LHDs, and community coalitions.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective				14.5	14
Annual Indicator			14.0	14.9	14.9
Numerator			9,812	10,715	10,715
Denominator			70,012	72,114	72,114
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	13.5	13	12.5	12	12

Notes - 2007
Data issue: 2007 data will not be available from the Bureau of Health Information and Policy until 2009. Furthermore, the Bureau of Health Information and Policy most likely will not have data for this indicator until 2010 after the revised birth certificate is implemented with a new on-line system (projected to be in place by 2009). Wisconsin was awarded the Pregnancy Risk Assessment Monitoring System (PRAMS) in April, 2006. We do not expect to have data from PRAMS until late 2008 or early 2009.

Notes - 2006
Source: The data for 2005 are wrong; they should be: 9,503/70,719 = 13.4%; the 2005 data were entered as provisional data for the 2007 application. There were 70,934 births in Wisconsin in 2005. Birth certificate data indicate that 61,216 reported they did not smoke during pregnancy; 9,503 reported smoking, and there were 215 missing. Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy. Wisconsin Interactive Statistics on Health (WISH), http://dhfs.wisconsin.gov/wish, Birth Counts Module, accessed 02/22/2007.
Data issues: The data for this indicator are not available in Wisconsin. Therefore, we are using data for SPM #7, the percent of women who use tobacco during pregnancy. 2006 data will not be available from the Bureau of Health Information and Policy until 2008. Furthermore, the Bureau of Health Information and Policy most likely will not have data for this indicator until 2010 after the revised birth certificate is implemented with a new on-line system projected to be in place by 2009. Wisconsin was awarded the Pregnancy Risk Assessment Monitoring System (PRAMS) in April, 2006. We do not expect to have data from PRAMS until 2008-2009.

Notes - 2005
Source: There were 70,131 births in Wisconsin in 2004. Birth certificate data indicate that 60,200 reported they did not smoke during pregnancy; 9,812 reported smoking, and there were 119 missing. Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy. Wisconsin Interactive Statistics on Health (WISH), http://dhfs.wisconsin.gov/wish, Birth Counts Module, accessed 04/05/2006.
Data issues: These data are from 2004 and for SPM #7, the percent of women who use tobacco during pregnancy. 2005 data will not be available from the Bureau of Health Information and Policy until 2007. Furthermore, the Bureau of Health Information and Policy most likely will not have data for this indicator until 2010 after the revised birth certificate is implemented with a new on-line system projected to be in place by 2009. Wisconsin was awarded the Pregnancy Risk

Assessment Monitoring System (PRAMS) in April, 2006. We do not expect to have data from PRAMS until 2010.

a. Last Year's Accomplishments
Relates to Priority Need #7--Smoking and Tobacco Use. In 2006, birth certificate data indicated 14.9% of Wisconsin women smoked during pregnancy, a slight increase from 2005 when 13.4% indicated they smoked during pregnancy (the most recent data for the U.S. for 2005 for the 36 unrevised [1989 birth certificate] reporting areas was 10.7%).

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

The Title V Program funded 31 LHDs totaling 35 objectives addressing a variety of perinatal-related issues.

As reported for 2007 in SPHERE, of those women who received a prenatal assessment utilizing both Title V funds and Medicaid PNCC, 48% reported smoking before pregnancy, 31% reported smoking during pregnancy, and 19% reported decreasing smoking during pregnancy. Other SPHERE data show of the women whose smoking changed during pregnancy and were followed, 78% reported maintenance of non smoking status and 35% reported exposure to secondhand smoke.

2. First Breath--Enabling Services--Pregnant women, mothers, and infants

The Title V Program continued its First Breath Prenatal Smoking Cessation Program partnership with the Wisconsin Women's Health Foundation (WWHF). In 2007, 1,513 women were enrolled. Preliminary analysis of quit outcomes indicates the abstinence rate remained at 36% with 1,394 women having quit smoking since the program's inception. At a Medicaid cost savings of $1,274 per quitter, this represents a $1,775,956 cost savings to the health care system.

3. Women and Tobacco Team (WATT)--Enabling Services--Pregnant women, mothers, infants

The focus of this group is on tobacco use and cessation among women of reproductive age. The group designed a 31-question survey on tobacco use practices among clinicians of women of reproductive age, specifically to Wisconsin family planning providers, advanced practice nurses with an OB/GYN specialty and licensed OB/GYNS. 215 of 746 surveys were returned (30% response rate). Key findings from the survey indicate that while many clinicians ask about tobacco use, advise women to quit, and assess their willingness to quit, few clinicians assist with the quit attempt or actively arrange follow-up support, including referrals to the Wisconsin Tobacco Quit Line. While many clinicians feel it is their role to help patients quit tobacco use, confidence in their ability to be effective is lacking. Just over half of clinicians indicated they received tobacco cessation training -- even fewer received training specific to women. Additionally, patients are infrequently advised on the dangers of secondhand smoke -- only a third of clinicians felt they were knowledgeable about secondhand smoke and its effects. The detailed report, titled "Report on Wisconsin Survey of Clinicians on Tobacco Use Practices for Women of Reproductive Age," is completed and accessible at www.wwhf.org.

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

Through the Medicaid PNCC program and the MCH-funded perinatal care coordination program women who are high risk for adverse pregnancy outcomes are receiving comprehensive, strength based individual care in the prenatal period and postpartum. One of the many focuses of care is tobacco use and cessation. Once identified the participants of the program are referred to the First Breath Program, for individual, strength based assistance with decreasing tobacco use. In SFY 2007, 582 women were reported as having made a change in tobacco use during the prenatal and postpartum period and 76% of women served by these programs reported not smoking in the postpartum period.

5. Preconception Service--Enabling Services--Pregnant women, mothers, infants

Both the Infant Death Center of Wisconsin (IDC) and WAPC had preconception initiatives with a smoking cessation focus. IDC distributed culturally sensitive brochures on preconception, and a preconception curriculum and power point presentation were developed for middle school students. WAPC developed preconception tool kits for clinical practitioners.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Title V Funded Perinatal Services		X		
2. First Breath		X		
3. Women and Tobacco Team (WATT)		X		
4. Prenatal Care Coordination (PNCC)		X		
5. Preconception Service		X		

b. Current Activities

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

The Title V Program funded 38 LHDs totaling 43 objectives addressing a variety of perinatal-related issues.

2. First Breath--Enabling Services--Pregnant women, mothers, infants

For CY 2008, 102 First Breath sites are participating in the program and 324 women have been enrolled.

3. Women and Tobacco Team (WATT)--Enabling Services--Pregnant women, mothers, infants

WATT continues to look for opportunities to share the survey results through local and state partnerships.

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

PNCC continues to include smoking cessation services to prenatal and postpartum women.

5. Preconception Services--Enabling Services--Pregnant women, mothers, infants

IDC continues to facilitate a safe sleep/smoking cessation workgroup for a coalition of representatives from Milwaukee hospitals. WAPC has a preconception committee working on a survey for healthcare providers about preconception practices including smoking cessation and has released the preconception tool kit for use in clinics.

c. Plan for the Coming Year

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

Due to the complex nature of smoking during pregnancy, this topic will continue to be a priority for the Title V Program. Title V funds will continue to be provided to the local level that encourage and support agencies to incorporate and provide services and counseling to women who use tobacco during pregnancy.

2. First Breath--Enabling Services--Pregnant women, mothers, infants

The Title V Program will continue as a partner to accomplish the goals of the First Breath Program. This partnership will focus on the following needs: invigorate and motivate participating

clinicians; compete with other health care needs for limited clinician time; address clinical challenges (i.e. the risk for post-delivery relapse, unsupportive significant others, willingness to cut down but not quit, untruthful self-report, and failure to implement the agreed-to quit plan); and identify sustainable funding. First Breath will also work to increase enrollment within existing sites, expand to reach incarcerated women and continue expansion efforts in Southeastern Wisconsin.

3. Women and Tobacco Team (WATT)--Enabling Services--Pregnant women, mothers, infants

The work of this team will continue, to include utilizing the results of the survey for clinicians on the smoking practices for women of reproductive age to determine what the priority areas are for provider continuing education and to determine other strategies to address the needs of clinicians.

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

The Medicaid PNCC program will continue to support individual comprehensive strength based services, to women during the prenatal and postpartum period. Education sessions for the Great Beginnings Start Before Birth curriculum will continue to be provided by region throughout the state. Strategies will be developed and implemented through regional PNCC provider groups and SPHERE user groups, and Regional Forums to promote data collection to identify key outcomes. Strategies will be developed through regional Healthy Baby Action Teams to identify and reduce disparities.

5. Preconception Services--Enabling Services--Pregnant women, mothers, infants

The Infant Death Center of Wisconsin will continue to disseminate preconception/interconception brochures that focus on women's health, including smoking cessation. The safe sleep/smoking cessation workgroup will continue to work with the community on education for creating smoke free environments. The WAPC Preconception Committee will develop an education plan for clinical providers on preconception health that includes a smoking cessation focus.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	7	7	9	9.2	9
Annual Indicator	11.2	9.5	11.0	8.4	8.4
Numerator	46	39	45	34	34
Denominator	409,420	409,811	409,101	404,777	404,777
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	8.7	8.6	8.5	8.5	8.5

Notes - 2007

Data issue: Data for 2007 will not be available from the Bureau of Health Information and Policy until 2009.

Notes - 2006
Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Bureau of Health Information. Wisconsin Interactive Statistics on Health (WISH), http://dhfs.wisconsin.gov/wish/, Mortality Module, accessed 04/10/2008.

Notes - 2005
Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Bureau of Health Information. Wisconsin Interactive Statistics on Health (WISH), http://dhfs.wisconsin.gov/wish/, Mortality Module, accessed 04/10/2007.

a. Last Year's Accomplishments
1. Anticipatory Guidance, Risk Assessment and Referrals--Direct Health Care Services--Adolescents

LHDs, in collaboration with others such as local human and social services, identified and implemented evidence-based risk assessments of depression for youth and made the appropriate referrals. Education and training was provided to communities, targeting both professionals and the general public. Mental Health America of Wisconsin (MHA), in collaboration with the Suicide Prevention Initiative (SPI) partners, continued its work with primary care providers, schools, and community groups to develop local coalitions, heighten awareness, provide education, ensure procedures and policies are in place in schools for prevention, intervention, and postvention of suicides. MHA successfully rolled out the Garrett Lee Smith grants as the state's designee to local communities. Two LHDs conducted community-based activities to address depression, mental illness, and suicide prevention in their communities, as reported in the MCH data system, SPHERE. Across the state, LHDs provided health teaching to 396 clients on depression, 39 clients on mental health primary prevention, and 10 clients on suicide. 326 clients were screened for depression, and 92 clients were referred for mental health services.

2. Training and Presentations to Raise Awareness and Reduce Stigma--Population-Based Services--Adolescents

SPI partners and others continue to provide training, presentations, workshops, and displays.

3. Suicide Prevention Initiative--Infrastructure Building Services--Adolescents

The expanded Suicide Prevention Initiative (SPI) functioned as the Steering Committee for the newly received SAMHSA Garrett Lee Smith grant. Ongoing support and technical guidance was provided to local coalitions and groups coming together to explore ways to prevent suicide and/or contagion within their communities through SPI membership attending local community meetings, providing trainings, materials, resources, and/or leadership.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Anticipatory Guidance, Risk Assessment and Referrals	X			
2. Training and Presentations to Raise Awareness and Reduce Stigma			X	
3. Suicide Prevention Initiative (SPI)				X
4. Data				X

b. Current Activities
1. Anticipatory Guidance, Risk Assessment and Referrals--Direct Health Care Services--Adolescents

The MCH staff, along with the SPI group and other partners around the state, work to provide support and technical assistance to LHDs, communities, and other organizations that have taken on suicide prevention as one of their priorities. Kenosha County HD successfully wrote a grant application and received funding to support a three-year project to improve risk assessment, referrals, and access to direct care for those at risk for suicide.

2. Training and Presentations to Raise Awareness and Reduce Stigma--Population-Based Services--Adolescents

SPI partners and others continue to provide training, presentations, workshops, and displays at conferences and events. Key efforts include work with the Garrett Lee Smith grantees (who target youth in their projects).

3. Suicide Prevention Initiative (SPI)--Infrastructure Building Services--Adolescents

The SPI group continues to meet on a bimonthly basis and provides guidance to MHA, who administers the Garrett Lee Smith grants around the state as the state's designee. Working with CHAW developing local child death review teams (CDRTs).

4. Data--Infrastructure Building Services--Adolescents

A statewide report, The Burden of Suicide in Wisconsin, will be released in late summer 2008. This document provides information on deaths due to suicide, suicide attempts, demographic and circumstance information, and the cost to our state

c. Plan for the Coming Year

1. Anticipatory Guidance, Risk Assessment, and Referrals--Direct Health Care Services--Adolescents

Work with community and professional groups to provide prevention, assessments, referrals and intervention will continue. We will keep template objectives on suicide prevention in the performance-based contracting and encourage communities to select these objectives to either develop their suicide prevention coalition or enhance their current coalition. Kenosha County will continue to implement their 3 year grant to increase risk assessment in schools, provide a referral system and direct services to their community. We will support them in any way possible.

2. Training and Presentations--Population-Based Services--Adolescents

Membership of SPI will continue to provide training and presentations locally and statewide to promote and enhance awareness, reduce stigma, develop coalitions, procedures, policies, programs and activities to prevent suicide across the lifespan. Training will also occur on the data and use of the report on the burden of suicide.

3. Suicide Prevention Initiative (SPI)--Infrastructure Building Services--Adolescents

SPI will continue to work with the Garrett Lee Smith grantees to build infrastructure within their communities as well as promote the development of other community coalitions and groups and support those who already have programs and activities in place.

4. Data--Infrastructure Building Services--Adolescents

We will continue to provide data and analysis assistance to LHDs and other community organizations. Analysis of WVDRS data will continue on at least a quarterly basis and subsequently disseminated to better understand the burden of suicide in Wisconsin. Working with local CDRTs to use National MCH CDR data system.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	74.5	75	81	81.5	82
Annual Indicator	80.2	77.4	80.6	74.8	74.8
Numerator	698	655	712	667	667
Denominator	870	846	883	892	892
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	82.5	83	83	83	83

Notes - 2007
Data issue: Data for 2007 will not be available from the Bureau of Health Information and Policy until 2009.

Notes - 2006
Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy.
Data issue: In Wisconsin, hospitals self-designate level of care. Wisconsin does not have a regulatory function to standardize these self-designations. 95% confidence intervals are: 77.6%, 72.0%.

Notes - 2005
Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy.
Data issue: In Wisconsin, hospitals self-designate level of care. Wisconsin does not have a regulatory function to standardize these self-designations. 95% confidence intervals are: 83.2%, 78.0%.

a. Last Year's Accomplishments
Impact on National Outcome Measures: NPM#17 relates to National Outcome Measures #1 Infant mortality rate and #3 Neonatal mortality rate. Hospitals in Wisconsin self designate level of perinatal care. Wisconsin does not have regulatory function over the designations.

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

The Wisconsin Association for Perinatal Care facilitated activities to support the use of levels of perinatal care adopted from the American Academy of Pediatrics definition of levels of neonatal care: Level I provides well newborn care for infants and stabilizing care for infants of 35-37 weeks gestation and beyond; IIA provides care for preterm or ill infants requiring stabilization efforts and are either expected to recover rapidly or are awaiting transfer to another facility; IIB provides care at IIA level plus mechanical ventilation for brief durations or continuous positive airway pressure; IIIA provides comprehensive care for infants born >28 weeks and weighing >1,000 g, able to provide life support and mechanical ventilation in addition to minor surgical procedures; IIIB provides comprehensive care for the extremely low birth weight infant (28 weeks, 1,000 g) with

advanced respiratory support, full range of pediatric subspecialists, advanced imaging, and surgical abilities; IIIC provides comprehensive care for premature infants at the IIIB level in addition to being able to provide ECMO and complex surgeries. WAPC contacted all birth hospitals and 2 NICU hospitals that do not perform births, to provide education on the self assessment tool located on the WAPC website, www.perinatalweb.org. In addition, WAPC provided distance-based Q&A sessions on the levels of care self-assessment initiative for assessment coordinators.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service DHC	ES	PBS	IB
1. WAPC Efforts on Regionalization of Perinatal Care				X

b. Current Activities

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

The Wisconsin Association for Perinatal Care is continuing to provide education to hospitals on the self-assessment tool and materials about the levels of perinatal care. WAPC is reviewing the first set of completed self-assessments submitted.

c. Plan for the Coming Year

1. WAPC Efforts on regionalization of Perinatal Care--Infrastructure Building Services--Pregnant women, mothers, infants

WAPC will obtain information about the levels of care that birth hospitals provide that mirror the levels proposed by the AAP, and make this available on the WAPC web site. WAPC will continue to promote the use of PeriData.Net, a web-based perinatal database, for quality improvement in birth hospitals, and plans to develop a module for newborn/NICU care.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	84.7	85	85.5	86	86.5
Annual Indicator	84.7	85.1	85.0	83.8	83.8
Numerator	59,296	59,666	60,309	60,610	60,610
Denominator	69,999	70,131	70,934	72,301	72,301
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	87	87.5	88	88	88

Notes - 2007

Data issue: Data for 2007 will not be available from the Bureau of Health Information and Policy until 2009.

Notes - 2006
Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Bureau of Health Information. Wisconsin Interactive Statistics on Health (WISH), http://dhfs.wisconsin.gov/wish/, Birth Counts Module, accessed 04/29/2008.

Notes - 2005
Source: Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Health Information and Policy, Bureau of Health Information. Wisconsin Interactive Statistics on Health (WISH), http://dhfs.wisconsin.gov/wish/, Birth Counts Module, accessed 04/11/2007.

a. Last Year's Accomplishments
Impact on National Outcome Measures: NPM #18 relates to National Outcome Measures #1 Infant mortality rate, #2 Disparity between Black and White IMR, #3 Neonatal mortality rate, and #5 Perinatal mortality rate. The overall proportion of women who received prenatal care in the first trimester was 84% in 2006, the same as in 1996. The proportion with first trimester care increased for mothers aged less than 15, 18-19, 20-24, and 40 and older; and in all race/ethnicity groups except whites.

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

The Title V program funded 845 women served through objectives addressing prenatal care. As reported in SPHERE and MCH end of year reports, 59% of women initiated prenatal care in the first trimester.

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

The Great Beginnings Start Before Birth curriculum was provided to enhance PNCC psychosocial support services. Data collection in SPHERE was encouraged for monitoring key outcomes. The Womens Health Now and Beyond Pregnancy project was piloted regionally, to enhance PNCC postpartum services to include a focus on preconception/interconception services before future pregnancies. Empowering Families of Milwaukee served 179 women prenatally providing comprehensive services and supporting early prenatal care.

3. Federal Healthy Start Projects in Wisconsin--Population-Based Services--Pregnant women, mothers, infants

The Title V Program has collaborated with The Black Health Coalition's Milwaukee Healthy Beginnings Project (MHBP) on the Milwaukee FIMR project. The project director of the MHBP has facilitated the Service Provider Meetings for the state's initiative to Eliminate Racial and Ethnic Disparities in Birth Outcomes. The Honoring Our Children Project with Great Lakes Inter-Tribal Council reports 70% (217/311) of prenatal women received first trimester prenatal care.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Title V Funded Perinatal Services		X		
2. Prenatal Care Coordination (PNCC)		X		
3. Federal Healthy Start Projects in Wisconsin			X	

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

The Title V MCH/CYSCHN Program is funding 35 objectives at local health departments to address prenatal issues.

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

Training sessions for PNCC and reproductive health were provided for the local health departments. Through regional PNCC provider groups and SPHERE user group meetings, data collection and monitoring of key outcomes is promoted. The Womens Health Now and Beyond Pregnancy pilot project has been implemented with services that include assuring women have emergency contraception and dual protection, with a plan for primary birth control on hand before delivery; along with promotion of the use of multivitamins with folic acid and women's health. Empowering Families of Milwaukee is in the 3rd year of providing comprehensive home visiting services and during the 2008 expects that 75% of new mothers will be enrolled in the program for services early in pregnancy.

3. Federal Healthy Start Projects in Wisconsin--Population-Based Services--Pregnant women, mothers, infants

Title V MCH/CYSHCN staff serve on advisory committees for the Healthy Start projects and participate in collaborative efforts related to FIMR. PNCC and Reproductive Health training well be provided for Tribal sites.

c. Plan for the Coming Year

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

The Title V MCH/CYSHCN Program will continue to support early entry into prenatal care by funding individual perinatal care coordination services and perinatal system-building activities at the local level.

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

Regional training sessions for Great Beginnings Start Before Birth curriculum will be provided. Use of data to monitor key outcomes will be promoted at regional PNCC provider group meetings and SPHERE user group meetings. The Women's Health Now and Beyond Pregnancy pilot project will be expanded statewide, providing preconception/interconception services to women, and promoting women's health with multivitamins with folic acid. An MCH conference is being planned to provide education on the lifecourse perspective of health and its relationship to birth outcomes. Contractual responsibility for EFM will transfer to the Department of Children and Families (DCF) beginning July 1, 2008. The Title V, MCH Program will continue to collaborate with the City of Milwaukee Health Department in cooperation with the DCF to assure continuing quality in programs and services to pregnant women and infants. Plans continue with an evaluation of the Empowering Families of Milwaukee program under the direction of the staff in the DHFS, Office of Policy Initiatives & Budget, Policy & Research Section with an interim report expected March 2009.

3. Federal Healthy Start Projects in Wisconsin--Population-Based Services--Pregnant women, mothers infants

Title V MCH/CYSHCN staff will continue to serve on advisory committees for the Healthy Start projects and participate in collaborative efforts related to the Milwaukee and Racine FIMR programs. Annual PNCC trainings are planned with Great Lakes Inter-Tribal Council and the tribal sites. The Great Beginnings Start Before Birth curriculum will be presented at the next educational session.