



State Title V Block Grant Narrative

The following PDF was created from the most up-to-date electronic files available from the State for its Title V Maternal and Child Health Services Block Grant 1999 annual report and 2001 application. Some changes in fonts, formatting, page numbers, and image quality may have occurred during the conversion of the document to a PDF.

Sections 5.4 – 5.7, containing standard forms and detailed descriptions of national and State performance and outcome measures, are not included in this PDF. Data from these sections can be viewed in interactive formats on the Title V Information System Web site (<http://www.mchdata.net>).

This PDF was produced by the National Center for Education in Maternal and Child Health under its cooperative agreement (MCU-119301) with the Maternal and Child Health Bureau, Health Resources and Services Administration, U.S. Department of Health and Human Services.



I. COMMON REQUIREMENTS FOR APPLICATION AND ANNUAL REPORT

1.1 Letter of Transmittal

1.2 Face Sheet

1.3 Table of Contents

I. COMMON REQUIREMENTS FOR APPLICATION AND ANNUAL REPORT ii

1.1 Letter of Transmittal ii

1.2 Face Sheet iii

1.3 Table of Contents..... 2

1.4 Overview of the State..... 4

1.5 The State Title V Agency 9

1.5.1 State Agency Capacity..... 10

1.5.1.1 Organizational Structure..... 10

1.5.1.2 Program Capacity..... 13

1.5.1.3 Other Capacity 19

1.5.2 State Agency Coordination 23

II. REQUIREMENTS FOR THE ANNUAL REPORT 34

2.1 Annual Expenditures..... 34

2.2 Annual Number of Individuals Served..... 34

2.3 State Summary Profile 34

2.4 Progress on Annual Performance Measures 34

- Direct Health Services..... 34

- Enabling Services 42

- Population Based Services 52

- Infrastructure Building Services 56

2.5 Progress on Outcome Measures..... 60

III. REQUIREMENTS FOR APPLICATION..... 61

3.1 Needs Assessment of the Maternal and Child Health Population 62

3.1.1 Needs Assessment Process..... 62

3.1.2 Needs Assessment Content 65

3.1.2.1 Overview of the Maternal and Child Health Population Status..... 65

3.1.2.2 Direct Health Care Services 83

3.1.2.3 Enabling Services 83

3.1.2.4 Population-Based Services..... 84

3.1.2.5 Infrastructure Building Services..... 86

3.2 Health Status Indicators..... 89

3.2.1 Priority Needs 89

3.3 Annual Budget and Budget Justification 91

3.3.1 Completion of Budget Forms..... 91

3.4.1 National Core Five Year Performance Measures 94

3.4.1.1 Five Year Performance Objectives..... 94

3.4.2 State “Negotiated” Five Year Performance Measures 94

3.4.2.1 Development of State Performance Measures..... 95

3.4.2.2 Discussion of State Performance Measures 96

3.4.2.3	Five Year Performance Targets.....	99
3.4.2.4	Review of State Performance Measures	99
3.4.3	Outcome Measures.....	99
IV.	REQUIREMENTS FOR THE ANNUAL PLAN.....	100
4.1	Program Activities Related to Performance Measures	100
4.2	Other Program Activities.....	112
4.3	Public Input	113
4.4	Technical Assistance.....	114
V.	SUPPORTING DOCUMENTS	SD
5.1	Glossary	SD 1
5.2	Assurances and Certifications.....	SD 2
5.3	Other Supporting Documents	SD 3
5.4	Core Health Status Indicator Forms.....	SD C1, C2, & C3
5.5	Core Health Status Indicator Detail Sheets.....	SD HSI <i>Detail</i>
5.6	Developmental Health Status Indicator Forms	SD D1 & D2
5.7	Developmental Health Status Indicator Detail Sheets.....	SD DHSI <i>Detail</i>
5.8	All Other Forms.....	SD Additional
5.9	National “Core” Performance Measure Detail Sheets.....	SD Core
5.10	State “Negotiated” Performance Measure Detail Sheets.....	SD 16
5.11	Outcome Measure Detail Sheets.....	SD Core .19-.24
	Technical Notes.....	Technical Notes
VI.	APPENDICES	VI.

1.4 Overview of the State

State of Wisconsin's Population Size and Distribution

The state's estimated population for 1999 of 5,250,446 reflects a slight increase over the 1998 estimated level of 5,222,124. Wisconsin's population growth is expected to continue. Wisconsin has 72 counties with the greatest growth rate found in the northeastern part of the state or the Fox Valley where Oshkosh, Neenah, Menasha, Appleton, and Green Bay are located. Other growth areas include the Wisconsin River Valley, Dane County (Madison), and southeastern Wisconsin. During 1997, the largest numeric growth occurred in Waukesha and Dane counties with nearly 40,000 residents each.

Wisconsin is a predominantly rural state with 96 people per square mile. However, the population density varies greatly from county to county. For example, Milwaukee County in the southeastern part of the state has 3,950 people per square mile while Iron County, in the upper tier of northern Wisconsin has only 8 people per square mile.

Females make up 51% of the state's population. The number of children under the age of 18 is 1,357,620 (1998 estimate) making up 30% of the state's population. The largest percentage of children live in the southeastern portion of the state (38%) and the smallest percent of children (9%) live in Wisconsin's northern tier.

The 1990 data indicates that 18% of children lived in single parent households. Births to single mothers have increased slightly from 25% in 1991, 27% in 1993 and 1995 and 28% in 1996 and 1997. The marriage rate per 1,000 residents has continued to decrease slightly from 7.6 in 1991 to 6.8 in 1997. The divorce rate per 1,000 residents has remained fairly static since 1993 hovering at 3.5 to 3.3 in 1997.

Income and Poverty in Wisconsin

Despite record low unemployment (5.5% in 1991 to 3.7% in 1998) and continued economic growth, Wisconsin's working families lost ground last year according to the U.S. Census Bureau. Wisconsin saw a decline in household income between 1996 and 1997, according to the Census Bureau's annual report on income and poverty. Adjusted for inflation, household income in Wisconsin fell from \$42,026 to \$40,257, a decline of 4.5%.

Wisconsin's poverty rate for all ages showed a slight decline, falling from 8.7% in 1995-1996 to 8.5% in 1996-1997. However, children are more likely to live in poor families. Since the late 1970's, the poverty rate among Wisconsin children (1997) has increased 50% from 10.4% to 15.1%, with those under the age of five most likely to live in impoverished families. Two counties in Wisconsin, Menominee and Milwaukee, have the highest percentage of children living in poverty - well above the state's average at 38% and 29% respectively.

Wisconsin's Racial and Ethnic Composition

It is expected that Wisconsin's population will continue to increase in racial and ethnic diversity to further enrich the state. The population of Wisconsin is primarily non-Hispanic white (90% in 1998). The racial and ethnic groups,

African Americans, American Indians, Southeast Asians, and Hispanics report a youthful age structure with proportionately more women entering the childbearing ages.

In 1998, African Americans represented the largest racial minority group comprising about 6% of the total population. The Hispanic-origin population (of any race) constituted the second largest minority group in Wisconsin (3%). The American Indian population in Wisconsin includes several distinct nations: the Chippewa (Ojibwa), Oneida, Winnebago, Menominee, Stockbridge-Munsee, and the Potawatomi. The 1998 projected census estimate was 46,304 American Indians in Wisconsin, an increase from 38,986 in 1990. The Southeast Asian population includes people of diverse national origins to include Hmong, Laotian, Vietnamese, Thai and Cambodian has grown from 52,782 people in 1990 to 79,778 in 1998.

Competing Factors Upon the Health Services Delivery Environment

BadgerCare - Wisconsin's Children's Health Insurance Program (CHIP), known as BadgerCare, enjoyed a strong start in its first nine months of operation. The program enrolled more than 61,000 people since beginning July 1999. BadgerCare employs a fundamentally different program design than most CHIP programs, enrolling "whole families" that lack health insurance and whose incomes do not exceed 185% of federal poverty guidelines. The state negotiated a waiver with federal officials for its program design.

There has been a higher-than-expected adult enrollment in BadgerCare. Although approximately two-thirds of enrollees are adults, the program and surrounding outreach helped pull an additional 10,000 – 11,000 mothers and children into Medicaid (entitlement) since BadgerCare began. Overall, more than 30,000 children have been enrolled into Medicaid or BadgerCare since BadgerCare started. BadgerCare is not an entitlement program and its enrollment is capped at 67,535 persons. As of April 2000, the Legislature has not expanded the program beyond the existing "cap."

Blue Cross Blue Shield Public Health Foundation - Blue Cross Blue Shield United of Wisconsin was recently granted approval to convert to a for-profit entity. As a part of that conversion, the health insurer agreed to disseminate an estimated \$250 million in assets to be used for public health purposes. The state Insurance Commissioner's order allowing the conversion requires several changes to the proposed conversion plan. The proceeds from the conversion will be distributed equally to the University of Wisconsin Medical School and the Medical College of Wisconsin.

Two significant modifications are: (1) that 35% of the funds resulting from the conversion be expended only for public health and public health community based activities, and (2) that a Public and Community Health Oversight Advisory Committee (PCHOAC) be established at each of the two medical schools and that the PCHOAC have authority over the funds allocated to a public health priority. The fact that the Commissioner has earmarked 35% of the funds to public health purposes is seen as significant. Also important is that the Commissioner created an opportunity for the public health community to share responsibility with the medical schools on how these public health funds will be distributed. It also stipulates other forms of oversight to assure greater accountability.

Reproductive Health and Family Planning Services - The Title X grantee in Wisconsin is Planned Parenthood of Wisconsin, Inc. Delivery of Title X-funded family planning services is coordinated with the Title V/ Wisconsin General Program Revenue-funded services. Title X funds have historically been used to subsidize family planning services in 21 of the 72 Wisconsin counties. Wisconsin's Title X allocation is approximately \$3 million.

Division of Public Health-funded family planning services support the provision of Title X services within the 21 counties. Pregnancy testing and short-term care coordination, pap tests, sexually transmitted disease tests, chlamydia treatment medications for patients and their partners, and continuing education, training, and technical assistance for Title X providers is supported through the Division of Public Health's family planning program.

Medicaid Health Maintenance Organizations (HMOs) - The Medicaid managed care delivery system in Wisconsin has recently undergone significant changes as a result of Wisconsin's new 2000 contract with managed care firms. Three HMOs, CompCare, Valley Health Plan, and Dean Health Plan have decided to withdraw or reduce their enrollment. These revisions may change the need for recipients to mandatorily sign-up with HMOs. However, new recipients may sign-up for BadgerCare or Medicaid and be treated in a "fee-for-service" environment even if no Medicaid HMOs are available in a certain geographic area.

While managed care organizations have certain benefits, such as better performance on HealthChecks, families of children with special health care needs sometimes prefer having their children treated in a fee-for-service environment. "Non-mandatory" status allows such families to do that. Overall, 43% of the state's counties – including the state's urban areas – are considered "mandatory" counties. Most "non-mandatory" counties are concentrated in the more rural northern half of the state.

Outreach Efforts - An overarching lesson in Wisconsin's early experience with the Children's Health Insurance Program is the critical importance of effective outreach. It is imperative to carry out a coordinated campaign to communicate the availability of these benefits to families and help them "navigate the system." The Wisconsin Maternal and Child Health Program has shown its commitment to outreach in the Medicaid program in the last year, with notable results. A dramatic 19% drop in the state's Medicaid rolls underscored the need for such outreach – the largest percentage drop in the nation – occurring from 1995 to 1997.

Several major public health outreach strategies have been implemented: the "free and reduced price lunch" initiative; the promotion of Health Professional Shortage Area (HPSA) bonuses for treating certain Medicaid recipients; and local health department outreach activities.

Utilizing enhanced Federal match for Medicaid outreach, totaling \$1,000,000 from the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, the Division of Public Health allocated funds to local health departments to perform specified activities. An additional \$1,000,000 was allocated for outreach for immunizations. The outreach goal was two-fold: to increase enrollment of eligible families in Medicaid and BadgerCare, and to improve vaccination coverage, primarily among children under two years of age. The period of the public health allocation extended from July 1, 1998 to September 30, 1999. During this time five DPH regional outreach

specialists were hired: to provide technical assistance to local efforts, to work with schools to identify uninsured children, and to monitor the local department's contracts.

Temporary Assistance for Needy Families (TANF) - On August 22, 1996, Wisconsin was the first state in the nation to submit its state plan for the Temporary Assistance for Needy Families (TANF) block grant and was approved as of September 30, 1996. To remain eligible for TANF funding, Wisconsin submitted a new two-year plan for FFY 1999 - FFY 2000 (October 1, 1998 - September 30, 2000). The TANF program in the state is known as Wisconsin Works or W-2.

The W-2/ TANF program required tremendous changes in the philosophy and the benefit delivery of cash payments and services to economically disadvantaged families. Under the TANF plan, Wisconsin will provide services to needy families at or below 200% of the Federal Poverty Level (FPL) with the level of services provided varying according to income and assets as outlined in the plan. W-2 is designed to provide assistance to needy families with (or expecting) children, and provide parents with job preparation, work and support services to enable them to leave the program and become self-sufficient. There are 72 W-2 agencies in 80 regions of the state. The agencies include a combination of public and private agencies selected through a competitive process.

Wisconsin Works (W-2) - W-2 is based on work participation and personal responsibility. Under W-2, there is no entitlement to assistance, but there is a place for everyone who is willing to work to their ability. The program is available to all parents with minor children with low assets and low income. Each W-2 eligible participant meets with a Financial and Employment Planner (FEP) who helps the person develop a self-sufficiency plan and determine their place on the W-2 employment ladder. The ladder consists of four levels of employment and training options, in order of preference:

- 1. Unsubsidized Employment:** Individuals entering W-2 are first guided to the best available immediate job opportunity.
- 2. Trial Jobs (subsidized employment):** For individuals who are unable to locate unsubsidized work, however, have a willing attitude, the FEP explores options for subsidized employment. These trial job contracts are a way to help the employer cover the cost of training a person who might need extra support in the first three to six months. Trial jobs are expected to result in permanent positions.
- 3. Community Service Jobs (CSJs):** For those who need to practice the work habits and skills necessary to be hired by a regular employer, CSJs are developed in the community. CSJ participants receive a monthly grant of \$673 for up to 30 hours per week in work training activities and up to 10 hours a week in education or training.
- 4. W-2 Transition (W-2 T):** Transition is reserved for those who, because of severe barriers, are unable to perform independent, self-sustaining work. W-2 T participants receive a monthly grant of \$628 for up to 28 hours per week participating in work training or other developmental activities up to their ability and up to 12 hours per week in education or training.

W-2 participants are limited to 24 months in a single employment position category (Trial Jobs, CSJs, or W-2 T). The maximum lifetime limit is 60 months. Extensions may be available on a limited basis when barriers exist that

prevent employment. A major part of W-2 consists of the related support services and features designed to facilitate access to and sustain employment.

- **Job Centers** combine job search, job opportunities, education, training, and W-2 services in one location. This promotes integrated access to many related services.
- **Local Children's Services Networks and Community Steering Committees** organize community leaders to coordinate resources leading to self-sufficiency.
- **Child Support** is paid directly to most custodial parents and does not cause a reduction of the W-2 payment.
- **Wisconsin Shares Child care** is available to most low-income working families. Families pay a co-payment based on their income.
- **Job Access Loans** are available to help families meet immediate financial needs that sometimes prevent them from working--like car repairs and personal emergencies.
- **Transportation Assistance** ensures that parents can get their children to day care and themselves to work.
- **Health Care** is available through Medicaid/BadgerCare.

As a result of W-2, there has been a growing need for quality child care that is accessible, affordable and can adequately meet the complex needs of children with special health conditions.

Tobacco Settlement - The Wisconsin Legislature's biennial budget, completed in 1999, creates a statewide Tobacco Control Program, administered by a new Tobacco Control Board. The new program is funded with a portion of the money the state received from the 1998 settlement of its lawsuit against the tobacco industry. Efforts by states to recover Medicaid costs from tobacco-related illnesses culminated when 46 states, including Wisconsin, signed a master legal settlement with five large tobacco companies. The state expects to receive about \$6 billion through 2025 and about \$160 million a year after that.

Act 9, the Wisconsin biennial budget bill in 1999, authorizes the Tobacco Control Board with the responsibility to appropriate \$22.9 million for grants for purposes such as:

- The Tobacco Research and Intervention Center at the University of Wisconsin-Madison;
- Smoking prevention and cessation activities at the Medical College of Wisconsin;
- The Thomas T. Melvin Youth Tobacco Prevention and Education Program;
- A youth smokeless tobacco cessation and prevention campaign in the Division of Public Health; and
- Various programs aimed at enforcement, marketing, education and treatment. Prominent target groups will include children, minorities and pregnant women.
- Local public health smoking cessation and intervention programs.

David Gundersen, staff in the Division of Public Health, Bureau of Chronic Disease and Health Promotion will serve as the Tobacco Control Board's Interim Executive Director.

1.5 The State Title V Agency

State Health Agency's Strategic Planning

Strategic Business Plan

The Department of Health and Family Services (DHFS) Strategic Business Plan supports the agency's capacity to promote and protect the health of mothers and children, including children with special health care needs. The Strategic Business Plan has five goals with supporting strategies outlined to achieve each goal.

Goal 1: DHFS will promote actions that improve and protect the health and well being of the people in Wisconsin.

Goal 2: DHFS will develop effective, efficient, accessible human service systems that provide quality care, services and supports.

Goal 3: DHFS will foster effective communication and partnerships with other organizations, communities, providers of service, consumers and families and the general public.

Goal 4: DHFS will identify and apply the best knowledge for achieving the greatest positive impact on health and social service needs.

Goal 5: DHFS will foster best business practices in its operations to most effectively serve the people of Wisconsin.

A copy of the progress report on the Strategic Goals is available upon request. As part of the strategic planning process, DHFS required all bureaus to develop scorecards to measure the progress on certain health indicators as approved by the Department. See Appendix A, DHFS Scorecards for Maternal and Child Health.

Turning Point Initiative - Turning Point is a statewide initiative to transform Wisconsin's public health system and prepare it to address current and emerging 21st Century health problems and issues. The goal is to create a healthier Wisconsin by establishing stronger partnerships throughout the public health system.

Turning Point is led by a "Transformation Team" of 45 people appointed by the Department of Health and Family Services' Secretary Joe Llean. This team represents a cross-section of public health partners from the private, nonprofit, public and voluntary sectors. The approach and outcomes of the initiative rest on four key foundations: 1) public health science, 2) collaborative partnerships, 3) strategic planning, and 4) quality improvement.

The planning process will generate important products: a definition of public health; identification of Wisconsin's top public health priorities; a public health improvement plan for 2010; recommendations for necessary policy changes; and implementation action steps.

A major deliverable requested by DHFS Secretary Llean is the identification of Wisconsin's top public health priorities. In response to this request, a Data Expert Advisory Workgroup has met to determine a process to identify the major public health concerns. To date, 55 important disease/conditions have been identified. More information about the Turning Point Initiative can be found at: www.dhfs.state.wi.us/health/TurningPoint/TPindex.htm.

1.5.1 State Agency Capacity

1.5.1.1 Organizational Structure

Organizational Structure and Placement of the Governor, State Health Agency, Maternal and Child Health Program (including Children with Special Health Care Needs)

On July 1, 1996, the Department of Health and Social Services officially became the Department of Health and Family Services (DHFS). The Department Secretary is a member of Governor Thompson's cabinet. In 1996, the Department was organized into five divisions: Division of Health (DOH); Division of Children and Family Services (DCFS); Division of Supportive Living (DSL); Division of Care and Treatment Facilities (DCTF); and the Division of Management and Technology (DMT), plus the Office of Strategic Finance (OSF).

Another reorganization occurred on July 1, 1998, when the Governor signed into law the creation of two new Divisions within the Department: the Division of Public Health (DPH) and the Division of Health Care Financing (DHCF). The division reorganization became official on September 28, 1998. The reorganization has had a favorable impact on health programming within the Department because sections were elevated to bureaus. Therefore, direct access to the Division of Public Health Administrator, as well as to the Secretary's Office, has improved significantly.

Divisions in the DHFS

- **The DPH** is responsible for providing public health services, developing and enforcing environmental and public health regulations, and performing disabilities determination. John Chapin serves as the Division Administrator. Kenneth Baldwin is the Deputy Administrator. The Title V MCH Block Grant funds are administered from the Division. The Bureau of Family and Community Health, Family Health Section is clearly demarcated within the Division as the designee for administration of the Title V activities. This clear demarcation is critical for ensuring comprehensive program activity and a single point of accountability. See *Supporting Documents 5.3, DHFS, DPH, and BFCH Organizational Charts*.

Division of Public Health Bureaus

There are six bureaus in the Division of Public Health:

- Family and Community Health with three sections: Family Health, Nutrition (including WIC) and WIC Vendor.
- Environmental Health
- Occupational Health
- Emergency Medical Services and Injury Prevention
- Chronic Disease and Health Promotion
- Communicable Disease

In addition, there are Chief Medical Officers, 5 DPH Regional Offices, and the Office of Operations that complete the Division of Public Health organizational structure.

- **The DHCF** manages the Medicaid Program. Peggy Bartels is the Division Administrator.
- **The DCFS** focuses on issues, policies, and programs affecting children and families and has the responsibility for the regulation and licensing of child care and child welfare programs. The DCFS is responsible for carrying out the program activities aligned with the Title V Abstinence Only funds. The Family Health Section works closely with this Division.
- **The DSL** has the responsibility to manage mental health programs, substance abuse, and developmental disabilities, as well as aging and long-term support programs.
- **The DCTF** operates the Department's institutions for persons with mental illness, managing treatment for sexual offenders, and those with developmental disabilities.
- **The DMT** provides management support for fiscal services, information technology, personnel, affirmative action, and employment relations.
- **The OSF** plays a major role in controlling costs while providing effective services.

Statute Statutes Relevant to Title V Program Authority

In 1993 Wisconsin Act 27, created Chapters 250-255 that significantly revised public health law for Wisconsin and creates an integrated network for local and state health departments.

- Chapter 250 defines the role of the state health officials including the state health officer, chief medical officers, the public health system, the power and duties of the department, qualifications of public health nursing, public health planning and grants for dental services.
- Chapter 251 describes the establishment of local boards of health, its members, powers and duties, levels of services provided by local health departments, qualifications and duties of the local health officer, and how city and county health departments are financed.
- Chapter 252 outlines the duties of local health officers regarding communicable disease to include the immunization program, tuberculosis, sexually transmitted disease, acquired immunodeficiency syndrome, blood tests for HIV, and case reporting.
- Chapter 253 mandates a state maternal and child health program in the Division of Public Health to promote the reproductive health of individuals and the growth, development, health and safety of infants, children and adolescents to include:
 - s.253.06 State supplemental food program for women, infants, and children
 - s.253.07 Family planning
Wisconsin Administrative Code Chapter HFS 151 describes family planning fund allocations.
 - s.253.08 Pregnancy counseling services
 - s.253.85 Outreach to low-income pregnant women
 - s.253.09 Abortion refused; no liability; no discrimination
 - s.253.10 Voluntary and informed consent for abortions

- s.253.11 Infant blindness
- s.253.115 Newborn hearing screening
- s.253.12 Birth defects prevention and surveillance system
- s.253.13 Tests for congenital disorders
- s.253.14 Sudden infant death syndrome

Refer to *Appendix B* to read *Chapter 253* in its entirety.

- Chapter 254 focuses on environmental health and includes health risk assessments for lead poisoning and lead exposure prevention, screening requirements and recommendations, care for children with lead poisoning or lead exposure, lead inspections, lead hazard reduction, asbestos testing, abatement, and management, indoor air quality, radiation, and other human health hazards.
- Chapter 255 addresses chronic disease and injuries and outlines cancer reporting requirements, cancer control and prevention grants, breast and cervical cancer screening programs, health screening for low-income women, tanning facilities, and the Thomas T. Melvin youth tobacco prevention and education program.

Other relevant maternal and child health statutes are summarized as follows:

- Chapter 20, Subchapter V Human Relations and Resources that:
 - s.20.433 Establishes the child abuse and neglect prevention board
 - s.20.434 Establishes the adolescent pregnancy prevention and pregnancy services board
 - s.20.435 Defines Health and Family Services Department
 - s.20.436 Defines the Tobacco Control Board
 - s.20.9275 Prohibits funding for abortion-related activities as a result of 1997 Wisconsin Acts 27 and 237
- Chapter 48 is the Children's Code and s. 48.981 addresses abused and neglected children and abused unborn children.
- Chapter 46 addresses social services. Specific maternal and child health related statutes are listed as follows:
 - s.46.22 County social services funding, power and authority
 - s.46.23 County department of human services, intent, delivery of services plan, and board makeup
 - s.46.238 Infants whose mothers abuse controlled substances or controlled substance analogs
 - s.46.24 Assistance to minors concerning parental consent for abortion
 - s.46.245 Information for certain pregnant women
- Chapter 49, Subchapter IV addresses Medical Assistance. Those of particular interest for maternal and child health are:
 - s.49.45 (44) Providers in Milwaukee County to provide prenatal, postpartum and young child care coordination for children who have not attained the age of seven
 - s.49.46 Medical assistance and recipients of social security aids
 - s.49.465 Presumptive medical assistance eligibility
- Wis. Stat. 51.44(5) creates the authority to implement a statewide program of services for children in the age group birth to 3 who are significantly delayed developmentally regarding cognitive development, physical development, and social and emotional development.

- Chapter 143 details services for hearing impaired children to include eligibility requirements for hearing impaired children in need of amplification and services, services available, financial services, and requirements for participating clinical audiologists.
- Chapter 146 collapses various miscellaneous health provisions together in one chapter. Several statutes are specific to maternal and child health as follows:
 - s.146.0255 Testing infants for controlled substances or controlled substance analogs
 - s.146.38 Health care services review; confidentiality of information
 - s.146.55 Emergency medical services programs
 - s.146.57 Statewide poison control system
Wisconsin Administrative Code Chapter HFS 167 establishes a statewide poison control system and describes the allocation of funds.
 - s.146.81 Health care records; definitions
 - s.146.815 Contents of certain patient health care records
 - s.146.819 Preservation or destruction of patient health care records
 - s.146.82 Confidentiality of patient health care records
 - s.146.83 Access to patient health care records
 - s.146.93 Primary health care program
- 1997 Wisconsin Act 237 s.99122 (3ty) (b) directs the Department to provide up to 10 grants to public or private hospitals to pay for specialized training and on-site consultation and support of medical personnel of neonatal intensive care units.

1.5.1.2 Program Capacity

The mission of the Wisconsin Maternal and Child Health Program is to:

promote the health and well being of all children including children with special health care needs, mothers, families and communities by assuring that an organized system exists in order to assist them to realize their full potential as responsible and productive persons.

Consolidated Contract Plan

1993 Wisconsin Act 27 establishes the principle that public health services in Wisconsin are the responsibility of the local health departments. In January 2000, the DPH put forward a consolidated contract plan to put the procurement practice for key public health services at the local level in line with this statutory directive. Local health departments are required by statute: to assess the community health status and available resources; to review and develop policy resulting in proposals to support and encourage better health; and to assure that needed services are available.

The consolidated contract process pulls together federal and state health-related funding, such as Title V MCH, Prevention, Immunization, Lead and Women’s Cancer Control, into one single contract. In addition to the

accounting change, there are program requirements that include: meeting specific quality criteria, negotiating performance-based objectives, outlining risk and recoupment strategies if objectives are not met, and identifying incentives if performance exceeds expectations. See *Supporting Documents 5.3, Quality Criteria and Monitoring Tool*. The Family Planning/Reproductive Health program is not a part of the consolidated contract accounting process, but must follow the same program requirements as mentioned above. Similarly, although the WIC Program will not be included in the consolidated contract accounting process, it will follow all other consolidated contract program requirements as of January 2001. The Native American tribes did not participate in the consolidated contract process in 2000, however negotiations are underway for 2001.

The consolidated contract plan places local health departments at the center of either the provision of those services or in the local management of those services if provided by non-public organizations. In instances where the local health department did not want to provide or subcontract services the state assumed a primary responsibility and assurance role by making the funds available for interested agencies or organizations through a competitive process.

Beginning January 2000, all public health departments (72 county health departments and 28 city health departments) received funds based on a formula derived from examining a combination of factors specific to each program. The MCH funding allocation considered: a base allocation linked with the public health department's level of functioning (1, 2 or 3); the county's population; target populations such as the percentage of children and women of childbearing age; risk factors such as poverty, educational level of mothers, infant mortality and very low birth weight; and geographic density of the county.

In the 2000 MCH Needs and Strengths Assessment (further described in Section 3), local health department directors were asked why they chose the MCH activities that they did for the consolidated contract.

There were 42 responses indicating that their activities were a direct response to a needs assessment. Typical responses included: the activities address an identified problem, were the result of a survey of need, or evolved from a community consensus or request.

There were 31 responses saying that the local health department had done the activity before successfully. Some said that the need the activity addressed continues, others that they wanted to build on or expand an existing service, while others said that they do a better job in providing the activity than other potential providers.

There were 47 responses indicating that the health department itself was concerned about an issue or had a desire to undertake the activity. Reasons for these activity choices include: to expand the number of local partners, to build on what was learned, to make the biggest impact, to enter a new service or geographic area, or to fill a gap.

Local health department directors also expressed a variety of responses to the consolidated contract overall in the 2000 Needs and Strengths Assessment. One director said, "We need to maintain flexibility in the funding stream so community needs are addressed. The consolidated contract may help. I would like to see more funding in this manner." Another, "I like the consolidated contract process. The focus on outcomes makes sense. It ties the budget to where we want to be and follows a program logic model." Another positive comment, "We feel the consolidated

contract process was helpful. WIC should be added in the future.” And, “I hope the information collected through the consolidated contract process will expand the selection of local and regional programming.” There were also concerns mentioned, particularly about the lack of money available to meet the overall need of the community.

The DPH Regional staff negotiated with the public health departments in the fall of 1999 to determine the performance-based objectives that they would be responsible for during the 2000 calendar year. This process will be repeated for 2001. A summary sheet was completed for each program that clearly outlined the funding amount, objectives, measures, data sources, baseline, success indicator, risk performance disincentive, recoupment strategy, and performance incentive. See *Supporting Documents 5.3, DPH Consolidated Contract Addendum Example*. Also see *Appendix C, 295 MCH Consolidated Contract Objectives*.

The MCH Program categorized the 295 objectives into four MCH Themes:

Theme 1: Increase the incidence of healthy birth outcomes.

Theme 2: Promote optimal growth and development and assure comprehensive primary care for children birth to 21, including children with special health care needs.

Theme 3: Promote healthy lifestyles among school-age youth, 6 to 21, in their communities, including children with special health care needs.

Theme 4: Assure access to safe, quality child care up to age six including children with special health care needs.

A summary detailing the theme selections by county and city health departments is found in *Supporting Documents 5.3, Consolidated Contract Summary*

MCH Statewide Programs Requests for Proposals

During July 1999, the Division released six statewide program request for proposals totaling \$3,027,163 that are not a part of the consolidated process.

➤ Public Health Information and Referral Services for Women, Children and Families (for hotline services)

Lutheran Hospital - LaCrosse will provide the *Public Health Information and Referral Services for Women, Children and Families*. They will provide services for several different hotlines that address maternal and child health including WIC, Medical Assistance information, and women’s health, Birth to Three Program, and children with special health care needs. The goals are to:

- Provide toll-free hotline services that operate 24 hours a day, seven days a week for all programs.
- Develop a comprehensive and current computer database.
- Provide quality information and referral services for each program.
- Ensure quality responses provided by the hotline staff.

➤ Statewide Services for Sudden Unexpected Infant Deaths

Children’s Hospital of Wisconsin provides *Sudden Unexpected Infant Deaths* services throughout the state.

The SUID program goals are to:

- Assure the uniform provision of information, counseling and support to Wisconsin families, day care providers, health care providers, and others who are affected by a sudden or unexpected death of an infant from Sudden Infant Death Syndrome (SIDS), trauma or illness in accordance with Wis. Stats. 253.14.
- Engage in collaborative outreach, educational and infant mortality review activities that will result in the reduction of preventable infant deaths.
- In collaboration with the public health system and national infant mortality programs, maintain a database on sudden, unexpected infant deaths that supports epidemiological study and required statistical reports.

➤ Statewide Perinatal Health System Building Program

Wisconsin Association of Perinatal Care provides statewide *Perinatal Health System Building* services. The project goals are to:

- Maintain an effective statewide system of comprehensive perinatal services through a multidisciplinary collaboration of public and private sector health care providers and consumers.
- Demonstrate a capability to identify and address emerging needs for improvement in the system for perinatal service delivery with a particular emphasis on Universal Newborn Hearing Screening.
- Conduct collaborative activities that assure the availability, accessibility, affordability, and acceptability of quality perinatal health services.
- Assistance with development of a multidisciplinary maternal mortality review process.

➤ Child Health System Building Program

Children's Hospital of Wisconsin provides *Child Health System Building* services statewide. The project goals are to:

- Strengthen the statewide system of child health services through a multidisciplinary collaboration of public and private sector health care providers and consumers.
- Demonstrate a capability to identify and address emerging system improvements to assure a comprehensive child health service delivery system.
- Conduct collaborative activities that assure the availability, accessibility, affordability and acceptability of quality child health services.

➤ Regional CSHCN Centers (see CSHCN Program Redesign)

➤ Family Planning and Reproductive Health Services (see Family Planning and Reproductive Health Services)

➤ A separate sole source contract was awarded for statewide genetic services

The University of Wisconsin's Clinical Genetics Center will:

- Develop a system of genetic services that will be accessible in all Division of Public Health regions.
- Provide genetics consultation services that include outreach, identification, diagnostic evaluations, counseling, education and follow-up.
- Provide education and training to community care providers, families and others.

➤ Regional MCH Education and Training Project

In January 2000, each of the five Division of Public Health regional offices received \$20,000 to support a Regional MCH Education and Training Project. The goal of this project is to assure the basic capacity and competency of local public health staff (public health educators, nurses and nutritionists) to effectively address maternal and child health needs at the local level.

Each regional office, with assistance from central office, developed a unique training plan to address the specific needs of local public health staff within its jurisdiction. Funds will support activities ranging from payment of registration fees and travel cost for local public health staff to attend various training sessions, to support of conference speaker and instructor fees. Content of various sessions ranges from nutrition, migrant health, day care, and breast feeding, to management skills such as negotiation and strategic planning. Each region's allocation includes \$1,000 to support participation of one local health department representative in the Illinois Public Health Leadership Institute.

Regional offices have also pooled their resources to establish multi-regional/statewide activities that will address more universal needs. Two one-day training sessions on strategic planning for MCH are scheduled for September 2000. One session will be in the northern part of the state and one in the southern part of the state. Several hundred local public health staff are expected to attend.

Regional offices are developing long term training plans that will address activities for the next four years. Training needs identified by local health department staff for the MCH five-year needs assessment will be considered in developing these plans. Priority training needs that were identified include electronic record keeping, utilizing the internet, team/coalition building, marketing and data collection, as well as new and emerging public health issues and technologies.

Children with Special Health Care Needs Program Redesign

The CSHCN Program in January 2000 awarded contracts totaling \$1,370,000 to establish Regional CSHCN Centers in each of the five Division of Public Health regions. The Regional CSHCN Centers will increase the capacity of local communities to serve families. The five Regional CSHCN Centers will work together to form a statewide, integrated system for children with special health care needs and their families. These Centers will begin to offer services to families and providers in fall 2000, after an initial planning period for infrastructure development and start-up activities.

The goals of the Regional CSHCN Centers are to:

- (1) Provide a system of information, referral, and follow-up services so all families of children with special health care needs and providers have access to complete and accurate information. Referrals will be made to various agencies and programs, as appropriate, based on the information requested and need for follow-up services. Examples include local health departments, county and tribal human/social services, Social Security Administration, schools, Child Care Resource and Referral agencies, child care providers, various local community-based organizations, WIC, Birth to Three, Family Support, and Independent Living Centers. The

Public Health Information and Referral Services for Women, Children and Families (First Step Hotline) program will support the statewide information and referral needs for the Regional CSHCN Centers. The Wisconsin Division of Health has contracted with Lutheran Hospital in LaCrosse to provide this service.

- (2) Promote a parent-to-parent support networks to assure all families have access to parent support services and health benefits counseling.
- (3) Increase the capacity of local health departments and other local agencies, such as schools, to provide service coordination.
- (4) Work to establish a network of community providers of local service coordination.
- (5) Initiate formal working relationships with local health departments and establish linkages for improving access to local service coordination.

The contracts for the Regional CSHCN Centers by region have been awarded to:

- Children’s Hospital of Wisconsin, Inc. with St. Vincent Hospital in Green Bay located in the Northeastern DPH Region.
- Family Resource Connection, Department of Sacred Heart/St. Mary’s Hospital, Inc, in Rhinelander located in the Northern DPH Region.
- Children’s Hospital of Wisconsin, Inc., in Milwaukee located in the Southeastern DPH Region.
- Board of Regents, University of Wisconsin System at the Waisman Center in Madison located in the Southern Region.
- Chippewa County Department of Public Health in Chippewa Falls located in the Western DPH Region.

Family Planning and Reproductive Health Services

Wisconsin’s Family Planning and Reproductive Health Services Program provides a combination of direct care and support services in all 72 counties. As stated previously, family planning/reproductive health services are funded by Title X in 21 counties at approximately \$3,000,000 annually (the current contractor is Planned Parenthood of Wisconsin). For calendar year 2000, a combined total of \$3,809,215 of Title V and state general purpose revenue [GPR] funds the remaining 51 counties. One county receives only GPR funding by a special statute. Title V also funds family planning/reproductive health agencies for early pregnancy testing (EIDP) services in all 72 counties.

Local health departments are providing family planning/reproductive health and EIDP services through a negotiated contract or by subcontract in 22 Wisconsin counties (including the Menominee tribal reservation). They had the “right of first refusal” for these funds and chose to accept them. Funding for the remaining 29 counties was released through a competitive request for proposals (RFP).

The following agencies were funded:

- Planned Parenthood of Wisconsin, Inc.
- Family Planning Services, Inc.
- Northeast Wisconsin Community Action Agency, Inc.

- Berlin Memorial Hospital Women’s Health and Resource Center
- Douglas County Community Clinic, Inc.
- Vilas County Health Services, Inc.

In addition, Title V/GPR funding is allocated for a specialized adolescent family planning clinic in Milwaukee at the Medical College of Wisconsin and additional family planning services at the Oneida tribal health clinic. GPR funds are also used for statewide training, technical assistance and continuing education by Health Care Education and Training, Inc. and to contract for laboratory services at the State Laboratory of Hygiene.

City of Milwaukee Request for Proposals

As mentioned previously, calendar year 2000 is the first year of funding MCH services in Wisconsin as part of a consolidated contract process. The City of Milwaukee was the only local health department that did not accept its entire MCH allocation. The MCH Program released an RFP for \$226,063 to fund a variety of prioritized services in the city of Milwaukee. The services chosen reflected an organized prioritization process with local MCH stakeholders, a review and analysis of data and reports and the experience of city health department personnel. The services were then categorized under the MCH Themes. See *Appendix D* for a list of *City of Milwaukee priorities*.

The following agencies were funded for MCH services in the city of Milwaukee:

- Medical College of Wisconsin for comprehensive health services for adolescents and teen parents.
- St. Mary’s Hospital, 16th Street Community Health Center and Planned Parenthood of Wisconsin for prenatal care coordination, targeting Latina pregnant women not eligible for Medicaid.

One time only funds of \$132,925 were also allocated for Children with Special Health Care Needs services in the city of Milwaukee:

- Children’s Hospital of Wisconsin was funded for a one-year grant to establish a sustainable structure within which to address appropriate placement and safe and healthy child care for children with special health care needs.

1.5.1.3 Other Capacity

There are 51.5 authorized MCH FTEs. The Bureau office consists of 3.7 FTEs comprised of: Millie Jones, Bureau Director; Richard Aronson, Chief Medical Officer; a financial specialist; and a program assistant. The Family Health Section office includes Susan Uttech, Family Health Section Chief; Sharon Fleischfresser, Medical Consultant for the CSHCN Program; a program planning analyst; health educator; and program assistant totaling 5.0 FTEs. See *Supporting Documents 5.3, Senior Staff Biographies*.

Family Health Section

The Family Health Section is comprised of two units: the Maternal and Child Health Unit (10.50 FTEs) and the Children with Special Health Care Needs Unit (8.0 FTEs.) Patrice Mocny Onheiber is the MCH Unit Supervisor. The MCH staff includes:

- four public health nurses who address maternal and perinatal, infant and young child health, child health, and MCH delivery systems,
- four public health educators who address MCH general health education, dental health, reproductive health and family planning, and adolescent health,
- one epidemiologist,
- and one program assistant.

Peggy Helm-Quest is the CSHCN Unit Supervisor. Over the past several years the CSHCN Unit has been undergoing significant program reorganization and efforts to reclassify several positions to better meet the new program direction. The CSHCN Unit consists of:

- two public health nurses who work with the recently established Regional CSHCN Centers and early transition issues for CSHCN,
- a public health educator,
- a nurse practitioner (vacant and in the process of hiring),
- an epidemiologist (vacant and in the process of hiring),
- a statewide parent consultant, (newly hired to begin June 26, 2000) and
- a program assistant.

Additional positions within the CSHCN Unit that are funded by different funding sources are:

- Birth Defects Surveillance Research Scientist.

The birth and developmental outcome monitoring program has been replaced through a new statute: the Birth Defects Prevention and Surveillance program (Wisconsin Act 114). The new program (funded through GPR dollars) requires physicians, certain clinics and clinical laboratories to report birth defects identified in children under the age of two, and requires the DHFS to establish and maintain a registry documenting the diagnosis of the birth defect(s). Under this statute, a birth defect is defined as a structural deformation, or a genetic, inherited or biochemical disease that occurs prior to or at birth and that requires medical surgical intervention or interferes with normal growth and development. In addition, the statute requires that a council on birth defects prevention and surveillance be established to advise DHFS regarding the registry and rules related to reporting.

- Public Health Educator/ Research and Outreach for Birth Defects Surveillance. This position will be filled as a limited term employee and is funded with state general purpose revenue.

- Genetics Planning Grant Coordinator.

The Genetics Planning Grant is a two year planning grant funded by MCHB to develop a Wisconsin State Genetic Services Plan and evaluate the flow of information involved in identification, treatment, and referral to service of children with special health care needs. The coordinator is a public health educator in a project position.

- An Audiologist who will be an employee of the Wisconsin Association for Perinatal Care but physically sit in the CSHCN Unit.

To help address the new legislation s.253.1 newborn hearing screening, Wisconsin applied for and received a

Universal Newborn Hearing Screening Grant. Wisconsin's Sound Beginnings, a four year MCHB grant funded program, supports the promotion of universal newborn hearing screening into an integrated service delivery system in Wisconsin. The program provides comprehensive, coordinated newborn hearing screening among Wisconsin's birthing hospitals, and develops and implements family-centered, culturally-competent and community based follow-up services through the following goals:

- ✓ Assess the statewide status of UNHS and follow-up programs in Wisconsin
- ✓ Ensure by January 2003, Wisconsin's birthing hospitals screen a minimum of 90% of newborns for hearing loss prior to discharge
- ✓ Provide professional, parent, and public education about newborn hearing screening
- ✓ Develop a statewide data and tracking system for universal newborn hearing screening and follow-up.

Parents of Special Needs Children on Staff

Over the past year, we have made great strides to establish a meaningful role for parents and families. The MCH Advisory Committee has had parent representation for quite a few years and this is still in place.

The statewide parent consultant is our first official hire to provide and coordinate the parent perspective. She will begin June 26, 2000 to provide guidance to family centered programming. The Regional CSHCN Centers are developing a structure that will establish a strong local parent network statewide. Each Regional CSHCN Center must have at least one parent coordinator on staff, and recruit one county parent liaison for each county in their region. In addition, the First Step Hotline must employ a parent who has a child with a special health care need to answer the calls Monday through Friday, from 8:00 a.m. to 5:00 p.m.

Several other positions are an integral part of the Family Health Section, but have different funding sources, including the Statewide System Development Initiative (SSDI) Agency Liaison funded from the SSDI allocation.

The Wisconsin Statewide System Development Initiative (SSDI) - The Wisconsin SSDI project is aimed at strengthening the infrastructure of the State's Maternal and Child Health (MCH) Program by intensifying comprehensive community system development activities. The Wisconsin MCH Program has been funded by SSDI since 1992. Activities have focused on leadership development; coalition building, needs assessment, Quality Improvement skill development, and system strengthening. These efforts have been directed at both the state and local level. Year 06 activities included; partnering with two Area Health Education Center (AHEC) System regional offices to plan and conduct a series of skill-building workshops, sponsoring a second regional and central office retreat, commencing a quarterly QI Communication Bulletin, partnering with the MCH Institute in the planning and conduct of the 1999 Summit Conference, establishing an email network of all regional and Bureau staff to assure timely updates, establishing an email network to regularly announce new Division employees, and the design and production of a MCH staff directory. See Appendix E, Year 06 SSDI Program Materials. Wisconsin was successful in receiving SSDI funding for an additional 2 years to support the MCH 5-year needs assessment process and to strengthen the MCH data set affirming the federal and state MCH Performance Measures.

- Newborn Screening (Congenital Disorders) Consultant and a Statewide Genetics Consultant (funded with state newborn screening surcharge) are State Lab of Hygiene employees, located in the section.

Nutrition Section

There are 3.02 MCH authorized FTEs in the Nutrition Section. The most recent addition is a public health nutritionist focusing on the special nutritional requirements of children with special health care needs. In addition there is a public health nutritionist for MCH, an MCH and WIC data system coordinator, and a program assistant.

Other DPH Bureaus/Sections

In addition, there are 20.37 FTEs placed throughout the Division:

- Dental Health Officer is located at the Division of Public Health Office (1.0 FTE). Significant progress continues to be made in Wisconsin regarding infrastructure and surveillance activities for dental sealants. Through a CDC grant awarded to the Department of Public Instruction and the Department of Health and Family Services, Wisconsin has implemented a *Healthy Smiles for Wisconsin* initiative. This initiative is a statewide effort to improve the oral health of Wisconsin children through school and community partnerships. Progress continues on developing a statewide plan for working with schools and communities to increase access to oral health education, prevention (dental sealants is a primary component), and treatment services for school-aged children. The *Back to School for Healthy Smiles Initiative*, developed a plan for incorporating school-based and school-linked education, prevention (dental sealants is again a primary component), and service delivery strategies into dental hygiene education programs in the Wisconsin Technical College System and at Marquette University. Through the *Healthy Smiles* initiative, a Youth Oral Health Forum on oral health surveillance and data collection with statewide participation was held in February of 1999. A surveillance committee met on a regular basis to plan and implement an oral health surveillance system in Wisconsin. The surveillance plan was completed and will be implemented, beginning the fall of 2000. A component of the system will include a plan to implement ASTDD's Screening Training Protocol. Another Youth Oral Health Forum on dental sealants was held in June 2000. The goal of the sealant forum, to begin to develop a plan to "Seal the State" and greatly increase the number of children with dental sealants in Wisconsin has begun. Two sets of regional meetings were held and multiple local coalitions have already formed. The program will be placing sealants in every region of the state, with a "kick off" planned for October 2000.
- Injury Prevention Section Chief is located in the Bureau of Emergency Medical Services and Injury Prevention (1.0 FTE).
- Injury Prevention Program Assistant also located in the Bureau of Emergency Medical Services and Injury Prevention (.55 FTE).
- Reproductive Hazards in the Workplace Program Consultant is located in the Bureau of Occupational Health (1.0 FTE).
- Lead Prevention Consultant is located in the Bureau of Environmental Health (.70 FTE).
- Primary Care Consultant in the Bureau of Chronic Disease and Health Promotion (.20 FTE).

- Office of Operations has 6.58 FTE to support the fiscal and administrative duties of grants management.
- Division of Public Health's 5 Regional Offices have 9.34 FTE to support portions of staff time provided by the regional office directors, nurse consultants, health educators, and nutritionists. The Regional Office staff provide the direct link to the local health departments and other community based agencies and organizations. The bureau director meets with the regional office directors monthly.

1.5.2 State Agency Coordination

Title V, WIC, Medicaid, CHIP and Disability Determination Programs

A Memorandum of Understanding (MOU) between the Wisconsin Division of Public Health (DPH) and the Division of Health Care Financing (DHCF), outlines comprehensive coordination between a number of state level programs. Programs represented by the DPH include the Wisconsin Maternal and Child Health and Children with Special Health Care Needs Program (Title V) and the Supplemental Nutrition Program for Women, Infants and Children (WIC). Programs represented by the DHCF include the Wisconsin Medicaid Program (Title XIX), HealthCheck (the Wisconsin EPSDT Program), BadgerCare (the Wisconsin SCHIP Program, funded by both Title XIX and Title XXI), and the Bureau of Disability Determination Services (DDS).

Medicaid Managed Care Expansion

- Efforts have been taken to develop an important, system link between Wisconsin's public health system and Medicaid managed care system consistent with the mission of public health and the core functions of public health assessment, assurance and policy development.
- Coordination and collaboration are promoted between local health departments, WIC projects, HMOs, and other Title XIX managed care programs.
- Title V and WIC funded agencies encourage recipients of Medicaid who are eligible for HealthCheck services to receive preventive care through HealthCheck screening. Medicaid children who are enrolled in managed care programs must receive Medicaid services from their assigned managed care providers.

Wisconsin's CSHCN Program

The Children with Special Health Care Needs Program and Title XIX continue coordination and cooperation efforts through established mechanisms including: electronic data exchange and other data exchange for administration, evaluation and analysis.

Non-duplication of Medicaid payments to SSI recipients under 16

- Title V assures the provision of rehabilitation services for blind and disabled individuals under the age of 16 receiving Supplemental Security Income (SSI) benefits under Title XVI (of the Social Security Act), to the extent such services are not covered under Title XIX (Medicaid).
- The DDS agrees to continue to send to CSHCN referral materials on all selected children under 16 years of age for whom a disability determination has been requested as part of the application for SSI benefits. These selection criteria are outlined in the screening device that was attached to the 1992 Cooperative Agreement.

The referral material will be sent after the disability determination has been made and will include identifying information and some medical or psychological reports. The DDS will send referral information on all selected children under age 16 whether their claim is allowed or denied.

Toll-free Telephone Numbers

MCH Hotline - Title XIX, Title V, and WIC maintain a toll-free MCH Hotline service for all Wisconsin residents including Title XIX recipients, who may call to locate: Title V grantees, HealthCheck, WIC, Healthy Start, Presumptive Eligibility, Genetic Services, Prenatal Care Coordination (PNCC), and other health care providers.

Medicaid Recipient Hotline - DPH will provide and update a list of Title V services available at the county level to the Medicaid Recipient Hotline for families currently receiving Medicaid or BadgerCare benefits.

CSHCN Program - The State of Wisconsin CSHCN Program has a toll-free number (800) 441-4576 intended to provide families with access to State CSHCN staff. CSHCN staff rely on these toll-free calls to facilitate rapid response to family needs. The CSHCN program will use the toll-free number as an additional opportunity to refer families for Title XIX and Title XXI services. In addition the CSHCN Program and the Birth to Three will have a comprehensive hotline called First Step to provide information and referral.

DPH and DHCF further agree to collaborate on the development and dissemination of materials used to publicize these toll-free numbers, including both print and electronic media.

HealthCheck (EPSDT)

The purpose of HealthCheck is to provide comprehensive preventive services, to identify health problems early and to assure coordinated follow-up services to Medicaid children and youth birth to 21 years of age. Title V state agencies and Title XIX state agencies have a mutual commitment - to improving services to this population. Title V providers serve a predominantly low-income population, many of whom are Title XIX eligible. Title V providers are responsible for billing Title XIX for covered services, so as to maximize availability of Title V funding for non-Title XIX clients.

In order to maximize the effective operation of Wisconsin's fee for service Title XIX, Title V and WIC Programs, a number of methods for coordination have been established, including:

- Title V agencies certified and providing HealthCheck Outreach services may request listings of Medicaid providers in their service area from DHCF for purposes of referral.
- HealthCheck outreach agencies will refer all identified Title XIX recipients to the appropriate ancillary service such as; WIC Program, Title V projects, local health departments, community based agencies, Head Start, school health programs, the CSHCN Program, and any other public or private provider.
- The Title V and WIC providers must refer all Medicaid HMO enrolled children to their HMO for the comprehensive HealthCheck screening.

- Title V agencies certified as HealthCheck providers will identify all primary health care and nutritional needs of their Title XIX recipients and will refer patients, as appropriate, to the WIC program, Title V projects, local health departments, community based agencies, Head Start, school health programs, the CSHCN Program, and any other appropriate public or private provider.
- The Title V and Title XIX agencies will inform providers of Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents, which is listed as a resource for providers conducting HealthCheck comprehensive examinations. HealthCheck providers, however, will be expected to adhere to the HealthCheck periodicity schedule. The Title V and Title XIX agencies will cooperate when providing technical consultation and support sessions for potential HealthCheck.
- Payment and reimbursement procedures and policy clarification are provided to all HealthCheck providers and the Title V Program. Additional assistance with billing instructions is provided by the Title XIX fiscal agent. The Title XIX Agency will provide technical training on Medicaid policy and billing for HealthCheck certified providers, including the HealthCheck "other services" component.

Medicaid Applicant Identification and Assistance

Wisconsin Title V, Title XIX, and WIC Programs agree to collaborate on programs and services to identify pregnant women and children who may be eligible for Medicaid and once identified, to assist them in applying for such assistance, including the following:

- Healthy Start
- Presumptive Eligibility
- BadgerCare

Title V, Title XIX, and State WIC programs agree to collaborate on assisting Medicaid recipients with selecting an appropriate managed care delivery system.

Cooperative and Collaborative Relationships

Title V, Title XIX, and the State WIC programs agree to establish cooperative and collaborative relationships, including work groups and periodic meetings, with respect to the following programs and services, including, but not limited to:

- HealthCheck (EPSDT)
- Immunizations (see Memorandum of Understanding between DPH and DHCF)
- CSHCN
- Recipient Access/Provider Participation including Electronic Benefits Transfer
- Medicaid Clinical Review
- Prenatal Care Coordination
- Healthy Start
- Birth to Three

- Children Come First
- Expansion of Medicaid Managed Care programs statewide
- Medicaid outreach and eligibility
- BadgerCare including Title XXI
- Family Planning waiver service
- Implementation of Medicaid eligibility functions with the Department of Workforce Development

Title V and Child Welfare

As mentioned previously, Title V also works closely with the Division of Children and Family Services (DCFS), the state agency responsible for the regulation and licensing of child care and child welfare programs. In addition to carrying out the activities of the Abstinence only funds, DCFS also has Memoranda of Agreement (MOA) with the DPH. These MOAs transfer general purpose revenue (GPR) funds and the administering responsibility for two home visitation projects: Wisconsin's Prevention of Child Abuse and Neglect Program (known as POCAN) and a pilot project in the inner city of Milwaukee, the Milwaukee Family Project. Both of these projects are discussed in detail "Other Coordination Efforts".

DPH and DCFS also collaborate on two other state initiatives, along with other state level agencies. Staff of the Title V Program have been active members of the state "Brain Team", an inter-departmental workgroup which formed as a response to the findings of early brain research. Under the auspices of the Maternal and Child Health Training Institute funded by the Wisconsin Title V Program for five years, (1994-1999), a "train the trainers" curriculum was developed and materials were disseminated across the state. These materials are currently housed with the March of Dimes and continue to be used. Title V program staff also continue to participate in the DCFS-sponsored Brighter Futures Initiative: The Wisconsin Plan to Prevent Adolescent Pregnancy. These activities are integrated at both the state and local level with Title V funded services. The Brighter Futures Initiative also uses the MCH Five Guiding Principles.

State Medical Society of Wisconsin

Maternal Mortality Review

A new effort to be undertaken by Title V program staff is the responsibility for convening a state level maternal mortality review team. Since 1953, the State Medical Society (SMS) of Wisconsin has conducted maternal mortality reviews. Through a Memorandum of Understanding with the Department of Health and Family Services, potential cases were identified and sent to the SMS semi-annually. The State Title V Chief Medical Officer and Perinatal Nurse Consultant have attended the case review meetings. All medical records were de-identified and results have been published as 10 year aggregate studies in the *Wisconsin Medical Journal*.

In the fall of 1999, the SMS finalized a series of organizational changes and informed the Title V Program that it could no longer conduct maternal mortality reviews. Plans are underway to begin a new process, with the assistance

of the Statewide Perinatal Systems Building project, funded by Title V and described in the “Program Capacity” section.

Summer Preceptorships

Each summer the SMS sponsors a medical student for a summer internship with the Title V program. Students come from either the University of Wisconsin Medical School in Madison or the Medical College of Wisconsin in Milwaukee.

Wisconsin Medical Journal

The April 2000 issue of the *WMJ* was devoted to Maternal and Child Health in Wisconsin and featured a number of articles authored by Title V Program staff and the DPH administrator. See [*Appendix F*](#) for a copy of the *April 2000 issue of the WMJ*. This was an initial effort on the part of the SMS and Title V to collaborate on issues of mutual concern and paves the way for future endeavors.

Primary Care and AHEC

The Title V Program contracted with Wisconsin AHEC to conduct the SSDI activities for several years. This laid the foundation for a working relationship between public health and AHEC that continues. In the fall of 1999, a day-long seminar was held to explore how Title V, Primary Care, and AHEC could look at ways to increase cooperation once the SSDI was reintegrated into the Title V central office. The intent is that these three programs can work together to address provider shortages and public and primary care access in underserved areas of the state.

University of Wisconsin Schools of Medicine, Nursing and Population Health

Over the past several years, Title V in Wisconsin has developed a relationship between the University of Wisconsin Schools of Medicine and Nursing, and recently, with the School of Population Health. The MCH Program has been host to a number of graduate students as an internship site and we participate in a public health rotation for pediatric residents during their residency program. Students conducted various projects and as a result relationships with faculty have been formed to share data and further develop our programs.

In addition, the Title V Chief Medical Officer gives pediatric Grand Rounds every year at the Department of Pediatrics. We will continue to explore these opportunities to further enhance our capacity to address maternal and child health in Wisconsin.

Inter-Bureau Collaboration at the Division of Public Health

Numerous opportunities for collaboration with other Bureaus within the DPH exist for the Title V program in Wisconsin. Environmental and occupational health, chronic disease and health promotion, communicable diseases, emergency health and injury prevention are all areas of public health whose staff frequently interact at the programmatic level with Title V staff, housed within the Bureau of Family and Community Health. A recent example of this collaboration was an ad hoc workgroup of representatives from each bureau assigned to develop a

series of integrated proposals for tobacco settlement funds. Prevention and cessation of smoking for pregnant women and the prevention and reduction of SIDS and asthma by reducing children's exposure to second hand smoke were ranked with the highest priority as they moved forward within the department.

Office of Strategic Finance

During Calendar Years 2000-2002, Title V will be collaborating with the Office of Strategic Finance (OSF) of the Department of Health and Family Services to conduct an evaluation of the Title V program. This is one of a number of prevention programs within the department legislatively required to be evaluated. A final report is due to the legislature by June 2002. We have chosen to evaluate two local health department's programs to provide comprehensive well child health exams and referrals for services (Theme 2). We will be working closely with OSF and the local health departments to carry out this evaluation.

Other Coordination Efforts

Healthy Start Collaboration - Wisconsin Title V's collaboration with Healthy Start has been strong since its inception in 1991. In 1989, with the release of *Healthier People in Wisconsin: A Public Health Agenda for the Year 2000*, the State MCH Program identified the City of Milwaukee and the Wisconsin Native American population as high priority groups for the reduction of infant mortality. We have strongly supported efforts to address this issue among these two populations. We believe that our focus on this issue played a part in the start-up and growth of the two Healthy Start projects in Wisconsin, one for the City of Milwaukee (Milwaukee Healthy Beginnings Project - MHBP) and one for the statewide Native American population (Honoring our Children with a Healthy Start).

Milwaukee - The partnership with Milwaukee to reduce infant mortality started in the early 1990's with Title V leadership in the start-up and implementation of the Fetal Infant Mortality Review Project (FIMR), Milwaukee Common Ground, the Milwaukee Family Project, and Healthy Start, all of which are inter-connected. Several Title V staff became active members of the consortium that grew out of Milwaukee's initial unfunded Healthy Start application in 1991. The Chief Medical Officer (CMO) for Maternal and Child Health (Richard Aronson) and the Perinatal Nurse Consultant (Laurie Tellier) worked closely with the Milwaukee Healthy Women and Infants Project (MHWIP), which served as the Healthy Start grantee from 1994 to 1997.

The CMO played a central role in negotiations with HRSA that led to the Black Health Coalition of Wisconsin becoming the Healthy Start grantee in 1998. This represented an important achievement in assuring that Healthy Start in Milwaukee would continue to have a strong community-driven and family-centered approach. He continues to be actively engaged in many aspects of the project, called the Milwaukee Healthy Beginnings Project (MHBP). He chairs the Sustainability Committee of MHBP, serves as a guiding force in Common Ground (which MHBP now houses), and represents Title V on the Consortium. Laurie Tellier, our Perinatal Consultant, serves on the case review team for the Fetal and Infant Mortality Review Project, which is now funded by MHBP through a contract with the Milwaukee Public Health Department.

The CMO for MCH attends the Healthy Start Grantees meeting every year, with his expenses paid for by the two Healthy Start projects. A team has formed, consisting of the two Healthy Start project directors and the Title V CMO. At the 1998 Healthy Start Grantee meeting, they initiated a planning process to integrate the two Wisconsin Healthy Start projects with other MCH programs, services, and systems in the state. This resulted in a unique conference in July 1999 entitled “Families Helping Families Gathering: Promoting Healthy Families and Infants through Healthy Start Projects”. Unlike a typical conference, families from the two Healthy Start projects designed and carried it out from start to finish. One hundred and twenty five richly diverse children and adults, ranging from African Americans and Latinos from Milwaukee to American Indians from rural Northern Wisconsin, gathered for two days in Stevens Point, Wisconsin. They celebrated their cultures, shared information, and discussed with 40 MCH providers and policy makers, including the Wisconsin Family and Community Health Director (Millie Jones), and their perspectives on issues affecting the health and safety of families in their communities. Family members served as workshop facilitators. Staff from MHBP and Honoring Our Children played an advisory role. Providers engaged in dialogue during the sessions, but did not play the traditional role of expert speaker or panelist. This event created a forum in which families felt supported in voicing their concerns. The Wisconsin Title V Program recognizes that equipping families with tools that they can use to empower themselves, as happened at the Gathering, is a vital strategy for reducing health disparities among communities of color.

Native Americans - The reduction of infant mortality among Native Americans in Wisconsin has also been a focus of leadership and collaboration by Title V for the past decade. Title V staff helped start up a Native American Infant Mortality Work Group in 1990. This group developed and implemented a Native American Infant Mortality Review Project which was notable for its broad based, interdisciplinary, and community driven approach. It also raised awareness among many stakeholders, including the Legislature, in this issue. Title V assisted the Great Lakes Inter-Tribal Council (GLITC) in its successful 1997 Healthy Start application, Honoring Our Children with a Healthy Start. GLITC first became aware of the availability of Healthy Start funds from the State MCH Program. We helped with the writing of the grant, and have been involved in its implementation. We serve on their Advisory Board, provide data, and showcase their efforts at state and national conferences.

A recent analysis of Native American infant mortality in Wisconsin showed a decline in the rate from 20.2 infant deaths per 1,000 live births during the period of 1983 to 1987 to 10.8 during 1993 to 1997.

This high level of collaboration with Healthy Start in Wisconsin is an example of the potential for state-local partnerships that provide the framework for significant systems advancement and change on behalf of the MCH population. It has strengthened Title V's capacity to implement the MCH Five Guiding Principles of family-centered care, community wide leadership, resiliency, outreach, and cultural competence.

Milwaukee Common Ground - With strong guidance and leadership from the Wisconsin Title V Agency, Milwaukee Common Ground started in 1993 with the Black Health Coalition as a participant and evaluator of the first conference held in March 1994. This initiative grew out of a need to address the underlying systemic factors that contribute to infant mortality. Milwaukee Common Ground sponsored full two future search conferences in

1994 and 1995. Dozens of smaller meetings since then have strengthened the ties among families, care providers, community leaders, city and state officials, and the faith community. Participants in Future Search, a model to find common ground in organizations and communities developed by Marvin Weisbord and Sandra Janoff, have discovered and put into practice stronger collaborative strategies. These partnerships strive to achieve unity and respect and reduce turfdom and walls that had divided people and organizations from each other.

Milwaukee Common Ground provides for a way of dialogue that is unique and often lacking in MCH work. This dialogue emphasizes vision, honesty, giving each other the authority to be ourselves, openness to risk-taking and admitting mistakes, learning from each other's wisdom, and personal and professional growth. Common Ground brings a diverse group of people together who in the past lived and worked in separate worlds. As evidence of its impact, the Wisconsin MCH Coalition selected Milwaukee Common Ground as the recipient of its 1997 Achievement Award for State or Local Coalition Building. For example, Common Ground encourages dialogue about racism. In spite of the risk associated with this dialogue, it has started to shift the way that people work with each other. Outcomes of Common Ground include efforts to make access into the HMO system simpler and new partnerships between large health care systems and community organizations.

One major issue that has emerged through Common Ground is deeply divisive feelings of alienation based on race. Common Ground's efforts intensified after the first conference in 1994 when many participants experienced a growing urgency to include more families in the effort. The follow-up conference in 1995 and subsequent meetings have opened discussions and brought to light the enormous challenges that the participants face. Notable features of the second future search were the inclusion of Spanish and Hmong interpreters, on-site child care, and transportation help. "It told me", said one parent, "that they really wanted parents and community members involved. I had experienced many health professionals as cold and insensitive. At the conference I met many people who do care".

The outcomes of Milwaukee Common Ground are multifaceted. For example, the Milwaukee Fetal Infant Mortality Review Project (FIMR) Project in its present form may not have been possible without the family-centered and culturally competent influences of Common Ground. Common Ground led to an airing of many sensitive concerns and a greater respect for finding models and approaches for reducing infant death that focus on families and the community as driving forces.

The Title V Program is proud and excited that the Milwaukee Healthy Beginnings Project decided in 1998 to make the commitment to "house" Common Ground, i.e. to provide staff support and leadership. Several planning meetings, led by Milwaukee Healthy Beginnings, took place in 1998 and 1999, resulting in the decision to hold a third future search conference in 2000. Scheduled to take place in Milwaukee on June 29 through July 1, 2000, the conference is entitled "Future Search 2000: Sustaining Community Driven Efforts for Reducing Infant Mortality in Milwaukee".

Health and Child Care Collaboration – Recent efforts have been made to strengthen the collaboration between the MCH Program and the provision and funding of child care in Wisconsin. A workgroup, including representatives from the state agency responsible for child care and the MCH Program, has been meeting for the past 18 months to

address the issue of sick children in child care and is now prepared to broaden the scope to health and child care. A draft Child Care Health Consultant (CCHC) document and plans to establish a statewide Child Care Health Consultant network are in place. Twenty-three local health departments are contracted with MCH consolidated contract funds to provide health consultation and technical assistance to child care agencies in their jurisdictions. These 23 agencies plus the five Regional CSHCN Centers, in partnership with a several child care related organizations have a CCHC network “kick-off” planned for June 2000. Wisconsin has recently submitted its 3-year CISS continuation application, “Partners for Healthy Child Care”. This grant supports a .5 FTE project coordinator to spearhead the statewide network plans, educational and technical assistance sessions, and the promotion of health insurance coverage by the child care community.

Home Visiting for At-Risk Families - In May 1998, the Wisconsin Legislature enacted 1997 Wisconsin Act 293, the Wisconsin Child Abuse and Neglect Prevention Program (POCAN). This law resulted from the recommendations of the 1996 Special Committee on Prevention of Child Abuse and Neglect convened by the Joint Legislative Council. The Child Abuse and Neglect Prevention Program provides \$995,700 of state general-purpose revenue for a program of child abuse and neglect prevention services which includes home visiting to first time parents eligible for Medicaid, and a flexible fund for those receiving home visitation program services. The program also includes a flexible fund for individuals or families who have either been the subject of a child abuse or neglect report or who have asked for assistance to prevent abuse, who are willing to cooperate with an informal plan of services, and for whom there will be no court involvement. Act 293 requires a competitive grant process, which resulted in awards to six rural counties, three urban counties, and one Indian tribe effective January 1, 1999.

POCAN home visitation programs must be comprehensive and incorporate practice standards that have been developed for home visitation programs by entities concerned with the prevention of child abuse and neglect. Comprehensive national models of home visitation programs have in common the following 12 critical elements and these are being tracked in the POCAN home visitation programs:

- Initiate services during the prenatal period or at birth.
- Use a standardized assessment to identify families in need of services.
- Offer services voluntarily and develop a regular visitation schedule with the family.
- Offer services based upon needs, changing the intensity of services over time.
- Offer culturally competent services with staff and materials that reflect the populations being served.
- Focus on the parent as well as parent-child interaction and child development.
- Link all families to a health care provider and other services depending on need.
- Limit staff caseloads so home visitors can have adequate time with each family.
- Select appropriately prepared staff who are skilled and willing to work with diverse communities.
- Select staff whose education and/or experience enable them to handle the experiences of working with overburdened families.
- Provide staff with intensive training specific to family assessment and home visitation.

- Ensure that staff receive ongoing supervision so they can develop realistic and effective plans to help families meet their objectives, aid those who may not be making progress, and discuss their concerns to solve problems and avoid stress-related burnout.

The MCH Program is assisting the Department in the required evaluation. A preliminary report is expected September 2000. Through a contract with the University of Wisconsin – Extension, Family Living program staff developed an intensive curriculum of basic skills for home visitors and provide technical assistance for the home visiting projects. Additional training is directed toward home visitor awareness of key knowledge areas such as parent-child interaction, early brain development, issues of domestic violence, and maternal depression.

Medicaid Targeted Case Management - The MCH Program continues to support local health departments in their efforts to assure that Medicaid targeted case management services are available to meet the needs of families and other vulnerable population groups in Wisconsin. Local health departments serve many Medicaid eligible groups, such as families who have a child at risk of physical, mental, or emotional dysfunction. Wisconsin Act 293 requires programs providing home visiting services for this population, to bill Medicaid for the federal share of the service that meets Medicaid targeted case management program requirements. Billable case management services are likely to include, but not be limited to, assessment, development of a plan of care, and ongoing case management. Continuing MCH leadership is planned throughout 2000 to support local health departments in areas of assurance and policy development, building statewide case management capacity, and encouraging linkages with the expansion of professional and paraprofessional home visitation programs.

Prenatal Care Coordination - The Wisconsin Prenatal Care Coordination Program (PNCC) has continued as an example of successful collaboration effort between the Division of Public Health and the Division of Health Care Financing. The program is based on models of high-risk pregnancy care coordination used in public health nursing practice. In the most recently completed state fiscal year (July 1998 through June 1999) 165 certified providers served approximately 9,310 women. Revisions in the risk assessment have made pregnant teenagers under age 18 automatically eligible for care coordination services. By expanding services for pregnancy testing and presumptive eligibility for Medicaid, Wisconsin has been able to enroll more women into care coordination in the first trimester.

Milwaukee Child Care Coordination Project (Milwaukee Family Project [MFP]) - This is a community-led, state-supported initiative to increase access to family support and prevention services. This initiative is currently for Milwaukee families only, using a home visitation model, and continues to make progress. The 12 Critical Elements identified by national models of home visitation cited in the previous section on Home Visiting for At-Risk Families, have been adopted as standards of practice. The five MFP agencies are currently undergoing agency assessments using these 12 standards. Enhanced collaboration among state level agencies helps assure a continuum of intervention for eligible families, including those receiving services through the state managed child welfare program in Milwaukee. In addition, a pilot project focusing on an inner city area of Milwaukee with the highest incidence of child welfare cases, the Milwaukee Bureau of Child Welfare Region One is being developed. The plan for this pilot includes enhanced home visitation and family support services to all first time parents in this welfare

region. The Division of Public Health is assuming administration of additional child abuse and neglect prevention money from the Division of Children and Family Services to help support this enhanced service delivery. A substantial evaluation component is part of the overall plan.

Brighter Futures: The Wisconsin Plan to Prevent Adolescent Pregnancy - Brighter Futures has a goal of reducing adolescent pregnancy 1995 rates (females age 19 and under) by 15%, by the year 2001. Its mission is to assist adolescent males and females to successfully navigate the passage to adulthood without a pregnancy. This statewide plan helps communities and families support adolescents by building assets and resiliency and reducing risk factors in teenagers' lives.

A number of work groups have been established to draft an Implementation Plan related to **Brighter Futures**. These workgroups convene and report periodically on the progress being made toward the achievement of the recommendations. The success of **Brighter Futures** is dependent on broad ownership and action at both the community and state level. Local communities are encouraged to assess themselves against the plan and to develop local strategies for its implementation.

II. REQUIREMENTS FOR THE ANNUAL REPORT

2.1 Annual Expenditures

See Forms 3, 4, and 5

2.2 Annual Number of Individuals Served

See Forms 6, 7, 8, and 9

2.3 State Summary Profile

See Form 10

2.4 Progress on Annual Performance Measures

See Form 11

For CY98 (unless indicated) Wisconsin met our objectives for National Performance Measures 6, 8, 9, 10, and 14. However, we made progress on all of the performance measures and were close to meeting all of them. The technical notes for Form 11 provide further information. In Wisconsin, Title V funds serve approximately 24,000 individuals (not including family planning). Therefore, it is unlikely that our programs will have a significant impact on meeting objectives for performance measures that are population-based. We will continue to refine our MCH Data System and improve our ability to collect specific outcome data for the clients served by Title V funds.

Through an RFP process in 1994, the Division of Public Health awarded \$7.23 million to 128 agencies. Grantees wrote to the service activities that would best address their community needs. The following reports represent service activity summary reports for FY 98-99 or Year 05 of the grant cycle. The service activities are grouped by level of the pyramid and then by population served.

This is the fifth year of service activity data. Next year's application will capture consolidated contract data.

- Direct Health Services

Annual Report for PRECONCEPTIONAL WOMEN'S HEALTH SERVICES (1A)

Type:	Risk Factor	Related National Performance Measures:	6, 18
Category:	Direct Health Services; Enabling; Population	Related State Performance Measures:	2
Population served:	Childbearing age women/couples	Healthy People 2000:	5.1-3, 7, 11, 14.11, 19.1-3

Service activity 5 year outcome goal(s): By 1999, 60% of the women estimated* to be at risk of unintended pregnancy and in need of reproductive health and family planning services will be served.

*Alan Guttmacher Institute 1990 estimates: total women in Wisconsin at risk of unintended pregnancy (220,820) and below 250% poverty (101,990).

Summary of past years' progress: The 1A projects provide contraceptive and related reproductive health services to women/couples of reproductive age for whom services are inaccessible, unaffordable, or unacceptable. Projects also provide early identification of pregnancy and timely access to pregnancy related services.

1998: 61,186 total women patients: 28% of total estimated need; 60% of estimated need under 250% poverty.

1997: 58,203 total women patients: 26% of total estimated need; 57% of estimated need under 250% poverty.

1996: 60,844 total women patients: 28% of total estimated need; 60% of estimated need under 250% poverty.

1995: 60,051 total women patients: 27% of total estimated need; 59% of estimated need under 250% poverty.

Numbers served in 1999:	Total women patients – 54,311
Funding amount:	\$1,979,984 GPR and \$1,828,160 MCH Block Grant (including \$410,700 for laboratory tests).

The MCH 1A Service Activity is the designation for Division of Public Health's Family Planning Program. Its goals are to: maintain reproductive health; protect fertility; facilitate safe, effective, and successful contraception; reduce risks to future pregnancy; promote early pregnancy confirmation and early identification of pregnancy-related risks; and encourage early pregnancy-related care. Service components consist of public information and education (population-based services); health screening and assessment, medical, laboratory, and supply services (direct services); and patient education, anticipatory guidance, referral and follow-up, and short-term care coordination services (enabling services).

These MCH Block Grant/General Program Revenue funded services provide accessible and affordable care to residents in 51 counties through 32 organizations: 16 local health departments, 14 community-based health organizations, and 2 tribal health agencies.

Summary of Progress for 1999

Contraceptive services: 40,028 unduplicated women patients.

Pregnancy testing services: 23,229 unduplicated patients through Early Identification of Pregnancy (EIDP) services.

Services are targeted to those most vulnerable to consequences of an unintended pregnancy. The proportion of estimated need met *for contraceptive services* within the 51 counties was: 38.4% of estimated need under 250% of poverty, and 18.1% of total estimated need. Over 78% of all patients had incomes below 200% of poverty and 40% were under age 22.

Early pregnancy testing services are designed to facilitate continuity of care and timely access to appropriate care. Timely access to contraceptive services following a negative pregnancy test result can significantly prevent unintended pregnancies. Over 70% of patients requesting pregnancy testing services had negative pregnancy test results with over 60% of these patients receiving contraceptive services. Timely access to appropriate pregnancy-

related care contributes to maternal health, healthy birth, and infant health. Over 75% of perinatal patients received prenatal care beginning in their first trimester of pregnancy.

Emerging reproductive health and family planning issues include the need for: 1) increased awareness of and access to timely and affordable emergency contraception and pregnancy testing services; 2) increased protection of patient privacy and confidentiality rights in the context of computer-based information and client tracking systems, and requests from agencies and individuals for release of patient information without consent of the patient receiving services; 3) increased access to affordable contraceptive services (particularly in counties currently without clinic services); and 4) implementation of expanded eligibility for Medicaid family planning services in Wisconsin. Expansion of Medicaid family planning eligibility will expand services and improve access to affordable family planning and related reproductive health care.

Annual Report for PRIMARY CARE FOR INFANTS/YOUNG CHILDREN (3A)

Type:	Capacity	Related National Performance Measures:	3, 5, 8, 10,11, 12
Category:	Direct Health Services	Related State Performance Measures:	1, 9, 10
Population served:	Ages birth to 5 years	Healthy People 2000:	7.4, 9.3-6, 11.4, 14.1, 17.16, 17.20, 20.11

Service activity 5 year outcome goal(s): By 1999, 90% of Wisconsin infants and children ages birth through five years will receive comprehensive well-child assessments or HealthCheck comprehensive exams according to the American Academy of Pediatrics periodicity schedule.

Summary of past years' progress: The 3A projects provide well-child exams for under and non-insured children who may otherwise fall through the cracks. They also serve as a referral mechanism if further follow-up is needed.

1998: 7,554 clients served, 16,981 visits or contacts

1997: 9,625 clients served, 19,934 visits or contacts. EPSDT Screening rates: 0-12 months = 44%, 1-5 years = 69% (interim data)

1996: 9,925 clients served, 19,479 visits or contacts. EPSDT Screening rates: 0-12 months = 43%, 1-5 years = 56%

1995: 6,624 clients served, 9,186 visits or contacts. EPSDT Screening rates: 0-12 months = 45%, 1-5 years = 55%

Numbers served in 1999:	Clients - 7,958 Sessions - 114	Visits - 19,322 Participants - 855
Funding amount:	\$900,932	

Summary of Progress for 1999: During 1999, these 43 projects either met or came close to meeting their projected goal for number of clients served. All grantees provided comprehensive assessments using appropriate HealthCheck guidelines. The 3A projects continually strive to integrate WIC, immunizations, and lead screening and as a result,

there has been an increase in the percentage of completed immunizations and blood lead screens. Anticipatory guidance and counseling/education were provided. Appropriate treatment, referral and follow-up were provided for all children served with identified health problems. Referrals were made primarily for immunizations, Head Start, medical care, WIC, dental care, vision/hearing exams, and lead screens. Outreach materials including brochures, public service announcements, newsletters, newspaper and community shopper ads, and agency introduction letters were developed and disseminated. With regards to services provided to high-risk families, referrals and follow-up were conducted for parenting classes, counseling services, and AODA services. Joint visits by a public health nurse and an interpreter helped assure culturally appropriate assessments of family dynamics/interactions. Specific referral forms were developed and group training occurred related to parenting and child abuse/neglect.

Annual Report for ORAL HEALTH: DIETARY FLUORIDE SUPPLEMENTS (3F)

Type:	Risk Factor	Related National Performance Measures:
Category:	Direct Health Services	Related State Performance Measures:
Population served:	Children, ages 6 months-16 years	Healthy People 2000: Section 13, objectives 1 & 10

Service activity 5 year outcome goal(s): By 1999, increase the use of self-administered dietary fluorides to at least 85% of children not receiving optimal fluoride from their primary source of drinking water. By 1999, reduce dental caries (cavities) so that the proportion of children with one or more caries (in permanent or primary teeth) is no more than 35% among children ages 6 through 8 and no more than 60% among adolescents aged 15.

Summary of past years' progress: The Dietary Fluoride Supplement projects provide fluoride supplements to children not receiving optimal levels of fluoride from their primary source of drinking water. Regular use of fluoride supplements can reduce the prevalence of dental caries by up to 30%. These projects also provide a valuable educational component by promoting the preventive benefits of fluoride.

1998: 1,230 clients served

1997: 1,117 clients served

1996: 728 clients served

1995: Projects developed protocols and forms for program. Significant outreach efforts were conducted.

Numbers served in 1999:	Clients - 715 Sessions - 6	Visits - 1,099 Participants - 150
Funding amount:	\$15,293	

Summary of Progress for 1999: During 1999, these projects met their goals for providing dietary fluoride supplements to eligible children. Outreach was provided to various sites including WIC, HealthCheck, daycare centers and pre-school centers. On-site counseling was provided regarding water testing and analysis. Publicity was provided regarding fluorides via brochures, group sessions and press releases. All projects track client participation.

Annual Report for PRIMARY CARE FOR SCHOOL AGE AND ADOLESCENTS (4A)

Type:	Capacity	Related National Performance Measures:	6, 7, 8, 12, 13, 16
Category:	Direct Health Services	Related State Performance Measures:	1, 4, 5, 6, 9
Population served:	Ages 6-18 years	Healthy People 2000:	3.5, 4.6, 5.1, 7.1c, 7.2, 7.4, 7.8, 9.3-6, 13.8, 19.1-5, 19.10

Service activity 5 year outcome goal(s): By 1999, all children birth to 12 and 90% of adolescents will receive comprehensive primary health care services using Health Check guidelines as the minimum standard for timing and content of care.

Summary of past years' progress: The 4A projects provide well-child exams for under and non-insured youth who may otherwise fall through the cracks. They also serve as a referral mechanism if further follow-up is warranted.

1998: 2,582 clients served, 8,291 visits or contacts

1997: 1,783 clients served, 7,072 visits or contacts

1996: 3,411 clients served, 9,149 visits or contacts

1995: 7,593 clients served, 14,436 visits or contacts

Numbers served in 1999:	Clients - 2,566 Sessions - 47	Visits - 8,192 Participants - 627
Funding amount:	\$336,095	

Summary of Progress for 1999: During 1999, these nine projects either met or came close to meeting their projected goal for number of clients served. All grantees provided comprehensive assessments using appropriate Health Check guidelines. Anticipatory guidance and counseling/education were provided. Appropriate treatment, referral and follow-up were completed for all children served with identified health problems. Interperiodic visits were conducted to assess follow-through with treatment or resolution of health problems. Several projects noticed an increase in the number of identified health-related educational or behavioral problems. Access to dental services continues to be a challenge for many school age youth. Projects provided care coordination for the youth served such as appointment scheduling, contraceptive management, transportation, prenatal visits for teen mothers, and well-child care for children of teen mothers. The projects continually strive to find innovative methods for outreach. Targeted outreach to specific populations includes under and non-insured youth, Southeast Asian families, and immigrants/refugees. Health education sessions on topics such as self-breast and testicular exam, dental health, injury prevention, AODA, tobacco, HIV/AIDS, nutrition, and pregnancy prevention were conducted by the projects. Outcome measurement and evaluation are ongoing.

Annual Report for ORAL HEALTH: DENTAL SEALANTS (4E)

Type:	Risk Factor	Related National Performance Measures:	7
Category:	Direct Health Services	Related State Performance Measures:	None
Population served:	Children, ages 6 years-16 years	Healthy People 2000:	Section 13, objective 8

Service activity 5 year outcome goal(s): By 1999, increase to at least 25% the proportion of children in the target population who have received protective sealants on the occlusal (chewing) surfaces of permanent molar teeth. By 1999, reduce dental caries (cavities) so that the proportion of children with one or more caries (in permanent or primary teeth) is no more than 35% among children ages 6 through 8 and no more than 60% among adolescents aged 15.

Summary of past years' progress: Three projects are providing dental sealants on permanent molar teeth to eligible children. The projects not only provide a valuable preventive service to children; they promote the benefits of dental sealants and serve as a referral mechanism if further treatment is necessary.

1998: 1,096 clients served

1997: 1,415 clients served

1996: 1,502 clients served

1995: 602 clients served

Numbers served in 1999:	Clients - 905	Visits - 958
Funding amount:	\$49,917	

Summary of Progress for 1999: During 1999, these three projects provided dental sealants to eligible children between the ages of 6 and 16. Outreach activities included brochures, handouts, posters, newspaper articles, local cable television and radio stations. One project conducted an evaluation through a survey mechanism. The projects used a variety of delivery mechanisms in order to reach underserved populations. Referral mechanisms were in place for children requiring additional services.

Annual Report for ORAL HEALTH: SCHOOL-BASED FLUORIDE MOUTHRINSING (4F)

Type:	Risk Factor	Related National Performance Measures:	None
Category:	Direct Health Services	Related State Performance Measures:	None
Population served:	Children, ages 6 years-12 years	Healthy People 2000:	Section 13, objectives 1 & 10

Service activity 5 year outcome goal(s): By 1999, increase the use of professionally or self-administered topical or systemic (dietary) fluorides to at least 85% of children not receiving optimal fluoride from their primary source of drinking water. By 1999, reduce dental caries (cavities) so that the proportion of children with one or more caries (in permanent or primary teeth) is no more than 35% among children ages 6 through 8 and no more than 60% among adolescents aged 15.

Summary of past years' progress: One project has maintained fluoride mouthrinsing programs in ten elementary schools.

1998: 1,341 clients served

1997: 1,377 clients served

1996: 1,360 clients served

1995: 1,089 clients served

Numbers served in 1999:	Clients - 1,506	
	Sessions -382	Participants -51,537
Funding amount:	\$1,950	

Summary of Progress for 1999: During 1999, this project provided fluoride mouthrinsing services to children in ten elementary grade schools. Children at these schools do not benefit from adequate fluoride in their primary source of drinking water. Fluoride mouthrinsing can reduce the prevalence of dental caries by up to 30%. School administrators and teachers in this area continue to support this program.

Annual Report for ORAL HEALTH: DIETARY FLUORIDE SUPPLEMENTS (4G)

Type:	Risk Factor	Related National Performance Measures:	None
Category:	Direct Health Services	Related State Performance Measures:	None
Population served:	Children, ages 6 months-16 years	Healthy People 2000:	Section 13, objectives 1 & 10

Service activity 5 year outcome goal(s): By 1999, increase the use of self-administered dietary fluorides to at least 85% of children not receiving optimal fluoride from their primary source of drinking water. By 1999, reduce dental caries (cavities) so that the proportion of children with one or more caries (in permanent or primary teeth) is no more than 35% among children ages 6 through 8 and no more than 60% among adolescents aged 15.

Summary of past years' progress: The Dietary Fluoride Supplement projects provide fluoride supplements to children not receiving optimal levels of fluoride from their primary source of drinking water. Regular use of fluoride supplements can reduce the prevalence of dental caries by up to 30%. These projects also provide a valuable educational component by promoting the preventive benefits of fluoride.

1998: 1,230 clients served

1997: 1,117 clients served

1996: 728 clients served

1995: Projects developed protocols and forms for program. Significant outreach efforts were conducted.

Numbers served in 1999:	Clients - 411	Visits - 489
Funding amount:	\$15,293	

Summary of Progress for 1999: During 1999, these projects met their goals for providing dietary fluoride supplements to eligible children. Outreach was provided to various sites including WIC, HealthCheck, daycare

centers and pre-school centers. On site counseling was provided regarding water testing and analysis. Publicity was provided regarding fluorides via brochures, group sessions and press releases. All projects track client participation.

Annual Report for OPTIMAL NUTRITION STATUS FOR INFANTS/YOUNG CHILDREN (3E)

Type:	Process	Related National Performance Measures:	1, 2
Category:	Direct Health Services	Related State Performance Measures:	1
Population served:	CSHCN 0-6 years	Healthy People 2000:	7.7, 7.8, 7.11

Service activity 5 year outcome goal(s): By 1999, the number of infants and children whose nutritional status is optimized through services provided by the project will reach 150 annually. Less than 5% of the children who participate in the project will have low hematocrit.

Summary of past 4 years' progress: The 3E project provides medical nutrition therapy for children 0-6 years with special health care needs. It also provides professional education resources on nutrition for children with special needs as well as successfully collaborating with other providers of services to these children.

1998: 121 clients served, 245 visits, 4 group sessions, 23 participants

1997: 95 clients served, 147 visits, 6 group sessions, 72 participants

1996: 67 clients served, 132 visits, 1 group session, 20 participants

1995: 95 clients served, 147 visits

Numbers served in 1999:	Clients - 77 Sessions - 3	Visits - 158 Participants - 48
Funding amount:	\$15,000	

Summary of Progress for 1999: During 1999, this project used length or height as an additional nutrition indicator for children served by the project. The project has continuously met the indicator for hematocrit/hemoglobin with 0% of the clients having a low iron status. The goal of the additional indicator is to improve the rate of growth for infants and children at or below 5th percentile in length or height for age. There were 28 clients whose growth was at or below the 5th percentile. Ten clients showed improvements in growth and 5 were lost to follow-up. Other clients whose growth did not improve had medical and/or environmental concerns that may have influenced their growth during this period. The project continued to outreach through displays and professional education. Staff of the agency also took a leadership role in a training initiative that helped to prepare dietitians in underserved areas of the state to better serve children with special health care needs.

- Enabling Services

Annual Report for ANCILLARY PRENATAL/POSTPARTUM (2A)

Type:	Risk Factor	Related National Performance Measures:	9,16,18
Category:	Enabling	Related State Performance Measures:	3,7, 8
Population served:	Women at risk for poor pregnancy	Healthy People 2000:	5.1, 7.4, 9.3-6, 14.1, 14.5, 14.11, 17.20, 18c

Service activity 5 year outcome goal(s): By 1999, all perinatal women and infants will have a written, comprehensive care coordination plan within 10 days of referral. 95% of project perinatal/infant clients will receive coordinated care with a risk screening, appropriate assessments, care plan, on-going monitoring, health education, nutritional education, referral and follow-up.

Summary of past years' progress:

- 1998:** Collaboration with pregnancy testing sites and WIC has resulted in earlier enrollment in perinatal care coordination. Projects are noting longer duration of breastfeeding.
- 1997:** Continued refinement of collaborative intake with WIC, more agencies doing Medicaid presumptive eligibility to maximize Medicaid enrollment and reimbursement.
- 1996:** Agencies report that many clients are requiring a high level of "intensity" of care coordination in order to have any positive impact on birth or mother's health outcomes.
- 1995:** Agencies reported increased demand for postpartum support services due to very short hospitalization for childbirth.

Numbers served in 1999:	Clients - 5,723 Sessions - 755	Visits - 17,896 Participants - 16,558
Funding amount:	\$921,776	

Summary of Progress for 1999: Many agencies use these MCH funds to fill the gaps for perinatal care coordination to populations who are not eligible for Medicaid – teens (parent income too high), undocumented immigrants and women in county correctional facilities. Collaboration with other community partners focussed on the Family Resource Centers and state funded projects to prevent child abuse and neglect. Partnerships also led to the development of a clinic to serve uninsured residents. Barriers to providing service include mobility of clients and clients' required participation in work training requirements during the day. Clients continue to face challenges with substance abuse, domestic violence, and lack of transportation. Some agencies have noted decreased perinatal referrals, but see an increased need for services to high-risk families with infants and young children.

Annual Report for CHILD CARE COORDINATION (3C)

Type:	Capacity	Related National Performance Measures:	3
Category:	Enabling	Related State Performance Measures:	8
Population served: The priority target population includes those infants and other siblings, up to age six, whose mothers are or have been recipients of the Prenatal Care Coordination Medicaid benefit as defined in Wis. Administrative Code HSS 105.52 and HSS 107.34.		Healthy People 2000:	14.1, 20.11, 11.4, 7.4, 9.3-6, 17.20

Service activity 5-year outcome goal(s): By 1999, all children birth through five years, receiving Child Care Coordination, will have a completed care plan within 45 day of referral that includes the following: assurance of a “medical home,” age-appropriate well-child assessment or HealthCheck exams, up-to-date immunizations, appropriate lead screens, and nutrition and oral health assessments.

Summary of past years’ progress: (1998, 1997, 1996, and 1995): Considerable time was spent by all projects developing policies/procedures, establishing relationships with referral agencies and implementing outreach strategies during the first year. A uniform assessment form was not completed. The delivery system includes home visits, clinic and office visits, telephone and collateral contact. Early data from one project indicated a positive correlation between appropriate utilization of health care services and care coordination efforts. Unduplicated client count and contacts were substantially increased during the second year. Outreach activities with local clubs, development of brochures, and resource directories were enhanced. The recent Medicaid Managed Care expansion caused confusion for some recipients. The two projects in Milwaukee have been involved with activities resulting from a new Medicaid benefit in Milwaukee County (Milwaukee Child Care Coordination). An assessment form developed for this benefit was shared with all 3C providers. Barriers continue to include lack of data coordination, transportation, lack of child care, and lack of adequate food, housing and heat. Projects have established solid relationships with other community resources/agencies e.g., Kiwanis, Stand For Children, Early Childhood Program, and UW-Extension. One project has made great progress on data collection and statistical analyses, researched empowerment models to revise educational materials and embarked on a peer review process. Two projects began designing a client satisfaction process during this third year. Wisconsin Works (W-2) has prompted all projects to reconsider home visit times, increase telephone contact and to “brainstorm” additional strategies since clients are at work during the day. The unduplicated client count and contacts were slightly less than in 1995-96. The projects in Milwaukee are encouraged to pursue billing for the Medicaid recipients they are serving with MCH money. One project’s funding was not renewed by request in 1998; the five remaining projects continued services as in 1997. Billing by the Milwaukee projects increased during 1998 and was encouraged during 1999.

- 1998:** 606 clients served; 2,809 visits or contacts; 4 group sessions; 88 total attendance
- 1997:** 659 clients served; 3,340 visits or contacts; 7 groups sessions; 180 total attendance
- 1996:** 765 clients served; 4,494 of visits or contacts; 6 group sessions; 154 total attendance
- 1995:** 556 clients served; 2,056 visits or contacts

Numbers served in 1999:	Client - 619 Sessions - 8	Visits - 3,351 Participants - 164
Funding amount:	\$307,385	

Summary of Progress for 1999: One of the Milwaukee projects was successful in billing \$14,000 for Medicaid eligible clients; the other did not bill Medicaid. One project completed patient satisfaction surveys. The Milwaukee Family Project, (MFP) a home visitation program for Medicaid eligible families, did affect the number of families served by one project. Client data from *some* of the projects reveal the following: Immunization compliance rates ranged from 75% - 88%, lead screens 80%, appropriate height/weight ratio 90%, connected with a primary health care provider 100% and WIC enrollment at 98%. Most of the projects are using the MFP Family Questionnaire as their assessment tool. Several of the project coordinators are involved with more community or countywide home visiting efforts as this has become a increasingly popular and better funded model of service delivery statewide.

**Annual Report for PREVENTION OF VIOLENCE/INTENTIONAL &
UNINTENTIONAL INJURIES IN YOUNG CHILDREN (3D)**

Type:	Capacity	Related National Performance Measures:	8
Category:	Enabling Services	Related State Performance Measures:	9
Population served:	MCH providers and consumers	Healthy People 2000:	7.3, 7.4, 7.6, 7.8-7.11, 7.16, 7.17, 9.4-9.6, 9.8, 9.12-9.15, 9.15-9.21, 10.2

Service activity 5-year outcome goal(s): By 1999, reduce the occurrence of violence/intentional and unintentional injuries in the project target populations.

Summary of past years' progress: The seventeen 3D projects provided intentional and unintentional injury prevention information. Examples of activities/topics include: home safety inspections, provided and installed home safety devices, education on proper car seat/seat belt use and, proper bicycle/helmet use and, training of home visitors, HeadStart and child care staff.

1998: 1,087 clients; 5,019 visits; 344 sessions; 9,849 participants.

1997: 2,980 client contacts; 261 group presentations, reaching 6,503 persons.

1996: 745 unduplicated clients.

1995: An estimated 1,736 unduplicated clients were served.

Numbers served in 1999:	Clients - 1,193 Sessions - 298	Visits - 7,782 Participants - 6,826
Funding amount:	\$303,375 (verify)	

Summary of Progress for 1999: During 1999, the 3D projects continued activities aimed at preventing unintentional and intentional injuries. Collaborative connections included continued partnerships with WIC, Safe Kids Coalitions, hospitals, early brain development workgroups, as well as local businesses. Sample collaborative activities included dissemination of injury prevention/safety information, referral systems to appropriate programs, financial support, and professional staff in-services on injury prevention related topics. Several projects received

funding or in-kind support from local agencies. One project located several additional funding sources permitting expansion services. Community outreach and public awareness building regarding injury prevention is at the core of the projects activities. One program in particular continued to be successful in creating outreach networks for minority populations, particularly African American and Hispanic. Projects initiated outreach either to their target community to raise awareness for the program or by informing other agencies, thus establishing appropriate referral networks. One very successful component of many of these projects is a home visitation component, combined with in-home safety assessments. Through this component families were provided with tips for home safety improvement and were given free safety devices to correct the specific problem e.g., safety plugs for outlets, and cabinet latches.

**Annual Report for COMPREHENSIVE COMMUNITY-BASED
ADOLESCENT HEALTH EDUCATION (4B)**

Type:	Risk Factor	Related National Performance Measures:	6, 15
Category:	Enabling	Related State Performance Measures:	4, 5, 6
Population served:	Adolescents 11-18	Healthy People 2000:	Series 1, 2, 3, 4, 18, 19

Service activity 5 year outcome goal(s): By 1999, the percent of 12-19 year olds who are able to accurately identify the signs and symptoms of STDs/AIDS, ways to prevent STDs/AIDS, and how to obtain STDs/AIDS services will exceed 90%. Reduce the percent of adolescents, 12-21, who used alcohol in the past month to 0%. Increase to at least 30% the proportion of people aged 18 and older and to at least 75% the proportion of children and adolescents aged 6-17 who engage in regular physical activity that promotes the development and maintenance of cardiovascular fitness three or more days per week for 20 or more minutes per occasion.

Summary of past years' progress:

- 1998:** The Association of Retarded Citizens (ARC) served 31 students for 17 sessions. Waukesha served 1,235 students plus additional educational sessions.
- 1997:** ARC served 44 students for 27 sessions. Waukesha served 1,525 students plus additional educational sessions.
- 1996:** ARC served 11 students for 15 sessions and an additional 7 students for 4 sessions. Waukesha served 1,382 students plus additional educational sessions.
- 1995:** ARC served 11 students for 16 sessions and an additional 21 students received one-time training. Waukesha served 1,022 students plus additional educational sessions.

Numbers served in 1999:	Group sessions - 100	Visits - 51
	Clients - 45	Participants - 2,092
Funding amount:	\$49,600	

Summary of Progress for 1999: These agencies continue to meet or succeed their goals. ARC is a community-based organization that serves students with mild and moderate cognitive disabilities enrolled in special education

classes. ARC collaborated with Milwaukee Public Schools' South Division High School. To meet the unique needs of the students, curricula are modified. Training is provided on self-advocacy, sexuality, and self-protection. A variety of topics are included (health education, STD/HIV/AIDS prevention, dating, and others). All students are given pre-and post-assessments. Parents and faculty responded to a confidential evaluation. For the third year in a row, ARC staff presented at the Young Adult Institute's International Conference on Developmental Disabilities held in New York City. Waukesha County Department of Health and Human Services is a public health agency serving students in middle and high schools. *HealthPrint*, a health risk appraisal tool, is utilized. Questions cover topics of nutrition, alcohol, tobacco, other drug use, safety, physical activity, etc. This year, *HealthPrint* staff collaborated with the Wisconsin Department of Public Instruction in the implementation of a health appraisal pilot project at Grand Avenue Middle School in Milwaukee. Outcome data from this pilot project reflected solid evidence that this model is effective in promoting positive health behavior change among adolescents.

Annual Report for PREVENTION OF VIOLENCE/INTENTIONAL & UNINTENTIONAL INJURIES IN YOUNG CHILDREN (4C)

Type:	Capacity	Related National Performance Measures:	8
Category:	Enabling Services	Related State Performance Measures:	9, 10
Population served:	MCH providers and consumers	Healthy People 2000:	7.3, 7.4, 7.6, 7.8-11, 7.16, 7.17

Service activity 5-year outcome goal(s): By 1999, reduce the occurrence of violence/intentional and unintentional injuries in the project target populations.

Summary of past years' progress: The four 4C projects provide family-centered, community-based unintentional injury programming and intervention, focusing on the prevention of child abuse and the importance of family nurturing and support.

1998: 248 clients; 2,432 visits; 189 sessions; 6,138 participants.

1997: 3,113 visits or contacts with 439 unduplicated clients; 126 group presentations reaching 3,402 persons.

1996: An estimated 183 unduplicated clients were served.

1995: An estimated 342 unduplicated individuals were served.

Numbers served in 1999:	Clients - 354 Sessions - 73	Visits - 4,478 Participants - 1,042
Funding amount:	\$234,483 (verify)	

Summary of Progress for 1999: During 1999 these projects established community-based and individual client-oriented intervention with parents and their children to prevent intentional injuries. One project worked specifically with parents who are survivors of childhood abuse. One project displayed improved family functioning upon program completion and another a decline in child abuse and neglect data based on data since the inception of 5-year cycle. Secured funding outside of the block grant funds were achieved. One program in particular doubled their county's funding commitment due to success of the program and also secured community funding to further services

in their particular service area. The programs are founded on the need for community connection and outreach in order for their programs to be successful. One project in particular provides a specific focus and outreach to the African American community to raise awareness for their program based on resilience factors, and another targets teen parents.

Annual Report for UNINTENTIONAL INJURIES/SCHOOL AGE CHILD AND ADOLESCENT (4D)

Type:	Capacity	Related National Performance Measures:	8
Category:	Enabling Services	Related State Performance Measures:	9, 10
Population served:	MCH providers and consumers	Healthy People 2000:	9.4-6, 9.8, 9.12-21, 10.2

Service activity 5-year outcome goal(s): By 1999, reduce the occurrence of unintentional injuries in the target populations of each project.

Summary of past years' progress: The four 4D projects provided unintentional injury prevention education to the school age children and adolescent population, focusing on the following topics: rural safety, self-care and bicycle/helmet safety and proper use.

1998: 182 sessions; 6,045 participants.

1997: 3,390 contacts, primarily within schools.

1996: 3,086 youth contacts.

1995: An estimated 4,765 unduplicated youth were served.

Numbers served in 1999:	Sessions - 544	Participants - 13,083
Funding amount:	\$70,012 (verify)	

Summary of Progress for 1999: During 1999, these four projects continued activities aimed at preventing unintentional injuries using a community-based and/or individual client-oriented intervention with the target population. The major topics included self-care, bicycle and pedestrian safety, and safety in farm and rural settings, which included handling of farm equipment. One local project in particular received local resources beyond the grant to augment the program. All projects collaborated with local organizations that provide services and outreach to their specific project target population. Each project initiated outreach to their target community in order to raise awareness for the program, or informed other professional agencies in order to establish appropriate referral network. Local media were utilized to promote the activities community-wide.

Annual Report for STATEWIDE SYSTEM OF GENETIC SERVICES (6B)

Type:	Capacity	Related National Performance Measures:
Category:	Direct and Enabling Services	Related State Performance Measures:
Population served:	Birth-21 and their families	Healthy People 2000: 14, 17, 21

Service activity 5 year outcome goal(s): By 1999, at least 90 percent of families with children birth to 21 years of age, who have concerns about genetically determined disorders or conditions, will receive regionally based genetic services.

Summary of past years' progress: The main goal of this grant throughout the past five years has been the provision of direct clinical genetic services; with emphasis on providing services within the community, when feasible. Education and training are provided to professionals and non-professionals, including families affected with genetic disorders. A collaborative genetics clinic staffed by geneticists from the Medical College of Wisconsin and UW-Madison was initiated in Southeastern Wisconsin. Definitive plans have been made with providers and regional outreach coordinators of the UW Medical School to establish an outreach genetics program in the Northern region of the state. The Wisconsin Stillbirth Service Program continues to be a regional and national leader in professional education and advocacy. The teratogen information service continues to provide information regarding preconceptional and prenatal exposures to professionals and non-professionals statewide.

1998: 1,477 clients served, 1,674 visits or contacts, 192 group presentations

1997: 1,342 clients served, 1,519 visits or contacts, 177 group presentations

1996: 1,446 clients served, 1,641 visits or contacts, 194 group presentations

1995: 1,483 clients served, 1,679 visits or contacts, 148 group presentations

Numbers served in 1999:	Clients - 1,522 Sessions - 0	Visits - 1,720
Funding amount:	\$336,000	

Summary of Progress for 1999: Provision of direct clinical genetics services both at Madison-based clinics and at outreach clinics continued. Education and training activities to professionals, non-professionals and families regarding genetic issues also continued. More definitive plans are being made to establish genetics outreach clinics in both Ashland and Rhinelander in the year 2000. The outreach genetics clinic in Racine, which was previously struggling, saw a steady flow of patients in 1999.

**Annual Report for COMPREHENSIVE COMMUNITY BASED COORDINATED CARE FOR
CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN) (5A)**

Type:	Capacity	Related National Performance Measures: 1, 2, 3, 10, 11, 14 (as related to CSHCN Population)
Category:	Enabling Services	Related State Performance Measures: 1, 10
Population served:	Children with special health care needs and their families.	Healthy People 2000: 17.20

Service activity 5 year outcome goal(s): By 1999, all families served by the projects will have a written comprehensive care coordination plan within 45 days of referral that includes the following: assurance of a medical home, age appropriate well-child assessment or HealthCheck examination, up-to-date immunizations, and oral health and nutrition assessments.

Summary of past 5 years' progress: The 5A projects provided an accessible, family centered, coordinated, and culturally competent comprehensive health care system at the local community level for children with special health care needs (CSHCN). The projects assured families of CSHCN access to comprehensive coordinated care.

1998: 831 clients served, 4,802 visits or contacts; 197 sessions, 3,690 participants

1997: 838 clients served, 5,105 visits or contacts

1996: 631 clients served, 5,931 visits or contacts

1995: 565 clients served, 5,599 visits or contacts

Numbers served in 1999:	Clients - 800 Sessions - 887	Visits - 4,888 Participants - 57,285
Funding amount:	\$659,871	

Summary of Progress for 1999: Each project maintained advisory boards/councils as in past years. Collaboration with health care and community service providers to identify families of children needing care coordination was ongoing. A family-centered, coordinated, comprehensive assessment and annual service plan was completed for each child or family. Parents were linked with parent/provider coalitions, parent-to-parent networks and local resources to support service plan implementation. Consumer/parent surveys were conducted to assess satisfaction with project services and to determine if client needs are being met. Education, training, and technical assistance was provided to parents, community service agencies, and health care professionals. Topics include parenting skills, parent empowerment, parent mentoring, sibling support issues, high school transition, network/collaboration building, and cultural diversity. One project received a broadcast media award for its weekly educational television series on a community cable channel. The series provides information about specific disabilities, raises awareness of disabilities through collaborative and partnership efforts, and demonstrates effective use of this media. As a direct result of the CSHCN projects, collaboration has developed between multiple community agencies, such as local health departments, schools, and early interventions programs.

**Annual Report for UNIVERSITY OF WISCONSIN-MADISON STATEWIDE HEALTH PROMOTION
PROJECT FOR SUPPORTED PARENTING FOR PARENTS WITH COGNITIVE LIMITATIONS AND
CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN) (5A)**

Type:	Capacity	Related National Performance Measures:	2, 3, 11, 14 (as related to CSHCN Population)
Category:	Enabling Services	Related State Performance Measures:	1 & 10
Population served:	Families with parents with cognitive disabilities or chronic mental illness and their children.	Healthy People 2000:	17.20

Service activity 5 year outcome goal(s): By 1999, all families served by the projects will have a written comprehensive care coordination plan within 45 days of referral that includes the following: assurance of a medical home, age appropriate well-child assessment or HealthCheck examination, up-to-date immunizations, and oral health and nutrition assessments.

Summary of past years' progress: This project built family centered, coordinated, culturally competent, accessible comprehensive health care systems at the local community level. System issues include: health care access, service coordination, continuity of care, funding, and awareness of developmental disabilities.

1998: 22 clients served, 698 visits; held 214 sessions for 4,788 participants.

1997: 9 clients served, 287 visits or contacts.

1996: Held 20 group sessions for 689 participants.

1995: Served 56 families with 100 group sessions. 4 training sessions held with 177 participants.

Numbers served in 1999:	Clients - 11 Sessions - 98	Visits - 668 Participants - 1,613
Funding amount:	\$50,049	

Summary of Progress for 1999: This statewide care coordination project supports families headed by parents with developmental disabilities. Children in all the families are at risk because at least one parent has special health care needs. The project's advisory board includes parents with special health care needs, advocates, local county support workers, and health care professionals. The comprehensive assessment/individual service plan is developed with parents and is for the families as well as the children. Intensive in-home support is provided to assist families in raising healthy children. Nutrition, health care services and enrollment in educational programs were emphasized. Three counties continued to provide individual client services to families and group services/activities to families and professionals. Collaboration with the Wisconsin Council on Developmental Disabilities, ARC-Wisconsin, and Wisconsin Department of Public Instruction resulted in the development of the "Supported Parenting Resource Collection" for parents with low-level reading skills. These materials, which focus on reproductive health, nutrition, infant development home safety, and parenting, are available throughout the public library systems in the state. Workshops offered focused on advocacy, empowerment of parents with cognitive challenges, and helping parents understand that caring for themselves results in better care of the children.

Annual Report for Statewide Project: HEMOPHILIA, DIAGNOSTIC AND TREATMENT SERVICES FOR FAMILIES WITH GENETICALLY BASED CHRONIC ILLNESS (6F)

Type:	Capacity	Related National Performance Measures:	2, 3, 10, 12, 13, 16, 17
Category:	Enabling services and infrastructure	Related State Performance Measures:	1, 9, 11
Population served:	Birth to 21 and their families	Healthy People 2000:	17, 20

Service activity 5 year outcome goal(s): By 1999, all families of children/youth with hemophilia or a related bleeding disorder will have a written comprehensive care coordination plan within 45 days of referral including testing, assessment, emergency care, psychosocial care, genetic counseling, financial counseling and follow-up care.

Summary of past years' progress: Clients and their families were offered comprehensive care services which includes establishing and maintaining diagnosis and treatment. The program has consistently attempted to outreach underserved and unserved populations. Peer support is offered as part of meeting the mental/emotional needs of patients and their families. The Foundation has continued to provide statewide leadership to the hemophilia community.

1998: 364 clients served, 777 visits

1997: 352 clients served, 724 visits, 392 group presentations

1996: 337 clients served, 706 visits, 592 group presentations

1995: 1,500 clients served, 7,713 visits or contacts, 642 group presentations (1995 numbers are FEN and Hemophilia combined)

Numbers served in 1999:	Clients - 87	Visits - 77
Funding amount:	\$120,650	

Summary of Progress for 1999: GLHF is collaborating with Scenic Bluff Community Health Center and Gunderson Clinic to provide outreach to the Amish Community. Other collaborations include: Milwaukee Public School System to develop a curriculum on bleeding disorders; the corporate community and health care providers to distribute educational material. The Program Advisory Committee met monthly. The committee was instrumental in designing a patient needs assessment. Members include Board members, Foundation staff, clients and their family members. Comprehensive visits were offered to all known patients, including an increasing number of members of a minority group. Families have access to several peer support opportunities, and nurse coordinator, social work and financial counseling services. The social work staff gave 94% of active patients attending a comprehensive care clinic a social work evaluation. All patients/families undergoing comprehensive evaluation/assessment were linked with a primary care provider in their community.

- Population Based Services

Annual Report for PREGNANCY OUTREACH (2B)

Type:	Capacity	Related National Performance Measures: 13, 16, 18
Category:	Population Based Services	Related State Performance Measures:
Population served: Low-income women, children under age 6, and children born after September 30, 1993.		Healthy People 2000: 14.1, 14.11, 14.11a, 14.5

Service activity 5 year outcome goal(s): By 1999, 85% of all persons potentially eligible for Medicaid/Healthy Start will be enrolled in the program.

Summary of past years' progress:

- 1998:** There were 2,301 unduplicated clients.
- 1997:** There were 3,715 unduplicated clients.
- 1996:** There were 3,984 unduplicated clients.
- 1995:** There were 3,877 unduplicated clients.

Numbers served in 1999:	Clients - 1,161	Visits - 1,335
	Sessions - 45	Participants - 914
Funding amount:	Total Non-MCH Block Grant - \$299,033	

Summary of Progress for 1999: Pregnancy Outreach Activities -- Outreach to underserved populations intensified this past year, in conjunction with the July 1, 1999 advent of Wisconsin's CHIP program, BadgerCare. All projects implemented significant efforts in enrolling eligible Healthy Start participants. In terms of outcomes, Healthy Start enrollment increased markedly in the grant period, and especially in calendar 1999. Enrollment increased 8.8% from September 1998 to December 1999. (This increase exceeded the Medicaid program's estimate of about 7,000 additional enrollees that were expected to be brought in via BadgerCare.) Some local health departments exceeded their goals, both in outreach and in follow-up activities. For example, the City of Madison Health Department, using a variety of outreach techniques including a Hispanic outreach worker and print advertising in the state's second largest newspaper, recorded a 20.5% Healthy Start increase in Dane County. In some localities, school districts' free- and reduced-price lunch data became a promising tool for Medicaid outreach in 1999 as this program and Medicaid/BadgerCare use the same income guidelines. In the fall of 1999, the City of Madison Health Department sent about 6,900 letters to families of students eligible for subsidized lunches. The City of Milwaukee Health Department likewise targeted 27 Milwaukee public elementary schools with subsidized lunch participation rates of 90% or more. Ninety percent of these students in Milwaukee Public Schools live in households that were income-eligible for Healthy Start and BadgerCare.

The large variety of outreach activities and promotional items included: news releases, letters to the editor, telephone and one-to-one contacts with schools, rural and community organizations, physicians' offices, and related health and nutrition programs such as WIC. Efforts were common to target groups known to lack health insurance, such as Hmong, Hispanic, and farm families. Follow-up and evaluation activities included assessment of ultimate enrollment status, assurance of early prenatal care, and addressing enrollment barriers. A promising project-

evaluation development was the creation of a Wisconsin Medicaid program Internet web site, which contains county-specific Medicaid and Healthy Start enrollment numbers, by state and by county. Statewide, outreach activities have contributed to rising Healthy Start enrollment numbers in the last five years, though Medicaid enrollments overall have declined. Because of the enrollment of 49,000 BadgerCare recipients and the above-mentioned Healthy Start increase, this overall trend of Medicaid enrollment decline has been reversed.

Another significant change in pregnancy outreach occurred in 1999 with the redesign of the popular Healthy Start brochure to more clearly link the program with health insurance. The top of the front panel now says “Need Health Insurance? ... Healthy Start may be the insurance you need!” Previously, the brochure did not immediately explain the nature of Healthy Start on the brochure’s front panel.

Annual Report for SUDDEN INFANT DEATH CENTER (6A)

Type:	Capacity	Related National Performance Measures:	None
Category:	Population Based Services	Related State Performance Measures:	None
Population served:	Families who experience sudden, unexpected infant death, and professionals who provide services to or interact with the family.	Healthy People 2000:	14.1, 17.20

Service activity 5 year outcome goal(s): By 1999, 90% of Wisconsin families who experience a sudden and unexpected infant death will be offered prompt information and counseling that is community based, culturally competent and family-centered. Information will be provided within the time frame established by protocols. Number of families will reflect the demographic diversity of all families who experience a sudden and unexpected infant death. Families will receive counseling with their geographic region.

Summary of past years’ progress:

- 1998:** 268 families served. Partnership with the two federal Healthy Start projects in the state. Developed guidelines for emergency personnel who are in contact with newly bereaved families.
- 1997:** 269 families served. Project active in Milwaukee FIMR and federal Healthy Start project. More diversity and outreach by connecting with community based organizations and attending local ethnic and cultural events. Continue with annual professional and parent conferences. Working independently on revision of epidemiology tool. Expanded involvement with local child fatality review teams around the state.
- 1996:** 250 families served. Majority of referrals still from Milwaukee (also largest # of infant deaths in state).
- 1995:** 212 families served. Regional offices (Wausau, Green Bay, LaCrosse) are expanding services.

Numbers served in 1999:	Clients - 333 Sessions - 214	Visits - 2,839 Participants - 6,300
Funding amount:	\$115,837	

Summary of Progress for 1999: The Infant Death Center of Wisconsin served 333 families through counseling, peer-parent support, memorial programs, support groups, information and referral services, and the annual family

bereavement conference. Regional training programs for professionals were co-sponsored by the local health departments and the satellite IDC-W centers. Provided consultation to infant/child mortality review teams. Significant public awareness efforts regarding safe sleep environments for infants.

Annual Report for AMBULATORY HEALTH PROMOTION DAY CARE SETTING (3B)

Type:	Capacity	Related National Performance Measures:	5
Category:	Population Based Services	Related State Performance Measures:	None
Population served: Child care facilities which serve infants and young children ages birth to six years, with special emphasis on reaching those from inner city and rural families who are impoverished, highly mobile or socially isolated; families with psychosocial stress or children with special needs; and minority populations. Special attention given to family child care settings.		Healthy People 2000:	9.3-6, 11.4, 14.1, 17.16, 17.20, 20.11

Service activity 5 year outcome goal(s): By 2000, 95% of children attending licensed day care centers and 98% of school children in grades K-12 will have completed the doses of vaccines specified for their age or grade by administrative rule (HSS 144).

Summary of past years' progress: During the first year, relationships not already established were initiated and others enhanced. Some projects used their funding to provide HealthCheck/ well-child services; however, this is not really the goal of this service activity. A number of projects developed newsletters and one six-agency coalition evolved. Barriers included staffing delays and provider reluctance at scheduling safety and educational sessions. The number of individual client contacts greater than anticipated. Child care agency relationships continued to expand during the second year. Interesting and attractive newsletters were produced and distributed by most projects. Connections with organized child care provider support groups were made. Barriers cited included resistance from teen mothers and from child care facilities owned by national "chains." The number of individual client contacts were reduced and number of group sessions increased. Newsletters remained popular with providers. The Southeastern Day Care Alliance was reconvened with guidance from the Southeastern Regional Office Nurse Consultant. Again in the third year, individual client contacts decreased and group sessions increased. This data supports the goals of this service activity which are technical assistance and consultation rather than individual client services. Reluctance to participate from national "chains" continued.

1998: 194 clients; 273 visits; 312 sessions; 8,951 participants

1997: 234 clients; 771 visits or contacts; 268 group sessions; 5,681 total attendance.

1996: 400 clients; 859 visits or contacts; 157 group sessions; 2,482 total attendance.

1995: 706 clients; 1,521 visits or contacts; 233 group sessions; 3,395 total attendance (47 parents).

Numbers served in 1999:	Clients - 118 Sessions - 248	Visits - 141 Participants - 2,189
Funding amount:	\$183,102	

Summary of Progress for 1999: Total group sessions were similar to last year, although the number of number of participants was less. Most projects now track their newsletters, brochures, fact sheets, flyers and other written information using the public information screen. One project increased their newsletter circulation from 20 to 315. Another project distributed information about immunizations to 2,069 families by partnering with UW Extension. Topics of particular interest continue to be communicable diseases, first aid and CPR, injury prevention, safe playgrounds, bike safety, child growth and development and nutrition. One project noted a decrease in communicable disease outbreaks from 10 to 4 during the 5-year period of this grant as compared with the prior 5-year span. A high percentage of children screened positive for vision and hearing completed the recommended follow-up.

Annual Report for OPTIMAL NUTRITIONAL STATUS FOR SCHOOL AGE YOUTH (4H)

Type:	Process	Related National Performance Measures:	None
Category:	Population Based Services	Related State Performance Measures:	6
Population served:	Youth 6-21 years	Healthy People 2000:	7.12, 8.10

Service activity 5 year outcome goal(s): By 1999, the number of school age youth whose nutritional status is optimized through services provided by the project will be 200 annually. There will be plans with implementation strategies to identify the nutritional needs of school age youth in the service area.

Summary of past years' progress: The 4H project provides nutrition education to youth 6-21 years and their families through classroom presentations, displays, newsletters and other methodologies. The project has exceeded its goal of reaching 200 school age youth annually by more than 300% in each of the last 3 years. In addition, billboards, displays and news articles have reached many family and community members. Identification of the nutritional needs of youth in the service area is being accomplished by the feedback from contacts about services and evaluations of project activities.

1998: 31 group sessions, 674 participants.

1997: 18 group sessions, 756 participants.

1996: 19 group session, 857 participants.

1995: 2 group sessions, 69 participants.

Numbers served in 1999:	Sessions - 11	Participants - 834
Funding amount:	\$12,403	

Summary of Progress for 1999: During 1999, this project serving a single county greatly exceeded its goal of reaching 200 youth in formal settings, reaching a total of 834 youth in these settings. Billboards, newsletters and displays reached additional youth plus family and community members. The project staff outreached to school food service staff, 4-H and Girl Scout leaders, and summer cooking class instructors in addition to teachers. The nutritional needs of the youth were identified through feed back from teachers, youth leaders, and others that responded to staff outreach about the project. Nutrition education was based on the needs identified. The project

continued to be a valuable resource for nutrition education for the youth of Clark County. Nutrition education for these youth may help to reduce the cardiovascular disease rate, the number one killer in Clark County.

- Infrastructure Building Services

Annual Report for MCH EDUCATION AND TRAINING INSTITUTE (6G)

Type:	Capacity	Related National Performance Measures:	None
Category:	Infrastructure Building Services	Related State Performance Measures:	None
Population served:	MCH providers and consumers	Healthy People 2000:	17, 20

Service activity 5 year outcome goal(s): By 1999 the number of MCH-related provider recipients of the MCH Education and Training Institute services will reflect the multidisciplinary nature of coordinated care delivery through fields of provider expertise i.e., health, education, and social service, etc., and the delivery systems represented by the provider recipients. The number of consumer recipients (especially those with CSHCN) of the Institute’s services will reflect the demographic diversity of Wisconsin’s population and families and the identified MCH-related health education needs.

Summary of past years’ progress: The Institute continued to provide statewide, multidisciplinary provider, consumer MCH-related continuing education and resources. Detail is provided in the summary below.

1998: 1,856 people received training - (31 sessions)

1997: 2,922 people received training - 84% professionals and 16% consumers/others.

1996: 1,732 people received training - 75% professionals and 25% consumers.

1995: Data were not collected for this type of break down during the first year of program implementation.

Numbers served in 1999:	Sessions - 49	Participants - 2,363
Funding amount:	\$199,995 (verify)	

Summary of Progress for 1999: During 1999 the total membership for the Institute was forty-two. One membership meeting was convened during this grant year and the steering committee met quarterly. The Institute provided funding support and consultation for conferences conducted in each of the MCH life cycle areas during this grant period. Topics included teen pregnancy prevention/adolescent health, family health, CSHCN nutrition, home visiting, child abuse and neglect, and children with special health care needs. The Institute provided support for the *MCH Conference for Local Health Departments and Tribal Health Departments*. A culturally and ethnically diverse group gathered in the previous grant cycle to develop recommendations for program standards and evaluation and training resources regarding cultural competence. The recommendations of the workgroup were printed during this grant cycle and are being distributed statewide and nationally. Consumers and family participation is evident in all levels of Institute planning. Each member organization is encouraged to bring a consumer/family member to the annual summit conference. The *Good Breakfast for Good Learning* initiative continued activities and developed a breakfast assessment tool. This initiative has become a model for other states. The *Be a Friend...Please Don’t Smoke* initiative continued packet distribution. The *More than Just the Blues* public

awareness campaign continued distribution of consumer brochures and educational packets. Additionally, the workgroup translated the consumer brochure into Spanish and Hmong, developed curricula and training materials for use with home visitors and others, and compiled a resource directory listing local resources for women with or at risk for postpartum depression. A new campaign on infant brain development began, called *Building Blocks for Baby Brain Power*. A consumer brochure and professional provider packet were developed and distributed. The Institute was able to secure outside funding for the *More than Just the Blues* and *Building Blocks for Baby Brain Power* initiatives. A newsletter was distributed to membership biannually. The Institute developed an exhibit display that was taken to various conferences and meetings throughout the grant year. A mail management system and the lending resource library were maintained. The fifth annual Summit Conference was held with the theme outreach and community asset building. Proceedings of the conference were developed and distributed. The distance education workgroup developed a satellite program *Apple Pie in Action: How Communities Can Help Kids Thrive*. A website was developed via a subcontract with the focus on community asset building in Wisconsin. The website continues.

**Annual Report for PERINATAL SERVICES COORDINATION (6C)
WISCONSIN ASSOCIATION FOR PERINATAL CARE (WAPC)**

Type:	Capacity	Related National Performance Measures:	9, 10, 13, 15, 17, 18
Category:	Infrastructure Building Services	Related State Performance Measures:	3, 7, 8
Population served:	Consumers, health care providers and educators who work with individuals from preconception through first year of life.	Healthy People 2000:	3.5-4.6, 5.1, 14.1, 14.5, 14.11, 14.15, 17.20, 18c

Service activity 5 year outcome goal(s): By the end of each year the project will demonstrate statewide perinatal service coordination by identification of needs, collaborative planning, provision of professional education, data collection and analysis, public information and communication and advocacy.

Summary of past years' progress:

- 1998:** Taking the lead in implementation of universal newborn hearing screening. Developed consumer education materials for women with chronic disease who are planning a pregnancy. New public awareness initiative in postpartum depression.
- 1997:** Statewide conference on "Transition Planning: NICU to Community", (240 participants). Five regional training sessions on breastfeeding basics. Issued final report on "Recommendations for Prenatal Testing". Collaboration with WI HMO Association. Annual clinical conference, (242 participants).
- 1996:** Revision of perinatal nutrition criteria sets. Collaboration with Lawrence University Project on guidelines for responsible use of NICU. Statewide training initiative on HIV and pregnancy (400 participants). Developed preconceptional health training videotape and reference guide. Translated consumer education

materials into Spanish. Started workgroup to develop perinatal care paths. Annual clinical conference, (340 participants).

1995: Began coordination of WI Breastfeeding Coalition. Published position statement on universal counseling and voluntary testing of pregnant women for HIV. Part of the Healthy Baby Alert on folic acid. Launched the *PeriScope On-Line* web site. Conducted statewide meeting on postpartum hospital length of stay. Annual clinical conference, 325 participants.

Numbers served in 1999:	Sessions - 66	Participants - 2,029
Funding amount:	\$160,703	

Summary of Progress for 1999: WAPC has continued its effective leadership in perinatal services coordination. They released “Wellness Promotion through Breastfeeding”, a comprehensive, well-researched position statement that has been widely distributed. Work continued on establishing best practice guidelines for home gavage feeding of infants discharged from the NICU and on establishing standards for public health personnel who work with NICU infants discharged to their home communities. There were eight regional forums of stakeholders on implementation of universal newborn hearing screening. Workgroups have formed to develop revisions in PC-Log, the software used for electronic transfer of birth certificate information to the state vital records program.

Annual Report for CHILD HEALTH SYSTEM BUILDING (6D)

Type:	Capacity	Related National Performance Measures: 10, 11, 12, 14, 15, 16
Category:	Infrastructure Building Services	Related State Performance Measures: 1, 11
Population served:	MCH providers and consumers	Healthy People 2000: 7.4, 21.3, 21.5, 21.6

Service activity 5 year outcome goal(s): By 1999, the project will demonstrate statewide child health service coordination through collaboration and planning with providers who represent multi-disciplinary fields of child health expertise and with clients who represent the demographic diversity (geographic, ethnic/racial/cultural, age, economic and educational) of all potential child health clients in Wisconsin. Outcome objectives will be evaluated based on the work plan and completion of action steps.

Summary of past years’ progress: (1998, 1997, 1996, and 1995): A steering committee convened in October 1994 to recruit and hire an Executive Director who began in November 1994. Three interim subcommittees were formed, mission and vision statements written, and collaborations with child health organizations started. Three collaboration conferences were held as well as a "Leadership Forum." In late Year 01 and Year 02, a Board of Directors was elected, an officer structure approved, standing committees established, and board membership training completed. Also, rules of operation were developed and a regional structure design discussed. The Children’s Health Alliance of Wisconsin (CHAW) collaborated with the Comprehensive School Health Program (CSHP) on a statewide survey and with the Center for Public Representation (CPR) on a consumer brochure on welfare reform. The Executive Director resigned in September 1996. During 1996-97, CHAW made tremendous progress. A new Executive Director officially assumed her duties January 1997. CHAW focused on four projects;

1) Children’s Health Coverage, 2) Dental Care Access, 3) America’s Youth Passport, and 4) Comprehensive School Health Program. Standing teams addressing Education/Communication, Advocacy and Finance work to support the four projects. A quarterly newsletter was started and distributed to approximately 1,000 individuals and organizations in the state. CHAW continued to make significant progress during 1998: Board membership was expanded and grants from CDC school-based oral health initiative and Robert Wood Johnson were awarded. The dental work plan, developed as the result of two dental summits (and a great deal of "behind the scenes" work) was completed, as was a media event to launch the plan. Four newsletters were produced and distributed to over 1,500 individuals and organizations. Enhanced leadership opportunities assumed by the Executive Director include; MCH Coalition representative to the MCH Program Advisory Council, participation with the Wisconsin Public Health Association (WPHA) conference planning committee, and upcoming chair of the MCH Coalition. CHAW continued to work on securing positions and resources from other major child health systems in the state, e.g., Gundersen Hospital and Clinic in LaCrosse and UW Medical School. In the fall of 1998, CHAW held a very successful retreat, at which time the Board of Directors refined the vision and mission statements. In addition, they completed a SWOT analysis (Strengths Weaknesses Opportunities Threats), identifying four critical issues with goals, and developed a work plan for each. The America's Youth Passport project was put on hold temporarily. CHAW staff continued to meet the increased work demands with assistance from a graduate student while working to secure more permanent staff.

1998: 46 group sessions; 665 total attendance.

1997: 18 group sessions; 230 total attendance.

1996: 11 group sessions; 911 total attendance.

1995: 4 group sessions; 271 total attendance (47 parents).

Numbers served in 1999:	Sessions - 12	Participants - 158
Funding amount:	\$114,560	

Summary of Progress for 1999: A new governing structure was created consisting of stakeholders, board of directors and executive council. Staffing now include: project manager – Health Coverage, project manager – Oral Health (formerly CHAW Program Assistant), Project Coordinator, and .5FTE Program Assistant. Additional funding sources include: 3-year CDC oral health grant, 3-year RWJ grant for health insurance for children outreach, and the beginning of a Board-directed funding initiative. Major accomplishments include significant increase in reimbursement rates for Medicaid dental services, \$110,000 (GPR) for dental sealants, conducted Pediatric oral health grand rounds, hosting 5 regional and one statewide forum on CHIP, member of Milwaukee BadgerCare Coordinating Council, distributed copies of the updated “Data and Dialogue” presentation to public health offices, MDs, HMOs and others and continued information sharing efforts. Partly due to CHAW’s dental efforts, new dental clinics are now either operational or planned for Milwaukee, Manitowoc, and Wautoma. The quarterly newsletter was redesigned and now reaches over 2,500 individuals in the state. About 250 individuals receive electronic mail updates regularly; MCH organizations have access to CHAW’s database for mailing labels or

material distribution. CHAW's Executive Director continues to be actively engaged with a number of children's organizations addressing children's health issues and works closely with other MCH related activities in the state.

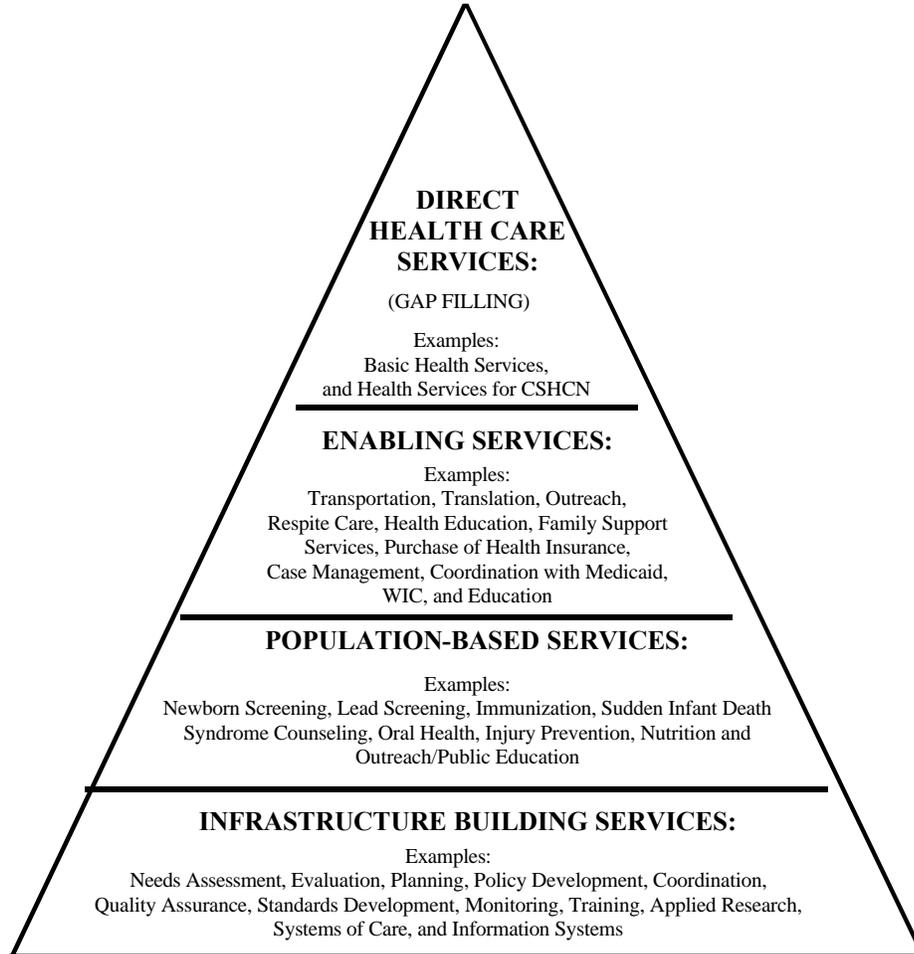
2.5 Progress on Outcome Measures

See Form 12

III. REQUIREMENTS FOR APPLICATION

FIGURE 2

**CORE PUBLIC HEALTH SERVICES
DELIVERED BY MCH AGENCIES**



3.1 Needs Assessment of the Maternal and Child Health Population

3.1.1 Needs Assessment Process

The first year of the State Systems Development Initiative (SSDI) has been to support the 2000 MCH Needs and Strengths Assessment.

Overview - The purpose of the assessment design was to supplement the quantitative data we have in the state and federal performance measures and the health status indicators. We wanted to know what key health leaders perceive and feel about important maternal and child health matters, that is, to put a “human face” to the numbers.

Wisconsin’s 2000 Needs and Strength Assessment utilized 23 professional staff in the state Division of Public Health’s Bureau of Family and Community Health (BFCH) to conduct 85 key informant interviews of 90 minutes duration with the directors of all county local health departments and Tribal Health Centers or Clinics in the state. City health departments were invited to attend their respective county’s interview. The Milwaukee City Health Department director was also interviewed. Carefully crafted interview outlines, as well as other explanatory information, was mailed to directors prior to the interviews.

Focus - Within BFCH, preventive and primary care services for pregnant women, mothers, infants, children to age 18, and children with special health care needs are integrated. Therefore, our needs and strengths assessment quite naturally incorporated all of these groups. We also intentionally added the term “families” to our assessment.

Needs and Strengths - Early in the planning process, we determined to assess *both* the needs *and* the strengths of the above populations in Wisconsin. We were aware that much of what we do to improve the health of mothers, children, and families is dependent on their own strengths. Our experience working with families makes it clear that their strengths, assets, and resilience are of great importance in determining their health and well being. (Note: For simplicity’s sake, the needs and strengths assessment is referred to as “NA” in this section.)

Primary and Secondary Goals - The NA’s primary goals were to meet the federal MCH Bureau’s requirement to conduct a five year needs assessment, to ensure that BFCH is accurately targeting funding to the areas of greatest need, and to provide an opportunity for BFCH to re-look at our state priority needs and performance measures. The secondary goals were to increase BFCH contact with local health departments, to demonstrate interest and concern on the local level, and to learn from local experience.

NA Coordinator - The Wisconsin NA Coordinator is also the director of the State Systems Development Initiative (SSDI). This person oversaw the planning and coordination of the needs and strengths assessment process. She is also responsible for development of future projects and initiatives related to assessment findings.

NA Planning Team - BFCH’s past quality improvement experience taught us the importance of working in a team model when undertaking significant projects. For six years, previous SSDI funding was used to provide training for all MCH public health staff in the state (central, regional, and local offices) in quality improvement procedures as a way to improve communications and provide consistent management practices.

The NA Team, consisting of 12 BFCH and DPH Regional Office staff and managers, met from January – April 2000. Significant tasks included refining the NA design, reviewing and reworking the NA interview outline(s) and field testing the interview outline with non-involved DPH staff. See *Supporting Documents 5.3, NA Interview Tools*.

Expert Consultation - BFCH utilized the expertise of a quality improvement consultant to test ideas pertaining to the key informant interviews. This person affirmed our perception that key informant interviews are a viable method for accomplishing our objectives of obtaining qualitative information. She shared relevant literature for us to review and agreed to provide training for the 23 staff who were serving as interviewers.

Key Informant Interviews as a Methodology - Key informant interviews are an accepted information gathering method, used in public health and other human service areas. Utilizing this process requires that there be a group of recognized experts, or key informants, in the chosen field. The interview entails a structured, focused, time-limited discussion with the key informant using a previously constructed “tool” or interview outline. An advantage of this method is that it reveals the human side of programming and allows for broad variation of experiences. It facilitates relationship-building, incorporates the richness of responses, and yields a great amount of information. Limitations include that the results are less predictable than numbers, they are anecdotal, and, therefore, may be subject to interpretation.

Enhancing Methodological Advantages - In order to increase advantages and decrease limitations of the key informant interview process, BFCH created the following design. We utilized professional staff and managers as interviewers; all are very familiar with the broad range of MCH issues and have worked extensively with local health departments. Interviewers participated in a required, intensive day-long training that included both interview theory and role-playing. The NA Coordinator and NA Team developed carefully honed and tested interview outline(s) to guide the interviews and ensure consistency. A number of additional template materials were developed for use at every stage of the NA process in order to limit individual interpretation. Furthermore, we limited interview subjects to agency directors, who are by definition experts in the public health field. In instances where local health department staff, other than, or in addition to the director, participated in the interviews, it was at the request of and with briefing from the director.

Interviewer Preparation - We wanted interviewers (Bureau Staff) to be knowledgeable about the county or tribe that they were visiting. The NA Coordinator collected and annotated numerous data sources. For counties, the data resources constituted information available on a county level, a great deal of it from our WIC Program and from the Office of Health Information. For tribes, the resources were primarily state or regional materials from Indian Health Service, with descriptive information on each tribe provided by the Great Lakes Inter-Tribal Council. These data sources were housed in a central location for staff to pursue and develop a “profile” as they prepared for each interview.

Key Informant Interviewees and Others - 94 directors (or in a few instances, their designee) were interviewed. Of these, 72 were county local health department directors. In one county without a unified county local health

department, a second local health department director was interviewed separately. In Milwaukee, the city health director was interviewed individually; however, 9 Milwaukee municipal directors (or their designee) were also interviewed as a group. Eleven directors of Tribal Health Centers were interviewed. In each instance, an interview outline was followed. The primary interview outline developed was for the local health department directors, with relevant modifications made for the Milwaukee group interview and for the tribal interviews. The interview outline, along with other explanatory documents, was mailed prior to the interviews. See *Supporting Documents 5.3, NA Interview Tools*.

It was left up to the directors whether or not to invite others to be present in the interviews. In numerous instances, directors included MCH and WIC staff; in some cases, community partners were invited. Frequently, DPH Regional Office staff and/or contract administrators were included. In many instances, it appeared as though pre-interview discussion and preparation had occurred on the interviewees part.

Review of Accomplishments to Date - Accomplishments include:

- Twenty-three professional staff conducted 85 ninety-minute key informant interviews.
- Interview timeframe from start to finish (April 3 – May 22, 2000) was met.
- Information is amalgamated, collated, and, where feasible, totals tallied.
- Anecdotal information was preserved – e.g., MCH Success Stories. See *Appendix G, MCH Success Stories*.

Information Dissemination and Usage - Future plans include:

- June: Send NA summary to all interviewees, Regional Offices (RO), MCH Advisory Committee.
- July: Send completed Block Grant application to federal MCH Bureau.
- August: Send completed Block Grant application to interviewees, ROs, MCH Advisory Committee.
- Future: Highlight NA findings, address concerns, develop new projects.

Interviewer Responses - Some of the interviewer responses captured the success of this process:

- This agency was well prepared for the interview.
- The director is very competent and forward thinking.
- The staff treated this as a priority.
- This is time well spent.
- It's good to put faces to names.
- Very pleasant, even fun (are we supposed to have fun at work?).
- The director gave me a tour around the Reservation – lots of pride here.
- I gained insight into the local planning process.
- My heart went out to the director and her many valiant efforts with such few dollars.
- I was exposed to what local health departments deal with in the real world.

Interviewee Responses - Some interviewee responses were:

- It was nice that you came out and listened to us.
- The interview outline was helpful – we got together before hand to discuss it.
- We need to work together to raise public health’s visibility in Wisconsin.
- We are happy to have MCH dollars!
- Our Regional Office contract administrator is a pleasure to work with.
- I need to encourage staff to use you state consultants more.
- I am supportive of the manner you’ve gone about doing this assessment.
- I found this discussion helpful.
- Keep us involved in state planning.
- Thank you for coming.

Questions Raised

Why not also interview city/municipal health department directors? The assessment design was to focus on county and tribal health departments. However, there are approximately 8 counties that have city health departments in addition to their county local health department. In all instances, the county local health department director was encouraged to invite any city directors to participate in the interview. In all but two cases, this occurred with favorable results. BFCH did not have the staff capacity to conduct more than 85 interviews in the short time frame allowed to complete the NA for the block grant application.

Why not interview families? In the summer of 1998, BFCH conducted 5 MCH Regional Roundtables as an interim needs and strengths assessment. (The report was included in the 1999 MCH Block Grant application.) Major roundtable participants were parents, particularly those with special needs children. This interim assessment proved valuable in our understanding of issues and concerns from families directly.

3.1.2 Needs Assessment Content

3.1.2.1 Overview of the Maternal and Child Health Population Status

The health status of the maternal and child health population is discussed in Section 1.4.

During January 2000, the CSHCN Program developed and distributed a questionnaire to Wisconsin’s 100 local health departments to determine:

- 1) the level of services and activities provided to children with special health care needs
- 2) the strengths and barriers to providing CSHCN services
- 3) training and education needs, and
- 4) a CSHCN contact at each local health department.

The questionnaire was constructed around the core public health functions: assessment, policy development, and assurance as they relate to the CSHCN population. A copy of the questionnaire is found in Supporting Documents 5.3, CSHCN Survey. The response rate, after reminders were sent, was nearly 100%. Results were summarized and

presented at a Regional CSHCN Centers planning meeting. The information will assist the Centers in forming partnerships with their respective local health departments as it relates to providing information and referral, service coordination, and parent support to children with special health care needs and their families.

Local health departments described several strengths in serving children with special health care needs. They mentioned:

- valuing children and families and providing family-centered care
- being prevention focused
- having experience with multiple agencies and skilled staff with a knowledge of local community resources, and
- experience providing services such as home visits and school health and other related services such as prenatal care coordination, Birth to 3, WIC, and immunizations.

When asked to identify their greatest barriers in serving this population local health departments listed: limited funding, staff limitations, their own lack of awareness of the CSHCN population, and lack of communication from other CSHCN providers after a referral was made by the local health department. In addition, they cited an overall lack of CSHCN providers and family support groups available in the community.

Training and technical assistance priorities were identified as the following: an orientation to the new five Regional CSHCN Centers; learn about more resources available in their region; receive general education about CSHCN health issues and new medical interventions; learn what other local health departments are doing for this population; and gain a better understanding about data collection and evaluation. Specific technical assistance requests pertained to: screening for children with special health care needs, health benefits counseling, targeted case management, service coordination, writing policies, preparing outreach education materials, integrating with Birth to 3, and school health services.

Changes in the last five years - Wisconsin's 2000 MCH Needs and Strengths Assessment captures areas for ongoing program attention as well as family assets and community resources upon which to build. The following sections present information shared during interviews with 94 local health department and tribal health center directors.

The interviews demonstrate that the MCH population has experienced significant changes over the last five years. There is a resiliency and spirit portrayed that helps families, communities, and providers cope with the changes. Sections below include:

- Local Health Department directors' responses
 - welfare reform
 - child care
 - health care access
 - dental care access
 - the influx of immigrants, refugees, and minority groups not commonly located in certain area of the state
 - other changes, needs, issues

- American Indians - Tribal Health Center directors' responses
- Family Strengths

Welfare reform (W-2) - Community-based agencies, local health departments, and families anticipated some of the impact during the five MCH Regional Roundtables that the Bureau of Family and Community Health conducted in the summer of 1998, prior to W-2's implementation. (The Roundtables Summary appeared as an Appendix in last year's Block Grant application.)

Of the 94 directors who were asked about changes for mothers, children, and families in the last five years or their priority needs now, there were approximately 91 responses that mentioned W-2. W-2 has been described in Section I. This does not include childcare or parent education needs in relation to W-2, which will be discussed separately.

From the local health department's perspective currently, W-2 has meant "doing business" in a different manner, in many instances. For the most part, families are unavailable for services during typical working hours and many local health departments have expanded to evening and weekend hours. They have done more outreach and in some instances, have taken services to the workplace, daycares, and schools. A big city local health department director observed, "With families at work, we have had to take services to where they are. Two examples for us are day care centers and public schools." From a systems perspective, a positive effect is that some local health departments are working more closely with community partners in an attempt to provide safety nets for high-needs families. In some cases, churches have become more involved.

Nonetheless, directors comment that families are difficult to access because of limited time and the general struggle of managing work, home, and children, to say nothing of health care appointments for prevention efforts. For these families, preventive care is a luxury, not a necessity.

W-2 has ensured that almost all parents are working, as reported by the directors. However, many women work for minimum wage and may work 2nd or 3rd shift with 12 hour shifts or enforced overtime; the norm in several counties. Some employers do not allow time off for health care appointments. However, another county said that W-2 "created a viable workforce."

Local health departments have responded by expanding to evening and weekend hours, working more closely with their human or social service department, developing collaborations and coalitions with agencies and organizations to help meet the MCH population's changing needs.

Child care - In discussing changes over the last five years and current priority needs, directors mentioned child care approximately 59 times and in almost all cases connected their responses to the needs. Two director comments were "Moms are desperate searching for child care." and "There are no before or after school activities – children as young as 5 are left alone."

Child care issues mentioned by directors include too few licensed and certified daycare centers; untrained providers; not enough infant care slots; and little before or after school care. There is also little evening care or coverage for 3rd

shift workers. Care for sick children is spotty and is compounded by some employer's intolerance for parents' staying home with sick kids. There is also a lack of child care geared to children with special needs. In the absence of center care, children may be left unsupervised or care is patch-worked together so that many caregivers get involved in a child's life. Often, mothers turn to their family support system and have grandparents, fathers, or neighbors provide child care.

Welfare reform and the resulting increased focus on child care in a child's life is contributing to a shift in the public health delivery paradigm. Says the director of a large metropolitan local health department, "Child care providers have become key partners in public health service delivery. Children are, by and large, no longer at home and we must assure that their health needs are being met where they are."

Access to health care - In the discussion regarding five year changes and priority needs, directors attributed 62 responses that concerned problems in accessing care, inadequate or no health insurance, provider scarcity, or issues with HMOs. Some access issues relate to increased numbers of immigrants who don't have a payment source, others to employers not providing insurance for W-2 clients, farm families being unable to afford adequate insurance, or a shifting managed care environment.

Says one director, "Our BadgerCare/MA outreach has been quite successful. One idea we came up with was distributing a recipe card to the public with outreach information on the back of it and families really responded!" Another, "BadgerCare outreach has helped families in our county." Finally, "We have higher rates of insured families because of BadgerCare." Directors commented about the summer GuardCare program that offers preventive health service in targeted communities on several weeks during the summer, saying "That's the best thing on the horizon for meeting uninsured families' needs." and "Our GuardCare program provides free dental and medical access."

Many directors puzzle that HealthCheck (EPSDT) exams have decreased in their counties and some are not sure why. Numerous others, however, feel that HealthCheck exams provided by HMOs are minimal and that managed care lacks a prevention focus. One director comments, "80% of the children in our rural county should be getting HealthCheck exams. The doctors aren't doing them and our agency doesn't have the capacity to meet all that need". Another says, "We have to fight for basic services." See *Appendix H, Letter from Local Health Department*, describing the HMO situation in their county.

In some parts of the state, primary providers are scarce, making insurance status a moot point. Hospitals may be far distances, making transportation a major problem. High emergency room usage is mentioned. Several directors said they have no OB providers in their counties. One commented, "Moms are sometimes not seen until the 2nd trimester because of travel distance and difficulty getting in." Another, "Our HMO has severe delays for appointments – there was a two month wait for a 15 year old in her 3rd trimester." For some children, the only source of health care is what is offered in the schools. Specialized care for teenagers and mental health services are non-existent in some locations. Another, "Families in our area struggle with a lot of challenges, one of which is few

available physicians. Our health department does the best we can with very tight resources.” See [*Appendix I, Health Professional Shortage Area Maps*](#).

Dental - Access to dental care is one of Wisconsin’s most pressing needs. Children’s Health Alliance of Wisconsin (a statewide Title V MCH block grant funded project) conducted a survey in 1998 of programs around the state that provided dental care or access to dental care for the uninsured and underinsured including those covered by the Medicaid program. The handbook, *Dental Care Access Programs for the Uninsured and Underinsured in Wisconsin*, August 1998 revealed that it is difficult to find dentists who are willing to participate in the Medicaid program for various reasons. In 1998, 93% of Wisconsin’s children had health coverage; however only 25% of the children covered by Medicaid saw a dentist.

Results from the 2000 Needs and Strengths Assessment showed that there were 44 times that access to dental care was mentioned as a change in the last five years or a current priority need. In addition to the issues already mentioned with Medicaid this extends to BadgerCare, with directors feeling that... “having BadgerCare has not helped in getting dental care for kids.” Directors repeatedly commented that most dentists in their area would not see anyone with a Medicaid card. “We polled 30 dentists in our county and all surrounding counties and none would take Medicaid or BadgerCare,” says one director. Another said jubilantly, “We have a new dentist who takes Medicaid! But there is a huge waiting list.” An additional problem is that the mal-distribution of dentists parallels that of physicians so in many regions there simply are not enough dentists to meet rural families’ needs.

Local health departments have attempted to respond to the dental access crisis in creative ways, although it is often reported to be when the child has an infection and needs emergency care. One director says, “We quickly found money from the Salvation Army to pay for a child’s dental needs.” Another reports, “We applied for a rural health grant that funds dental hygienist students to provide exams and basic preventive services.” Another, “We located a retired dentist who will see special needs children in our area.”

Immigrants, refugees, and minorities - Thirty references were made to the relatively rapid influx into many counties of immigrants, refugees, and minorities by directors in response to discussion about five year changes and priority needs. Groups mentioned include: South Americans and other Hispanics, Bosnians, Kurds, Croatians, Albanians, Kosovians, Koreans, Hmong, and Amish. Directors perceive that the numbers of people in these new populations is growing.

In addition to wars and ethnic strife around the world, several directors hypothesized that with relatively full employment in the state, these immigrants fill a need for low-cost employees in farm work and meat packing plants. Few have insurance or qualify for public payment programs and, as mentioned above, this increases directors’ concerns regarding access to basic preventive health and dental services. Some immigrants have had very little western-style health care provided in their lives while family members may be knowledgeable about traditional folk care giving. Many have major health problems, often undiagnosed. TB is a concern, among other diseases. One county was concerned that the immigrants would skew their health statistics.

Providing care is described as labor intensive and frustrating, both because of language and cultural barriers and because of families' resistance to services. Not only do local health department directors feel they need teaching methods and materials in new languages, many say they are unable to find interpreters or translators in the language required, to say nothing of the funds to pay for these services. Several directors mentioned the problem of community acceptance of newcomers, the county's previous lack of diversity, and their own need for training in providing culturally competent service.

Directors shared some poignant stories about meeting these newcomers' needs. Some examples are shared as follows:

“Our Hispanic population has very high needs and few resources. We provide prenatal care coordination-like services using MCH funding. If we did not do this, these women would come to the hospital with no prenatal care.”

“We have worked slowly in building trust with and showing respect for the new Amish families who have moved here. We are now able to provide immunizations and dental exams as well as postpartum and well child exams. This would be unheard of in some Amish communities.”

“We teamed up with Head Start and Migrant Health Services to set up day care for farm workers.”

Another: “We provide a huge amount of time and support to our refugee families. We make sure they receive the health services they need.”

Finally, “Nine extended family members came as a group to our county to milk cows. They all live in one house. A young woman in the group was pregnant. We got her into prenatal care and on to WIC. Our MCH nurse, although not Spanish speaking, took the mom to the grocery store to help with shopping. This is the first non-English speaking family in our county so residents were a little leery.”

Other changes, needs, issues - There were several other areas of concern that deserve mention.

Changing role of public health: There appears to be a shift in the public health work force paradigm. The leadership focus is shifting from being experts in providing direct services to learning how to assure and ensure that someone else is providing services. Communication among partners – the providers and the assurers – becomes even more critical, particularly from the perspective of a big city director, with issues such as the sharing of confidential information about clients needing to be addressed. From the public health perspective, it is crucial that county and city boards of health and the public in general understand this paradigm shift since the majority of public health funding depends on support from local tax dollars.

Mental health problems: Many directors mention concern about a variety of mental health issues including increases in mental illness, cognitive delays, and suicide.

Adolescent substance abuse, teen homelessness, and child abuse and neglect are of concern. An increase in family dysfunction, apart from the welfare reform issues mentioned, is perceived.

Birth-3 and CSHCN: Many local health departments are seeing more special needs children, their numbers are perceived to be increasing, and there is greater complexity in these children's care. In some areas, home care is inadequate. Again, children seem to have greater developmental needs and there is a perception that autism may be increasing.

Community consensus: A number of directors mentioned that there is greater interest in collaborative planning in their communities. There seems to be more strategic planning to address health needs. Several said that the APEX process was a positive community experience and that APEX was helping to track progress.

American Indians - Tribal health center directors' responses - In Wisconsin there are approximately 46,000 American Indians. Historically, approximately half of the total number of American Indians have lived on or near the 11 tribal lands, or reservations. Currently, families are moving back to the tribal lands from urban areas because of increased job opportunities; however, the exact numbers are unclear. Each of the 11 reservations has a clinic or health center.

Over the last five years, the biggest change for some of the tribal health centers is the economic impact of tribal gaming operations. Although all tribes operate gaming facilities, there is variation in gaming prosperity, in part depending on location of casinos.

For some reservations, the gaming revenues have meant the ability to build new, more comprehensive clinics; to hire more staff; and to improve access to care. As one director says, "Our new clinic is in process of being built and will open in the autumn. The fact that the Tribal Council agreed to fund it totally is a community success story! I have had people from the area calling and asking if they can get on a list to work for us." Another: "We can afford to pay top salaries and benefits. We offer behavioral and mental health services, podiatry, speech, a pharmacy, PT and OT plus all the other health services of a one stop shopping center." Several reservations that are able to hire their own dental staff have greatly improved dental access.

Other positive changes cited by some directors include families moving back to live on or near tribal lands and a flourishing of interest in tribal history and native languages. There is an increased interest in wellness with one director saying, "We started a 100 mile walking club a month ago. We have 39 adults and 13 adolescents who participate. People are excited about trying to get in better shape!" Some directors are pleased with higher breastfeeding numbers, with one saying, "Our breastfeeding initiation rate is 74%. We also have a high rate of breastfeeding at 1½years."

Another change mentioned includes more jobs available as a result of gaming. Ramifications of this include greater need for child care and the health centers needing to adapt their hours to meet the needs of working families.

Some directors express concern that health access is still a major problem, in part because of less affluent clinics, in part because of the high cost of health care services, and in part because of insufficient funding from Indian Health Service to provide for those who do not qualify for other payment sources. As one director said, "Indian Health

Service funding does not increase to meet the need for increased services. The federal 2010 Objectives to overcome disparities are expensive!”

A priority need of families, as perceived by directors, is parenting education. Directors would like to enhance child well being in the first year of life, in particular. Affordable housing and reliable transportation are important needs. Some directors mentioned teen pregnancy as a concern while others said that the increased availability of contraceptives has decreased teen pregnancy. Earlier prenatal care was of concern as well as providing HealthCheck more regularly. Some felt an increase in AODA use, particularly by adolescents, and fetal alcohol syndrome was mentioned. On one reservation, an AA group has recently begun and is well attended. The need to increase emphasis on tobacco reduction is mentioned as an issue. Said one director, “Our Tribal Council office recently became smoke-free because several of the women who work there are trying to quit. They proposed it and the Council agreed.”

Two particular concerns were expressed by some tribal health center directors. The first is the potential loss of federal Healthy Start funding. One of two Healthy Start funding sites in Wisconsin is called Honoring Our Children and comes to the Great Lakes Inter-Tribal Council. The staff and activities funded by the Honoring Our Children grant are perceived to provide unique and highly valuable services. Says one director, “Honoring Our Children (HOC) is a great success story! We have been able to address our families’ needs from a new perspective. We do home visiting, mentoring, connecting families with services. HOC staff publish a newsletter with a calendar of health related events that the whole reservation reads.” Another says, “Honoring Our Children with a Healthy Start allows us to work with very high need women. One example is a young woman with alcohol problems who became pregnant. She lived at home with her parents but was helped to find her own housing. Transportation was provided her to early prenatal care, she eventually participated in birth preparation classes, and she delivered a healthy baby.” If the funds are folded into the Title V Block Grant federally, the directors hope that the state will continue to fund their clinics at the same levels.

The second concern expressed by directors is BadgerCare which requires a co-payment that directors perceive is unfair for families to pay. They do not feel that scarce Indian Health Services funding should be used to supply the co-pay. Therefore, families are not applying for or benefiting from BadgerCare, which is viewed as an inequity. Tribal clinic directors have worked with federal HCFA and Wisconsin Division of Health Care Financing on the matter.

Family strengths - The Wisconsin assessment intentionally focused on collecting information regarding family strengths by devoting one section of the interview to this topic. We were interested to know, from the director’s perspectives, what qualities and values helped families function well and cope with difficult situations. The following is a summary of director’s responses to the question: In your county, describe the strengths of families.

The most frequently mentioned individual qualities were personal resilience, self-sufficiency, and inner strength.

“WIC moms are resourceful! They have so little money but somehow make do.”

“Families have stamina in dealing with complex situations.”

“Families have good survival skills. They are adept at overcoming barriers.”

“Families who are assertive in dealing with the ‘system’ do the best.”

Willingness to seek help, interest in expanding their knowledge, openness to health information, and a desire to better their lives are cited as additional markers of family strength. Directors say that families are aware of community resources and comfortable working with them. One example: “Our MCH nurse offered to do a developmental assessment on a two year old whose mom was enrolled in prenatal care coordination and she found significant language delays. The mom agreed to services and is now trying to get her child into Head Start.” Most women are motivated to have healthy pregnancies, keep their appointments, and are responsive to health education. Says one director, “Many of our moms reduce or stop smoking prenatally and, more and more, are getting the dad (if he smokes) to smoke out of the house.” Another: “Parents are interested in educating themselves about parenting and breastfeeding. They very willingly attend birth education classes.”

Many directors spoke about the value of their area’s Family Resource Center as increasing parental self-esteem and bettering child rearing. One success story: “We mentored a young mother who frequented our Family Resource Center. She went on to become a member of the Center’s Board of Directors and then to college!”

Also frequently commented upon is valuing family life. Fathers who are active in parenting strengthen the family, and two-parent households are mentioned. One director relayed the story of a young couple who participated in the local health department’s parenting program. “The father was very unsure of himself as a parent but willing to learn. We linked him to books and videos and the entire parent group offered him weekly support. We saw this couple grow more comfortable in their parenting and marital roles, and, in fact, they took the class a second time!” Grandparents are often support people behind the scenes or active caregivers for children. Moms and dads spending time with their families is cited as strength, with the observation, “Parents here are interested in doing the best for their kids.” And “Children are highly valued.” Directors mention that parents help set up sports events and “develop kid’s activities from the grassroots”. The presence of extended family (whether related by blood or not) who provide an intergenerational support network is probably the most frequently mentioned resource to families. “We successfully counseled a mother and daughter in our tobacco prevention program, who wanted to quit together,” says one director.

Community support of families is a frequently mentioned strength as is families who are themselves invested in community life. Several directors said that parents made an intentional choice to live in the area because they valued the life style. One example of community support: “One of our tiny communities rallied around a family whose child had encephalitis. Neighbors helped clean up old tires with standing water and had a fund raiser for the family.” Where strong school systems exist, they are mentioned as an asset, with parents responding to school

outreach. Faith communities that are responsive to families' needs are mentioned frequently and, as cited above, in some instances churches and synagogues have united with community groups to provide food and shelter safety nets for vulnerable families. One example: "Several groups worked over a long time with a homeless couple who at the time were expecting a baby. Currently, they have housing and live together as a family. The man has held a job for 18 months, has paid off his debts, and almost has a driver's license." Community volunteerism is a strength. One director says, "In our community, retired folks are active in 'asset-building' programs for youth." A feeling of community safety is important as well as the ability to trust that, by and large, children will "do the right thing."

Most parents have a strong work ethic and value access to employment. Where the business environment is thriving in a community, creating a sense of economic prosperity, families thrive, according to directors. Parents working for community-focused employers and being paid fair wages with health insurance benefits strengthen family life. Several such employers were mentioned: a car manufacturer, a utility company, and a large private clinic.

For American Indians, major family strengths mentioned include being able to rely on the entire community as extended family. There are many support people to turn to when in need. Additionally, there is more personal pride in being "able to make it on your own" because of increased income. Finally, as one director said, "Our cultural ceremonies – namings, pow-wows, dancing, community feasts, births, deaths, marriages – are glue for families."

The lack of community networks for immigrant or transient families is seen as a liability and points to the value of community support systems. A story one director relayed, "We are proud of our work with a Hispanic family not on Medicaid because they had 'no papers'. We provided prenatal care coordination-like services funded by MCH dollars. After birth, there was trouble getting Medicaid for the baby because of an error with the Social Security number. The family called our nurse because of the trust established and she untangled things. The baby is doing well – up to date on HealthChecks and immunizations." Extended family support is mentioned as a strength among some of the new population groups and ethnic pride is seen as important for the dominant community to respect. One director commented that a strength of the majority community is its ability to accept new minorities.

Current Status of Wisconsin Medicaid Coverage, Medicaid Expansion and Medicaid and SSI follows:

Wisconsin Medicaid

Both federal and state tax dollars support Medicaid. For state fiscal year 1998, Medicaid expenditures were \$2.52 billion. Of that amount, \$905 million was contributed by the state and nearly \$1.61 billion by the federal government. Medicaid is the second largest program in the state's budget, representing 9.3% of total state-funded expenditures. The program costs have increased over the years primarily due to expanded eligibility and rising health care cost.

Four major groups received medical services through Medicaid: the aged, the blind/disabled, the Healthy Start population, and recipients who qualified under the former Aid to Families with Dependent Children (AFDC) standards. Of the total Medicaid-eligible recipients, well over half were eligible through AFDC or Healthy Start,

accounting for 19% of Medicaid expenditures. The aged/blind/disabled make up approximately 35% of the eligible population and account for 81% of the program expenditures.

Medicaid Expansion

Wisconsin was one of the first states to initiate managed care for the AFDC/Healthy Start Medicaid population by receiving a federal waiver in the early 1980s. The HMO program expanded statewide in 1996 and 1997 beyond the original five counties. Expansion for the AFDC/Healthy Start population into additional counties occurred systematically in three phases starting in the eastern Wisconsin counties. By the end of 1997, over 290,000 Medicaid recipients had enrolled in 18 HMOs in 70 counties for at least a part of that year.

According to the 1997 Wisconsin Medicaid HMO Comparison Report: (data on health care delivered by HMOs enrolling Medicaid recipients) for most health care areas measured, health service utilization is quite stable relative to 1996 and HMO enrollees in Milwaukee County are largely satisfied with their care.

Relative to 1996, there were slight to moderate improvements in the utilization rate of:

- Health Check screens. Approximately 94% of eligibles were screened per eligible-year through Health Check services.
- Non-Health Check visits. These visits are an indication of the ease with which children receive routine and acute care. The availability of these visits helps establish a primary “medical home” for children enrolled in the AFDC/Healthy Start Medicaid population.
- Cesarean sections. C-Section rates continues to meet federal goals.
- Pap tests.
- MMR immunizations
- Hospitalization for asthma. The development and implementation of care management for enrollees with asthma resulting from inter-HMO cooperative efforts, will likely result in further reduction of hospitalizations for this populations.

Improvements may reflect improved data reporting by the HMOs and increased provision of services.

Improvements are still necessary in most areas of health care, but in particular dental services and behavioral health care. In addition, Medicaid coverage has expanded to include additional populations:

- **BadgerCare** is a Medicaid expansion program for families with higher incomes than Medicaid would usually allow. The funding for Badger Care comes from a combination of federal Medicaid and Children’s Health Insurance plan (CHIP), state General Purpose Revenue (GPR), and premium revenues.
- **Medicaid Purchase Plan.** Beginning in March 2000, people with disabilities who are working or interested in working are eligible to purchase Medicaid coverage by paying monthly premiums.
- **Family Care.** Four pilot sites have begun to provide managed long term care services to people who are elderly, to adults with physical disabilities, and to adults with developmental disabilities.

Beginning November 1999, Wisconsin Medicaid changed the policy on how Medicaid eligibility is determined for certain groups of individuals.

As a result of a case decision, the financial resources of a family member who is not the mother, father, or spouse of an individual cannot be used to determine that individual's Medicaid eligibility. Family members who were found ineligible for Medicaid due to too much income or assets, may now meet the Medicaid income or asset limits.

Medicaid and SSI

Caretaker Supplement for Parents who Receive SSI.

This program began in December 1997 to provide a monthly cash benefit to eligible SSI recipients with children for whom the children do not receive SSI, but for whom the children are eligible for Medicaid. Approximately 12,000 children are served through this benefit with \$250.00 per month for the first eligible child and \$150.00 per month for each additional child added to the parent's monthly state SSI check.

Priority Health Problems Focus on High Need Populations

The following describes a number of priority health problems for high need maternal and child health populations in Wisconsin.

Infant Mortality - Overall, in Wisconsin, the infant mortality rate decreased steadily from 10.3 deaths per 1,000 live births in 1980 to 7.2 in 1998. White infant mortality followed this trend, declining from 9.6 in 1980 to 5.6 in 1998. African American infant mortality has remained about the same since 1980 at 18 infant deaths per 1000 live births, even though the overall percentage of African American live births in Wisconsin increased from 6% in 1980 to 10% in 1998. The ratio of African American infant mortality to white infant mortality rates increased from 2 to 1 in 1980 to 3.2 to 1 in 1998. While the Wisconsin African American infant mortality rate remained even since 1980, the US rate declined from 22.2 in 1980 to 14.1 in 1998. The Wisconsin African American rate in 1998, 17.9, surpassed the national rate.

Smoking Among Pregnant Women - In Wisconsin, smoking rates among pregnant women (analyzed using birth certificate data) are above the national average. The US smoking rate for pregnant women decreased from 18.4% in 1990 to 12.9% in 1998. The Wisconsin smoking rate for pregnant women has consistently been about 4 percent points above the national average. In 1990, the rate was 22.9%; in 1998, the rate was 17.9%. Recent analysis of birth certificate data indicate that smoking rates are higher among women who were younger, unmarried, American Indian, or African American, received late or no prenatal care and did not graduate from high school.

Asthma - Asthma is a chronic lung condition affecting children and adults that can result in hospitalization or even death, as witnessed by recent news reports. In 1998, close to 6,000 asthma hospitalizations occurred in Wisconsin at a cost of \$26,000,000. One-fifth of this cost was borne by Medicaid dollars. Many asthma hospitalizations represent repeat admissions for asthma that is not well self-managed and/or medically treated.

Wisconsin's racial minorities and children represent a disproportionate share of asthma costs. African Americans residing in Milwaukee's central city have asthma hospitalization rates up to eight times higher than the state rate, according to a 1994 review. Preliminary research suggests that 10% of urban school-age children have asthma. In Milwaukee, 16-29% of students at two high schools reported having asthma. Further, about 70% of asthmatic children in Milwaukee Public Schools do not have a written asthma self-care plan and two-thirds with persistent symptoms do not use appropriate control medications. The basics of asthma management are known to reduce hospitalizations and other health care utilization. In response to this emerging problem, we have planned that for the Children's Health Alliance of Wisconsin, a statewide MCH project, to organize an asthma summit in 2000.

In our collaboration with organizations that focus on reducing MCH disparities, we have found that the guiding principles of community wide leadership and resiliency are particularly effective. The following two examples demonstrate an approach that we are likely to apply with increasing frequency as we strive to focus on populations that have high rates of adverse health outcomes.

Youth Violence Prevention - One organization with whom we have developed a strong working relationship over the past decade is the Black Health Coalition of Wisconsin. Coalition members include health care professionals as well as staff members from professional organizations such as the Black Nurses Association, the Wisconsin Association of Black Social Workers, and the Black Lawyers Association. Broad-based organizations such as the Milwaukee Urban League are also members of the Coalition.

During the MCH Block Grant funding cycle from 1994 through 1999, we awarded the Coalition a Title V grant to carry out a Family Resiliency Violence Prevention Program to study and apply through elementary school curricula the resiliency of African American families as a protective factor against interpersonal youth violence. The program started with a study that identified resiliency factors among African American families in Milwaukee that protected youth from interpersonal violence. The study found that resilient families had higher levels of education, employment, male partner and other family support networks, and church attendance. They tended to be more mobile, as reflected by greater car ownership than the non-resilient families and an increased likelihood to have recently moved to a safer location within the city. Resilient families had a stronger sense of being able to succeed in managing their lives. The Black Health Coalition used the findings from its study to design a youth violence prevention curriculum for the Milwaukee Public Schools.

African American Infant Mortality - A second example of our efforts to become more community-based and resiliency-focused in our work with high need populations relates to the large disparity in infant mortality between black and white infants in Wisconsin. Infants born to African American women in Wisconsin are three times as likely to die in the first year of life as infants born to white mothers. The Wisconsin African American infant mortality rate has averaged 18 deaths per 1,000 live births over the last decade. On the other hand, the ratio of American Indian infant mortality to the white rate has fallen from three to one in the mid 1980's to two to one in the late 1990's.

Previous research has attempted to explain disparities in health outcomes by focusing on traditional risk factors such as differences in socioeconomic status and higher levels of risk behavior among African American women.

However, according to several studies in the United States, the gap between the two groups for low birth weight, a major contributing factor to infant mortality, persists regardless of socioeconomic status.

The Division of Public Health convened a work group in 1995 to come up with a fresh approach to reducing African American infant mortality in the state. The group, chaired by the Chief Medical Officer for Family and Community Health, includes members of the African American community (including faith-based organizations) as well as public health and medical professionals. The group has developed unique partnerships. Conversations among people who would not necessarily otherwise talk with each other occur through this group. For example, an academic family practice physician has talked in detail with the director of a community-based organization serving people of color in Milwaukee.

The group has decided to focus on the potential for resiliency factors to improve black infant survival. The purpose of the study is to determine the extent to which resiliency in African American women, families, and their communities improve infant survival and thriving. The study addresses a person's ability to thrive and takes into account the capacity to deal with less studied risk factors such as the impact of stressful life events, racial discrimination, residential segregation, and gender roles on birth outcomes and infant health. In 1999, the Wisconsin Council on Developmental Disabilities awarded the Black Health Coalition a \$25,000 grant to pilot a resiliency questionnaire and to seek larger funding for a comprehensive study.

The primary leadership for the study comes from the Black Health Coalition of Wisconsin, which, as mentioned above, has carried out research on African American family resiliency related to the prevention of interpersonal violence among youth in Milwaukee. The results of the infant mortality resiliency research will be used to develop resiliency-based policies, programs, and services that specifically address closing the gap between African American and white infant mortality in Wisconsin.

In our work with the African American, Latino, American Indian, Southeast Asian, and other communities of color, the Title V Program in Wisconsin has gained valuable insight on the complexities and opportunities inherent in implementing the Five Guiding Principles. See *Appendix J, Summary of Development and Implementation of the Five Guiding Principles*. These communities have inspired us to examine the principles in greater depth and humility. Organizations such as the Great Lakes Inter-Tribal Council and the Tribal Health Centers have practiced in an exemplary way the family-centered and community-driven strategies needed to eliminate unjust health disparities due to deeply rooted systemic factors. By working with these communities, we acquire knowledge that we can apply to all children and families in the state.

These initiatives have inspired Title V to incorporate the vital importance of community driven coalitions into all MCH efforts in Wisconsin. In order to sustain the work of these efforts, we need a wide diversity of people - consumers, advocates, community residents, public health, HMO's, business, the media, policy makers - who are willing to take shared responsibility for and investment in this work.

Both Healthy Start projects in Wisconsin, for example, have consortiums that bring to the table numerous family members whose voices are consistently validated. We have been able to support these and other projects that make every effort to welcome and include family members in all phases of implementation. Title V in Wisconsin has greatly appreciated the leadership provided by these programs.

The capacity to sustain community-driven and family-centered MCH programs in the long term and in a systemic way is one of our greatest challenges over the next decade.

MCH Block Grant Activities – As previously stated in Section I, the MCH Block Grant cycle for FFY 2000-2004 focuses on four major themes. A local health department must select at least one of the four themes to receive MCH Block Grant funding.

Theme 1: Increase the incidence of healthy birth outcomes following the Guidance Manual for Prenatal Care Coordination and Family Planning Reproductive Health Standards of Practice.

Theme 2: Promote optimal growth and development and assure comprehensive primary care for children ages birth to 21, including children with special health care needs following Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents.

Theme 3: Promote healthy lifestyles among school-age youth, 6 – 21, in their communities, including children with special health care needs following Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents.

Theme 4: Assure access to safe, quality child care up to age six, including children with special health care needs following *Caring for Our Children: National Health and Safety Performance Standards Guidelines for Out-of-home Child Care Programs*.

Services provided under these themes must include:

- assessment and surveillance
- delivery of a public health service based on standards of care including family centered and culturally competent care
- appropriate record keeping
- information, education and outreach activities
- coordination with related programs
- a referral network
- provision of guidance for staff
- sound fiscal management, and
- data collection, analysis and reporting.

Consolidated Contract Evaluation - As part of the consolidated contracting process, a monitoring tool has been developed by the DPH to be used to evaluate and assess all local health departments at six-month and one year intervals. The Quality Criteria and Monitoring Tool has recently been piloted across the state. Contract monitors

will be using it to assess compliance with the various program quality criteria (immunization, lead, MCH, etc.) and evaluating the supporting evidence. See *Supporting Documents 5.3, Quality Criteria and Monitoring Tool*.

In addition, statewide and regional maternal and child health projects were determined through a competitive request for proposal process as described in more detail in Section 1.5.1.2. These projects primarily provide population-based services and infrastructure building addressing a broad array of MCH issues. They are as follows:

- Statewide Genetic Services
- Statewide Perinatal Health System Building
- Statewide Child Health System Building
- Statewide Services for Sudden, Unexpected Infant Deaths
- Regional Children with Special Health Care Needs Centers
- Public Health Information and Referral Services for Women, Children and Families which contains the MCH Hotline and Children with Special Health Care Needs Hotline (First Step)
- Family Planning and Related Reproductive Health Services
- Regional MCH Education and Training Project

Family-centered, culturally competent care - All MCH funded projects, including local health departments are expected to demonstrate their effectiveness in integrating the MCH Five Guiding Principles in all programs, services and systems. This year Family Health Section, under the guidance of the Chief Medical Officer, developed the MCH Five Guiding Principles Organization Self-Assessment Tool. See *Supporting Documents 5.3, MCH Five Guiding Principles Self-Assessment Tool*.

The purpose of the tool is to help agencies and organizations assess their level of activity in providing family-centered care, community-wide leadership, resiliency, outreach, and cultural competency. The intent is for agencies and organizations to use the self-assessment tool annually to determine their progress and develop a plan to better integrate and improve service delivery. Progress made and future plans can then be discussed during the contract negotiations for the next funding cycle.

Availability of specialty services - Wisconsin's Medicaid capitated health plans are not required to allow children with special health care needs access to a pediatric specialist as their primary care provider. In addition, these plans are not required to allow children with special health care needs to obtain ongoing care for specific medical conditions from a specialist without first seeking a referral from their primary care physician. However, the five categories of children with special needs, as defined in the Balanced Budget Act of 1997, are able to opt out of Wisconsin's capitated health plans and obtain Medicaid covered services in a fee-for-service environment.

Existing resources for specialty care that is community-based - Wisconsin does boast several large specialty clinics/hospitals (St. Joseph's Hospital-Marshfield Clinic, Gundersen Lutheran Hospital/Clinic, Children's Hospital of Wisconsin in Milwaukee, and UW Hospital and Clinic in Madison). However, access to these specialty services is oftentimes more difficult for rural populations, regardless of Medicaid eligibility or insurance carrier.

Financial barriers to include habilitation and rehabilitation – Habilitation services are not a Wisconsin Medicaid covered service unless they are found to be preventive, restorative, or provide maintenance. This oftentimes creates a financial barrier to recipients seeking strictly habilitative services where there may not be any other means of payment. Medicaid will cover rehabilitative services under “spell of illness” as defined under a recipient’s plan of care as a new disease, injury or medical condition or an increase in severity of a pre-existing medical condition.

Linkages that exist to promote services and referrals – The public health structure in Wisconsin is locally driven. The Division of Public Health has five DPH regional offices that are responsible to certain counties within the state determined by geography. See *Supporting Documents 5.3, DPH Regional Map*. The DPH regional offices provide regular communication to the local health departments. In turn, the central office works closely with the DPH regional offices.

Findings from the 2000 Needs and Strengths Assessment indicate that local health departments are intricately connected to all sorts of agencies and organizations in their community that address the full range of services demanded by the MCH population. A question asked during the assessment interview was: What are examples of people, groups, or organizations working together to improve the health and quality of life in your community?

Responses provided many examples of community and countywide partnerships and collaborations aimed at assessing, tracking, and meeting a broad range of family and child health and human service needs. Most frequently these linkages involved numerous segments of the community in addition to the health department, with involvement from schools, human service agencies, hospitals and clinics, early intervention and education programs, non-profit and service organizations, law enforcement and the judicial system, libraries, AHECs, vocational/tech schools and university extensions, local foundations and charities, day cares, and businesses. Naturally, different linkages are established based on the need to be met. For example, linkages for reproductive health will differ from linkages for services needed by children with special health care needs.

A sampling of the coalition and program names is intriguing - Start Smart, Healthy Family Network, Parents as Teachers, Health Watch, LIFE, Play Shop, Family Circle, Health Council, Hispanic Coalition, Love Life Program, Volunteers for Youth, Home Nurturing Program, Starting Points, ABC Healthy Families, Genesis, Lighted School House, Concern for Children, Safe Kids Coalition, The Family Center, Child First, Council of Healthy Communities, Family Impact Seminars, Home Alone Program, Honoring Our Children, Hmong American Partnership, Right from the Start, Healthy County 2010, Next Generation, Healthy Families Collaboration, Families and Communities Together, Safe and Stable Families, Parenting Enrichment Network, ABC Healthy Families, CARE about Youth Issues, Protect All Kids, Watch 2000, TOYS - to name a few.

Two examples from directors:

“We do lots of community education on MCH issues, especially regarding reproductive health. We work very well with the tribal health nurses at the Reservation clinic, making referrals back and forth.”

“A baby born in our county had Spina Bifida and the hospital nurse felt strongly about a public health referral. Our nurse made many home visits and services place Birth-3, Katie Beckett, Healthy Families, and WIC. The family has coped well, although there is no support group in our area so the nurse is still looking for resources for them.”

The directors also mentioned a number of other community collaboration success stories:

“We plan to do "our own" APEX a second time with multiple other agencies represented on the County Health Partners Coalition. Over the next five years we will focus on "a disease of the year" based on our statistics; we anticipate addressing tobacco use the first year.”

“Our County Prevention Council started in 1993 when a judge ordered a multidisciplinary group to come together to look at a truency problem in the schools. By now there are 4 sub-groups of this Council: ATODA, Early Childhood, Domestic Abuse and Family Preservation. The Council has a community resource directory and our Parent Resource Center is a by-product of the Prevention Council.”

“The results of our Coalition’s last big community needs assessment are being used to expand education and collaboratiion in the community through the development of our family centers in eight different communities. We recently hired a home visitor.

“In a rural county, everyone wears multiple hats which can make collaboration easier. One of the people on our needs assessment committee is the minister of both the Lutheran and the Presbyterian churches and he is also the EMT.”

“A number of years ago we developed a consortium of metropolitan organizations to address our high central city infant mortality rate. The consortium wanted to develop an infant mortality review project and sought funding from national and local organizations and private foundations as well as state and city health departments. Our current infant mortality review project is funded by the federal MCH Bureau Healthy Start program.”

“Our Target Health Group was established in 1991 and annually issues a status report on health priorities. I (local health department director) co-chair it with the local clinic director and it includes representation from physicians, the sheriff, clergy, business leaders, town representatives and schools.”

“Our strength is in networking with others. Much of the health care in our county is provided by a large, private clinic system. Our reproductive health program collaborates particularly well with this clinic. And physicians there requested that we take the lead in providing prenatal care coordination for high-risk pregnancies.”

“Our First Born Program is for at risk mothers. The moms are identified as being at risk for child abuse or neglect by various health, human services, and school personnel. We use a mentoring, role-model approach and our nurse works with the mentors and social workers. We provide transportation and

linkages to other community resources. This program is seen as successful in the entire community and is a true prevention effort.”

“We are proud of the one-stop service model we’ve fashioned over the years. It is truly seamless from prenatal care coordination to WIC to Family First to Birth to 3. This has resulted in high immunization rate, the ability to identify risk factors early and provide prevention services (and fewer intervention services). Birth to 3 and our nurse follow families jointly. We have a good transition into the school system for young children and families.”

The creation of the five Regional CSHCN Centers is a unique effort to strengthen the linkage to service and referral for the CSHCN population. The Regional CSHCN Centers must partner with the local health departments and provide information and referral. Also, the MCH and First Step hotlines are also available 24-hours a day, seven days a week to provide consumers and providers with information and referrals to many agencies and organizations in the state. Plans are in progress to have this database available to local health departments on the internet.

The following sections 3.1.2.2 - 3.1.2.5 identify MCH service components based on need by level of the pyramid and population group.

3.1.2.2 Direct Health Care Services

Women and Infants

- Provide contraceptive and reproductive health services, screening, assessment, sexually transmitted disease testing, counseling and treatment, and pregnancy testing services.

Children and Adolescents

- Provide well child assessments to all children, including those in child care settings, not covered by private health insurance or Medicaid.
- Provide medical nutritional therapy by a dietitian to children and youth, ages birth to 21.

Children with Special Health Care Needs

- All activities under Children and Adolescents and service coordination provided by the Regional CSHCN Centers.

3.1.2.3 Enabling Services

Women and Infants

- Provide reproductive health education, anticipatory guidance, short term care coordination and presumptive eligibility (Medicaid) services.
- Provide perinatal care coordination for pregnant adolescents and high-risk women.

Children and Adolescents

- Provide case management to all children with confirmed blood lead levels >20ug/dl.

- Provide case management to all children with confirmed hearing loss through universal newborn hearing screening.
- Provide home visits to all newborns or subpopulations identified as at-risk.
- Provide health education to families on child related topics identified through the community needs assessment.
- Assure adequate transportation services, respite care, and family support by partnering with community groups.
- Assure/develop peer counseling programs with school and community partners for healthy lifestyle choices for school age youth.
- Assure/develop care coordination for youth with psychosocial issues and nutritional needs.
- Assure/develop health education programs to assist school age youth in making healthy lifestyle choices.
- Facilitate and work with schools and community groups to promote physical activity/fitness.
- Provide technical assistance and education to child care providers on the care of mildly ill or special needs children.
- Provide technical assistance and education to child care providers on prevention of injury and communicable disease.
- Assure that health education materials are age, developmentally, and culturally appropriate to the population being served.
- Provide technical assistance for the development of health-related policies and procedures in child care settings.

Children with Special Health Care Needs

All activities under Children and Adolescents, and:

- Assure CSHCN receive regular, ongoing medical care within a medical home.
- Assure CSHCN receive the specialty and subspecialty services, including care coordination, not otherwise accessible and/or affordable to them.
- Provide education, technical assistance, and advocacy related to health benefits counseling to Regional CSHCN Centers and local health departments to assure funding for health care interventions for CSHCN.

3.1.2.4 Population-Based Services

Women and Infants

- Develop a community education and outreach plan that identifies the availability of reproductive health and pregnancy testing services, assists with reproductive health risk reduction and health promotion, and informs the public about patient privacy and confidentiality standards.
- Develop a community education and outreach plan that identifies the availability of WIC, breastfeeding support and nutrition services; ATODA counseling and treatment; options for health care coverage; and the need for early entry into perinatal medical care and care coordination services.
- In collaboration with CDC and March of Dimes, implement a professional and public education campaign on folic acid.

- Provide timely information, counseling and grief support services to the families who are affected by a sudden or unexpected infant death.
- Provide research-based education and training programs to professionals who come into contact with bereaved families.
- Maintain a central program and a regional "satellite" structure to assure community-based provision of services to families affected by a sudden or unexpected infant death.
- Provide targeted outreach and information to select communities to reduce the disparity for infant mortality between ethnic and racial groups.
- In collaboration with local health departments, conduct timely public health nurse interviews with bereaved families.
- Maintain a database on sudden unexpected infant deaths, to include annual reports of the epidemiological information in the public health nurse family interviews.
- Assure that genetic services are provided by qualified staff, are consistent with standards of care and include: identification, evaluation, counseling, education and follow-up with particular focus on families with children with special health care needs.
- Assure that genetic services are available in all five regions of Wisconsin, with particular focus the northern region of the state.
- Document that genetic services are first billed through private insurance and Medicaid, with Title V as payer of last resort.
- Develop linkages with the Regional CSHCN Centers to assure coordinated services.
- Link with the MCH Regional Education and Training Centers to assure that community care providers and other health professionals receive appropriate education and training regarding genetic issues and availability of services.
- Provide technical assistance to the Wisconsin Birth Defects Surveillance Program
- Develop a genetic assessment tool for use by the Birth to 3 service providers.
- Conduct biannual meetings of the Greater Wisconsin Genetics Exchange.
- Provide 24-hour toll-free hotline services for maternal and child health consumers and providers.

Children and Adolescents

- Provide/assure all children receive immunizations according to the schedule approved by ACIP, AAP and AAFP.
- Provide/assure screening for lead exposure and testing of children when required or recommended at ages 1 and 2, and appropriate follow up for children with lead levels >10ug/dl.
- Assure all third grade children receive necessary dental sealants.
- Provide public education about the need for regular assessments of nutritional status for all children.
- Provide public education about the value of longer duration of breastfeeding, and related issues about returning to work.

- Assure implementation of multi-faceted health education programs that increase public awareness of healthy lifestyle choices for school age youth.
- Facilitate implementation of nutrition education programs for school age youth, families and school staff.
- Collaborate with community advocates on hunger and food security issues for school age youth and their families.
- Assure implementation of one or more physical activity/fitness programs for school age youth.
- Provide community-based education and outreach to school age youth and their families regarding ATODA issues.
- Facilitate and work with community/student groups to organize non-alcoholic events and promote smoke-free environments.
- Promote public awareness and provide education to child care providers and families about lead screening, dental sealants, sudden unexpected infant death counseling, and breastfeeding support services.
- Assure/conduct safety assessments in at least three new child care settings annually.
- Collaborate with WIC, local nutritionists and the Child and Adult Care Food Program staff (who visit child care sites four times a year) to assure healthy and safe food preparation in child care settings.
- Provide 24-hour toll-freehotline services for maternal and child health consumers and providers.

Children with Special Health Care Needs

All activities under Children and Adolescents, and:

- Provide training and education about the exceptional needs of CSHCN to program staff, agencies, educators, community members, and others working with CSHCN.
- Provide education about the role of medical nutrition therapy when a feeding or nutrition problem is identified.
- Assist in the development of a Universal Newborn Hearing Screening Program.
- Provide 24-hour toll-freehotline services (First Step) for the children with special health care needs population.

3.1.2.5 Infrastructure Building Services

Women and Infants

- Develop a community partnership to ensure access to comprehensive reproductive health services, provision of quality reproductive health care based on established standards of practice, and continuity of care in accordance with clients' reproductive health service needs.
- Develop a community partnership to ensure access to perinatal medical care and care coordination, provision of quality perinatal health care based on established standards of practice, and continuity of care in accordance with clients' perinatal service needs.
- Develop a minimum of one quality assurance guideline for perinatal services delivered by managed care organizations.
- Collaborate with other agencies to promote primary prevention of maternal and infant deaths.

- Promote provision of preconceptional health services, to include resources for health care providers and consumers.
- Develop strategies to promote initiation and duration of breastfeeding.
- In collaboration with the designated Regional Children with Special Health Care Needs Centers, develop a system to assure timely transition into community based services for high risk infants.
- In collaboration with the Wisconsin Program for Children with Special Health Needs and the designated Regional Children with Special Health Care Needs Centers, develop and implement a system to provide universal hearing screening for all newborns before hospital discharge.
- Coordinate implementation of a statewide perinatal data system, to include PC-Log and the MCH Data System, to provide data for needs assessment, research, quality assurance and to document progress toward required national and state performance measures.
- In coordination with the MCH regional education and training groups, provide professional education on perinatal health issues that supports evidence-based practice.
- Develop perinatal consumer education programs and resources that increase consumer knowledge about positive health behaviors and effective use of the perinatal health care system.

Children and Adolescents

- Develop a local consortium to develop and implement programs/policies to improve the health and well being of children in the community.
- Partner with the MCH Regional Education and Training plan to determine and implement programs appropriate for children’s health issues.
- Partner with the Statewide Child Health System initiative to develop or implement clinical standards or best practice models.
- Monitor and analyze data related to children’s health issues.
- Assure the development of community partnerships to implement “Brighter Futures: Wisconsin’s Plan to Prevent Adolescent Pregnancy.”
- Assure the development of and/or collaboration with community partners to strengthen and enforce underage smoking and drinking laws.
- Assure the development of and/or collaboration with community partners for Coordinated School Health Programming.
- Coordinate the implementation of identified priorities from local needs assessment for school age youth.
- Identify and develop the role for a local public health contact person to partner with the local Child Care Resource and Referral and District Regulation and Licensing staff.
- Secure commitments from major private and public child health organizations to participate in the development of a statewide coordinated primary, preventive child health delivery system.
- Provide “system” support (training, quality assurance, data collection and analysis) to local health departments related to their role of assuring primary, preventive child health services.

- Develop a collaborative initiative to obtain health insurance coverage for all children.
- Develop a process for tracking and selecting emerging child health issues that necessitate attention.

Children with Special Health Care Needs

All activities under Children and Adolescents, and:

- Assure the CSHCN Regional Centers conduct activities, including data collection, that will help the State achieve favorable outcomes for the national performance measures.
- Establish a method to determine family satisfaction with services received.
- Assure the development of protocols, standards of care and guidelines for best practice, with input from families, to assure quality health care for CSHCN.
- Provide education and training regarding protocols, standards of care and guidelines for best practice to CSHCN Regional Centers, other MCH initiatives and projects, key regional and community agencies, and providers.
- Assure collaboration between families, CSHCN Regional Centers, other MCH initiatives and projects, key regional and community agencies, and providers, to promote standards of care and best practice for CSHCN.
- Provide education, training, and ongoing technical assistance to increase the capacity of local health departments and other local agencies, such as schools, to provide care coordination services.
- Provide technical assistance to CSHCN Regional Centers, other MCH initiatives and projects, and key regional and community agencies to enhance their capacity to provide care coordination and other services for CSHCN and families.
- Provide technical assistance to facilitate the establishment of formal working relationships between local health departments and the CSHCN Regional Centers to identify, refer, and negotiate care coordination services for CSHCN.
- Establish a quality improvement mechanism to assure CSHCN and their families receive care coordination and quality care services.
- Assure the development of parent-to-parent support networks and other mechanisms which provide all families with access to parent support services and health benefits counseling.
- Plan and provide for a uniform ongoing mechanism to gather local, regional, and statewide information which will aid in planning outreach, referral, education, and training for parent-to-parent support activities.
- Assure the development of education and training programs for parents to become better mentors, leaders, and advocates for CSHCN.
- Establish leadership and liaison with key groups such as managed care and insurance providers, Division of Health Care Financing (for Medical Assistance, BadgerCare, and related issues), Social Security Administration (for SSI and Survivor's Benefits related issues), and Office of the Insurance Commission.
- Provide education, training and technical assistance to service providers and parents to assure early identification of and provision of services for infants and CSHCN.
- Collaborate in planning for improved access and program transitions for very young and school age children at the community level, including health, education and social services.

- Establish a statewide plan for early identification and intervention for CSHCN, including transitioning from NICUs to communities.

3.2 Health Status Indicators

See Supporting Documents Section 5.4 and 5.5 for core and developmental health status indicator forms.

3.2.1 Priority Needs

During the 2000 MCH Needs and Strengths Assessment, local health department directors were asked the question, “What new needs have emerged as a priority over the last five years?”. This information was tabulated and when compared to the previous priority needs list, it is surprisingly similar. However, two new priority needs emerged:

- Need for a [local] system of care for children with special health care needs, and
- Need to address health disparities among minority and immigrant populations.

In addition, from the aggregated data it was possible to rank the priority needs from most important to least important. With the addition of the two new priority needs, well child and injury moved into 11th and 12th place as they were mentioned least often by directors. Local health department directors often mentioned that they are less and less likely to provide well child exams because HMOs have assumed this role. Regarding injury, MCH programming inherently includes injury prevention and intervention activities when improving parenting skills. In addition, the health status indicators maintain a considerable focus on injury statistics.

The following table lists the priority needs in order of importance as determined by the Wisconsin’s local health department directors, and for purposes of the application are organized by levels of the pyramid.

Ten Priority Needs in Order of Importance	Direct	Enabling	Population	Infrastructure	Women/Infants	Children	CSHCN
1. Dental access and care To assure dental health for children HP 2010 21 –2b		X				X	X
2. Health access To assure quality standards, care coordination, and access to health care				X	X	X	X
3. Child care To assure safe and healthy child care				X	X	X	X
4. Family and Parenting To increase parenting skills	X		X		X		
NEW 5. Systems of care for CSHCN To assure a community-based system of care for CSHCN				X			X
NEW 6. Health disparities for minority and immigrants To assure culturally competent services				X	X	X	X
7. Teen Pregnancy To increase teenage pregnancy prevention efforts			X			X	
8. ATODA To decrease ATODA among women and children		X			X	X	X
9. Early prenatal care To increase early prenatal care especially among minorities	X				X		
10. Immunizations To improve immunization rates and access	X				X	X	X
11. Well child To assure all children receive a well child exam		X				X	X
12. Injury To decrease unintentional and intentional injuries			X		X	X	X

3.3 Annual Budget and Budget Justification

3.3.1 Completion of Budget Forms

See Forms 2, 3, 4, and 5

Other Requirements

MAINTENANCE OF EFFORT

	<u>1989</u>	<u>2001</u>
WIC.....	978,800	167,300
Reproductive Health.....	1,150,000	1,955,200
Pregnancy Counseling.....	275,000	275,000
Congenital Disorders.....	505,000	1,456,400
Immunization.....	660,000	0
Pregnancy Outreach.....	250,000	350,000
WisconCare.....	903,000	0
Lead Poisoning-Detec/Control.....	0	1,004,100
Poison Control.....	0	375,000
Child Abuse & Neglect Prevention.....	0	995,700
Informed Consent.....	0	50,000
Women’s Health.....	0	50,000
BDOMP.....	0	50,000
TOTALS.....	4,721,800	6,778,700

State Match – In addition to the above state Maintenance of Effort, match and program income generated from grants to local agencies are projected to be \$3,545,148 and \$4,385,412 respectively. This will result in a total match of \$14,709,258. (See Form 2, Lines 3 and 6).

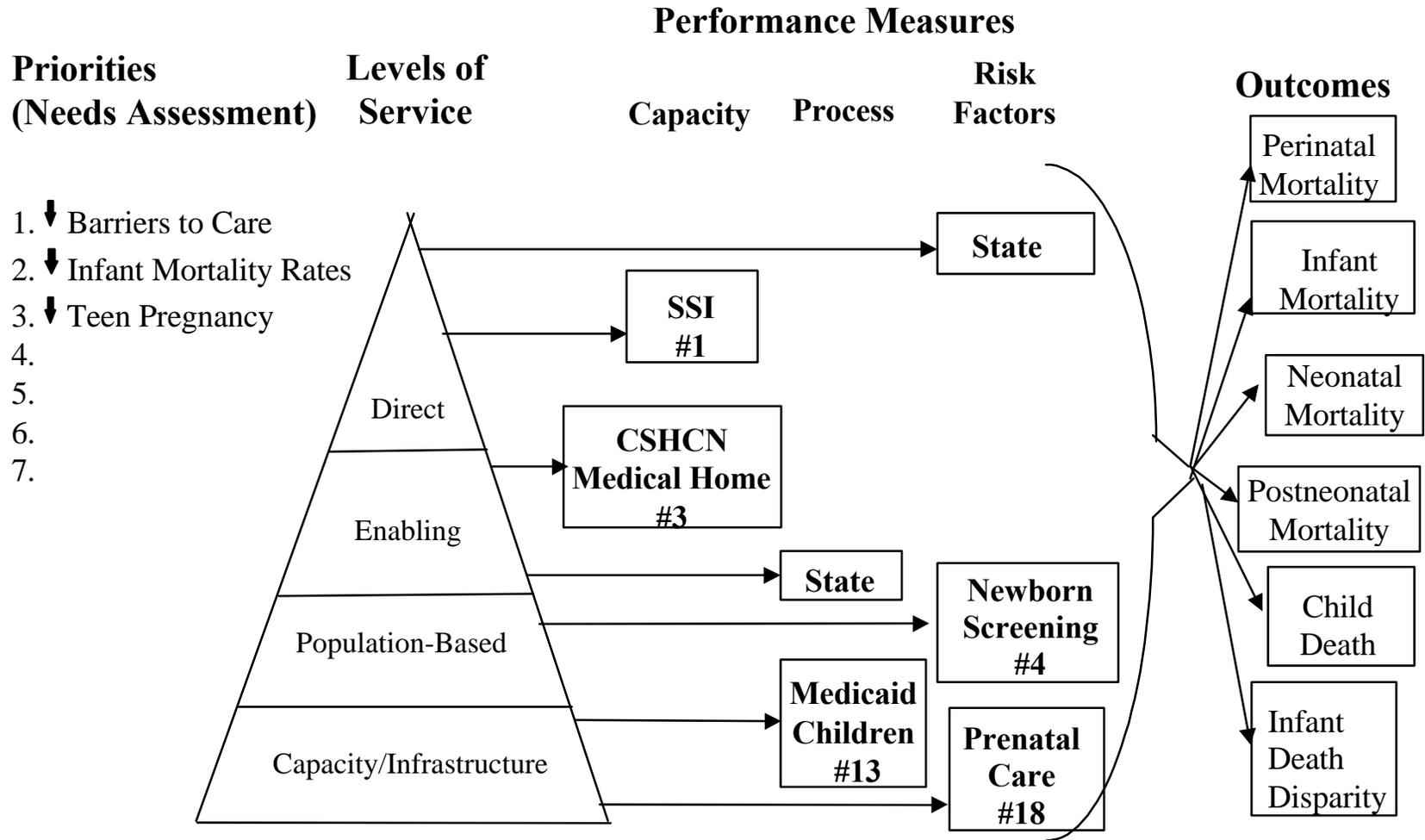
Other federal funds for 2001 total \$74,473,600 as follows:

SSDI.....	100,000
Abstinence Education.....	795,900
Healthy Start.....	185,780
WIC.....	57,530,000
CDC:	
Sexual Assault Prevention.....	803,000
Immunization.....	9,500,000
STD Control.....	583,947
Lead Control.....	1,000,000
Tobacco Control.....	1,141,000
AIDS/HIV.....	726,750

Other:

Lead Control (HUD)	1,333,333
Lead Abatement Training (EPA)	200,000
School Asbestos Control (EPA).....	100,000
Univ Newborn Hearing Screening (MCHIP).....	<u>95,497</u>
TOTAL	74,473,600

FIGURE 3
Title V Block Grant
Performance Measurement System



OSCH/MCHB 4/97 *PERFORMANCE MEASURE NUMBER(Examples Only)

3.4.1 National Core Five Year Performance Measures

3.4.1.1 Five Year Performance Objectives

See Form 11.

3.4.2 State “Negotiated” Five Year Performance Measures

3.4.2.1 Development of State Performance Measures

FIGURE 4

PERFORMANCE MEASURES SUMMARY SHEET

Core Performance Measures	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
1) The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.	X				X		
2) The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.	X				X		
3) The percent of Children with Special Health Care Needs (CSHCN) in the State who have a “medical/health home.”		X			X		
4) Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies (e.g., the sickle cell diseases) (combined).			X				X
5) Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.			X				X
6) The birth rate (per 1,000) for teenagers aged 15 through 17 years.			X				X
7) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.			X				X
8) The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children.			X				X
9) Percentage of mothers who breastfeed their infants at hospital discharge.			X				X
10) Percentage of newborns who have been screened for hearing impairment before hospital discharge.			X				X
11) Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN Program with a source of insurance for primary and specialty care.				X	X		
12) Percent of children without health insurance.				X	X		
13) Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.				X		X	
14) The degree to which the State assures family participation in program and policy activities in the State CSHCN Program.				X		X	
15) The rate (per 100,000) of suicide deaths among youths 15-19.				X			X
16) Percent of very low birth weight live births.				X			X
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.				X			X
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.				X			X

Negotiated Performance Measures	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
1) Percent of children less than 12 years of age who receive one physical exam a year.	X					X	
2) Percent of pregnant women at risk of unintended pregnancies (as defined by Alan Guttmacher Institute) receiving family planning and related reproductive health services through publicly funded clinics.	X						X
3) Percent of women who use tobacco during pregnancy.		X					X
4) Percent of high school youth who self-report taking a drink in the past 30 days.		X					X
5) Percent of high school youth who self-report tobacco use (e.g., cigarettes, chewing tobacco, etc.) over the past 30 days.		X					X
6) Percent of 6-17 year olds that are overweight.			X				X
7) Percent of women enrolled in WIC during pregnancy who initiated breastfeeding.		X				X	
8) Percent of infants born with low birth weight among all racial/ethnic or age groups.			X				X
9) Percent of children aged 6-8 years with untreated dental decay in primary and permanent teeth.			X				X
10) Percent of MCH clients who receive parenting skills and training.				X	X		

NOTE: DHC=Direct Health Care ES=Enabling Services PBS=Population Based Services IB=Infrastructure Building
C = Capacity P = Process RF = Risk Factor

3.4.2.2 Discussion of State Performance Measures

Local health department directors were asked to react to the ten State Performance Measures and determine which two or three were most important to their county, and if there were any important measures missing from the list. Most directors agreed with the current state performance measures. Their most frequent responses included: access to health care, dental care and access, ATODA issues, parenting, reproductive health, day care and immunizations. Directors suggested new state performance measures in the area of family violence, especially child abuse and neglect, a more general approach to nutrition and its relationship to obesity rather than the youth's consumption of fruits and vegetables, STDs, and mental health.

This information was considered in relation to the new emerging priority needs they identified, availability of data, areas already addressed by the National Performance Measures and Health Status Indicators, and future program plans in the Bureau of Family and Community Health to finalize Wisconsin's ten state performance measures for 2000. In addition, the DHFS has outcome scorecards to monitor progress on key health issues in Wisconsin including maternal and child health. It is necessary to take into account the Department scorecards in this process as well. See [Appendix A](#).

Two new state performance measures have been created to address the concern for dental access and care voiced around the state. The other state performance measure focuses on the reduction of obesity among children and

adolescents. The following text describes the rationale for the inclusion of these two new state performance measures.

Dental access and care

New State Performance Measure: Percent of children aged 6-8 years with untreated dental decay in primary and permanent teeth.

The Children's Health Alliance of Wisconsin, a Title V subcontract, has been actively involved in improving dental access and care. Additional Family Health Section program efforts are underway to hire a Public Health Educator as a dental health consultant trained as a dental hygienist with experience in public health. Once the dental health consultant is hired, the incumbent will oversee oral health surveillance, to determine the baseline for children 6–8 years with untreated dental decay and participate in clinical screening assessments.

Child care

At this time a state performance measure has not been identified for this priority need. This could be discussed at the August application review.

Parenting and family

Directors suggested adding a performance measure focusing on family violence. Although this was not done, it was decided that efforts to increase MCH clients who receive parenting skills and training would include information that addresses family violence and stress including intentional and unintentional injuries. Following that logic, the state performance measure, percent of MCH clients who received injury prevention services was dropped.

New state performance measure: Percent of 6-17 year olds that are overweight.

Directors felt that a more comprehensive nutrition approach should be adopted. Therefore, the state performance measure dealing with percent of high school youth who self-report eating fruits and vegetables during the previous day was eliminated. This new state performance measure fits nicely with the Bureau of Family and Community Health's plan to expand nutrition services to a comprehensive, community-based program broader than WIC focus.

Systems of care for CSHCN

Although a specific state performance measure was not created to match with this emerging need, it was exciting to have the directors identify systems of care for CSHCN as a priority. For now, it was decided that the six national performance adequately addresses the systems concern. The Family Health Section program efforts to develop CSHCN services at the local level are underway with the establishment of the five regional CSHCN centers and the required partnership between the centers and local health departments.

Health disparities for minority and immigrants

The Family Health Section will work on increasing local health departments capacity in providing family centered, culturally competent services through regional education and training efforts. As part of the consolidated contract

process, local health departments are asked to complete the MCH Guiding Principles Organization Self Assessment tool annually to determine their progress on providing family centered, culturally competent care and to develop a plan to improve their progress. See *Supporting Documents 5.3*.

The following table summarizes the priority needs, state performance measures and national outcome measures.

Wisconsin's Ten Priority Needs	MCH State Performance Measures	MCH National Outcome Measures
1. Dental access and care	NEW Percent of children aged 6–8 years with untreated dental decay in primary and permanent teeth. [Population-based] SPM #9 HP 2010 21 2b	
2. Health access	Percent of children less than 12 years of age who receive one physical exam a year. [Direct] SPM #1 Percent of pregnant women at risk of unintended pregnancies, receiving family planning and related reproductive health services through publicly funded clinics. [Direct] SPM #2 Refer to NPM #6 for immunization.	#1 Infant mortality rate #2 Disparity between Black and White infant mortality rates #3 Neonatal mortality rate #4 Postneonatal mortality rate #5 Perinatal mortality rate
3. Child care	No SPM	
4. Parenting and family	Percent of MCH clients who receive parent skills and training. [Infrastructure] SPM #10 NEW Percent of 6–17 year olds that are overweight. [Population-based] SPM #6	#1 Infant mortality rate #2 Disparity between Black and White infant mortality rates #3 Neonatal mortality rate #4 Postneonatal mortality rate #5 Perinatal mortality rate #6 Child death rate
5. Systems of care for CSHCN	Refer to NPM #1, 2, 3, 11	#1 Infant mortality rate #2 Disparity between Black and White infant mortality rates #3 Neonatal mortality rate #4 Postneonatal mortality rate #5 Perinatal mortality rate #6 Child death rate
6. Health disparities for minority and immigrants	Percent of infants born with low birth weight among all racial/ethnic and age groups. [Population-based] SPM #8	#2 Disparity between Black and White infant mortality rates

Wisconsin's Ten Priority Needs	MCH State Performance Measures	MCH National Outcome Measures
7. Teen pregnancy	Percent of pregnant women at risk of unintended pregnancies, receiving family planning and related reproductive health services through publicly funded clinic. [Direct] SPM #2	#1 Infant mortality rate #2 Disparity between Black and White infant mortality rates #3 Neonatal mortality rate #4 Postneonatal mortality rate #5 Perinatal mortality rate #6 Child death rate
8. ATODA	Percent of women in Wisconsin who use tobacco during pregnancy. [Enabling] SPM #3	#1 Infant mortality rate #2 Disparity between Black and White infant mortality rates #3 Neonatal mortality rate #4 Postneonatal mortality rate #5 Perinatal mortality rate
9. Early prenatal care	Percent of pregnant women at risk of unintended pregnancies, receiving family planning and related reproductive health services through publicly funded clinics. [Direct] SPM #2 Percent of infant born with low birth weight among all racial/ethnic and age groups. [Population-based] SPM #8 Percent of women enrolled in WIC during pregnancy who initiated breastfeeding. [Enabling] SPM #7	#1 Infant mortality rate #2 Disparity between Black and White infant mortality rates #3 Neonatal mortality rate #4 Postneonatal mortality rate #5 Perinatal mortality rate
10. Immunizations	See NPM #6	

3.4.2.3 Five Year Performance Targets

See Form 11.

3.4.2.4 Review of State Performance Measures

Staff are requesting a discussion about addressing health in daycare settings particularly because there are no state or national performance measures identified, yet the need is high.

3.4.3 Outcome Measures

See Forms 12 and 16.

IV. REQUIREMENTS FOR THE ANNUAL PLAN

4.1 Program Activities Related to Performance Measures

Our annual plan is developed from Wisconsin's ten priority needs, the national performance and outcome measures, state negotiated performance measures, the MCH themes and its related consolidated contract objectives, and the MCH statewide and regional projects.

The four MCH themes are:

- Theme 1: Increase the incidence of healthy birth outcomes following the *Guidance Manual for Prenatal Care Coordination and Family Planning Reproductive Health Standards of Practice*.
- Theme 2: Promote optimal growth and development and assure comprehensive primary care for children ages birth to 21, including children with special health care needs following *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*.
- Theme 3: Promote healthy lifestyles among school-age youth, 6 - 21, in their communities, including children with special health care needs following *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*.
- Theme 4: Assure access to safe, quality child care up to age six, including children with special health care needs following *Caring for Our Children: National Health and Safety Performance Standards Guidelines for Out-of-home Child Care Programs*.

Individual objectives were developed by the local health departments and regional Division of Public Health staff, in conjunction with the Bureau of Family and Community Health, Family Health Section. A total of 295 objectives were generated. See [Appendix C](#). Each objective has been assigned to one of the four MCH themes. Of the 96 local health departments participating in the consolidated contract plan:

- 50 agencies have at least one objective that addresses healthy birth (Theme 1)
- 45 agencies have at least one objective dealing with healthy children (Theme 2)
- 27 agencies that speak to healthy lifestyle activities for children (Theme 3), and
- 23 agencies are tied to activities for safe and healthy child care (Theme 4).

See [Supporting Documents 5.3, MCH Consolidated Contract Summary](#).

The consolidated contract plan is compiled with the family planning/reproductive health services and the statewide and regional projects described in Section I.

MCH Themes and Statewide/Regional Projects that address National Performance Measures

National Performance Measures (abbreviated)	Theme 1 Healthy Birth	Theme 2 Healthy Children	Theme 3 Healthy Lifestyles	Theme 4 Safe and Healthy Child Care	Statewide or Regional Project
1. SSI beneficiaries less than 16 years old		X			Regional CSHCN Centers
2. Pay for specialty and subspecialty care for CSHCN		X			Regional CSHCN Centers
3. CSHCN with medical home		X			Regional CSHCN Centers
4. Newborns with at least one screening	X				Genetics and Newborn Screening Program
5. Children age 2 complete immunizations		X			
6. Birth rate for teenagers			X		
7. Third grade children who have protective sealant		X			Child Health System Building
8. Motor vehicle death rate for children		X			
9. Mothers who breastfeed	X				
10. Newborns screened for hearing impairment	X				Perinatal Health System Building
11. CSHCN with source of insurance					Regional CSHCN Centers
12. Children without health insurance					Child Health System Building
13. Potentially MA eligible children		X			
14. Family participation in CSHCN program					Regional CSHCN Centers
15. Suicide rate among youths			X		
16. Very low birth weight live births.	X				Perinatal Health System Building
17. Very low birth weights delivered at facilities for high risk deliveries	X				Perinatal Health System Building
18. Infants born to women receiving early prenatal care.	X				Perinatal Health System Building

MCH Themes and Statewide/Regional Projects that address National Outcome Measures

National Outcome Measures	Theme 1 Healthy Birth	Theme 2 Healthy Children	Theme 3 Healthy Lifestyles	Theme 4 Safe and Healthy Child Care	Statewide or Regional Project
1. Infant mortality rate	X				Perinatal Health System Building Services for SIDS
2. Disparity between black and white infant mortality rate	X				Perinatal Health System Building Services for SIDS
3. Neonatal mortality rate	X				Perinatal Health System Building Services for SIDS
4. Postneonatal mortality rate	X				Perinatal Health System Building Services for SIDS
5. Perinatal mortality rate	X				Perinatal Health System Building Services for SIDS
6. Child death rate		X	X	X	Child Health System Building Regional CSHCN Centers

MCH Themes and Statewide/Regional Projects That Address State Performance Measures

State Performance Measures (abbreviated)	Theme 1 Healthy Birth	Theme 2 Healthy Children	Theme 3 Healthy Lifestyles	Theme4 Safe and Healthy Child Care	Statewide or regional project
1. Children less than 12 years of age who receive one physical exam a year		X			Child Health System Building
2. Pregnant women at risk of unintended pregnancies	X				Family Planning / Reproductive Health
3. Women who use tobacco during pregnancy	X				Perinatal Health System Building
4. High school youth who drink			X		---
5. High school youth who use tobacco			X		---
6. Children are overweight			X		---
7. Women who breastfeed	X				Perinatal Health System Building
8. Infants born with low birth weight	X				Perinatal Health System Building
9. Children with untreated dental decay		X			Child Health System Building
10. MCH clients receiving parenting skills			X	X	---

Following is a description of the annual plan's proposed activities for FFY 2001, organized by population served and level of the pyramid, and their relationship to the federal Healthy People 2010 MCH objectives.

POPULATION SERVED: WOMEN AND INFANTS

Family Planning/Reproductive Health

Reduce the incidence of unintended pregnancy and reproductive health morbidity by provision of comprehensive, community-based family planning and related reproductive health services.

Healthy People 2010: 9-1, 9-2, 9-3, 9-7

Category: Direct Health

- Provide contraceptive and reproductive health services, screening, assessment, sexually transmitted disease testing, counseling, and treatment, and pregnancy testing services.

Category: Enabling

- Provide reproductive health education, anticipatory guidance, short term care coordination and presumptive eligibility (Medicaid) services.

Category: Population Based

- Develop a community education and outreach plan that identifies the availability of reproductive health and pregnancy testing services, assists with reproductive health risk reduction and health promotion, and informs the public about patient privacy and confidentiality standards.

Category: Infrastructure Building

- Develop a community partnership to ensure access to comprehensive reproductive health services, provision of quality reproductive health care services based on established standards of practice, and continuity of care in accordance with clients' reproductive health service needs.

Theme 1: Increase the incidence of healthy birth outcomes

Increase the incidence of healthy birth outcomes through community-based integrated pregnancy testing and perinatal care coordination services.

Healthy People 2010: 16-1, 16-4 through 16-8, 16-10 through 16-12, 16-14 through 16-19

Category: Enabling

- Provide perinatal care coordination for pregnant adolescents and high-risk women.

Category: Population Based

- Develop a community education and outreach plan that identifies the availability of WIC, breastfeeding support and nutrition services; ATODA counseling and treatment; options for health care coverage; and the need for early entry into perinatal medical care and care coordination services.

- In collaboration with CDC and March of Dimes, implement a professional and public education campaign on folic acid.

Category: Infrastructure Building

- Develop a community partnership to ensure access to perinatal medical care and care coordination, provision of quality perinatal health care based on established standards of practice, and continuity of care in accordance with clients' perinatal service needs.

Statewide Perinatal Health System Building Program

Healthy People 2010: 16-1, 16-2, 16-4, 16-5, 16-6, 16-8, 16-10, 16-11, 16-12, 16-13, 16-16, 16-17, 16-19, 16-22

Category: Infrastructure Building

- Develop a minimum of one quality assurance guideline for perinatal services delivered by managed care organizations.
- Collaborate with other agencies to promote primary prevention of maternal and infant deaths.
- Promote provision of preconceptional health services, to include resources for health care providers and consumers.
- Develop strategies to promote initiation and duration of breastfeeding.
- In collaboration with the designated Regional Children with Special Health Care Needs Centers, develop a system to assure timely transition into community-based services for high-risk infants.
- In collaboration with the Wisconsin Program for Children with Special Health Needs and the designated Children with Special Health Care Needs Centers, develop and implement a system to provide universal hearing screening for all newborns before hospital discharge.
- Coordinate implementation of a statewide perinatal data system, to include PC-Log and the MCH Data System, to provide data for needs assessment, research, quality assurance and to document progress toward required national and state performance measures.
- In coordination with the MCH Regional Education and Training groups, provide professional education on perinatal health issues that supports evidence-based practice.
- Develop perinatal consumer education programs and resources that increase consumer knowledge about positive health behaviors and effective use of the perinatal health care system.

Statewide Services for Sudden Unexpected Infant Deaths

Healthy People 2010: 16-1, 16-2, 16-13

Category: Population Based

- Provide timely information, counseling and grief support services to the families who are affected by a sudden or unexpected infant death.
- Provide research-based education and training programs to professionals who come into contact with bereaved families.
- Maintain a central program and a regional "satellite" structure to assure community-based provision of services to families affected by a sudden or unexpected infant death.

- Provide targeted outreach and information to select communities to reduce the disparity for infant mortality between ethnic and racial groups.
- In collaboration with local health departments, conduct timely public health nurse interviews with bereaved families.
- Maintain a database on sudden unexpected infant deaths, to include annual reports of the epidemiological information in the public health nurse family interviews.

Statewide Genetics Services Network

Healthy People 2010: 1-2, 1-3, 3-10, 3-12, 3-13, 16-1, 16-2, 16-3, 16-6, 16-14 through 16-18, 16-20 through 16-23, 23-17, 28-11

Category: Population Based

- Assure that genetic services are provided by qualified staff, are consistent with standards of care and include: identification, evaluation, counseling, education and follow-up with particular focus on families with children with special health care needs.
- Assure that genetic services are available in all five regions of Wisconsin, with particular focus to the northern region of the state.
- Document that genetic services are first billed through private insurance and Medicaid, with Title V as payer of last resort.
- Develop linkages with the regional CSHCN Centers to assure coordinated services.
- Provide technical assistance to the Wisconsin Birth Defects Surveillance Program.
- Help organize and run two meetings of the Greater Wisconsin Genetics Exchange.
- Provide teratogen information to the public and professionals.
- Provide education and training specific to genetics to community care providers, families and others.

POPULATION SERVED: CHILDREN AND ADOLESCENTS

Theme 2: Promote optimal growth and development and assure comprehensive primary care for children ages birth to 21 including CSHCN and

Theme 4: Assure access to safe, quality child care up to age six, including CSHCN

Promote optimal growth and development and assure comprehensive primary care for children ages birth to 21 including children with special health care needs.

Healthy People 2010: 16-2, 16-3, 16-19, 16-22

Category: Direct Health

- Provide well-child assessments to all children not covered by private health insurance or Medicaid.
- Provide medical nutrition therapy by a dietitian to children and youth, ages birth to 21.

Category: Enabling

- Provide case management services to all children with confirmed blood lead levels >20ug/dl.

- Provide case management to all children with confirmed hearing loss through universal newborn hearing screening.
- Provide home visits to all newborns or sub-populations identified at at-risk.
- Provide health education to families on child related topics identified through the community needs assessment.
- Assure adequate transportation services, respite care, and family support by partnering with community groups.

Category: Population Based

- Provide/assure all children receive immunizations according to the schedule approved by ACIP, AAP and AAFP.
- Provide/assure screening for lead exposure and testing of children when required or recommended at ages 1 and 2, and appropriate follow-up for children with lead levels >10ug/dl.
- Assure all third grade children receive necessary dental sealants.
- Provide public education about the need for regular assessments of nutritional status for all children and the role of medical nutrition therapy when a feeding or nutrition problem is identified.
- Provide public education about the value of longer duration of breastfeeding, and related issues about returning to work.

Category: Infrastructure Building

- Develop a local consortium to develop and implement programs/policies to improve the health and well being of children in the community.
- Partner with the MCH Regional Education and Training plan to identify and implement programs appropriate for children's health issues.
- Partner with the Statewide Child Health System initiative to develop or implement clinical standards of best practice.
- Monitor and analyze data related to children's health issues.

Theme 3: Promote healthy lifestyles among school-age youth, 6-21, in the communities, including CSHCN

Theme 4: Assure access to safe, quality child care up to age six, including CSHCN

Promote healthy lifestyle choices of school age youth ages 6 to 21, including children with special health care needs.

Healthy People 2010: 16-2, 16-3

Category: Enabling

- Assure/develop peer counseling programs with school and community for healthy lifestyle choice decision-making for school age youth.
- Assure/develop care coordination for youth with psychosocial issues and nutritional needs.
- Assure/develop age-appropriate and culturally-specific health education programs to assist school age youth in making healthy lifestyle choices.

- Work with schools and community groups to promote physical activity/fitness.

Category: Population Based

- Assure implementation of multi-faceted health education programs that increase public awareness of healthy lifestyle choices for school age youth.
- Facilitate implementation of nutrition education programs for school age youth, families and teachers.
- Collaborate with community advocates on hunger and food security issues for school age youth and their families.
- Assure implementation of one or more physical activity/fitness programs for school age youth.
- Provide community-based education and outreach to school age youth and their families regarding ATODA issues.
- Facilitate and work with community/student groups to organize non-alcoholic events and promote smoke-free environments.

Category: Infrastructure Building

- Assure the development of community partnerships to implement “Brighter Futures: Wisconsin’s Plan to Prevent Adolescent Pregnancy.”
- Assure the establishment of and/or collaboration with community partners to strengthen and enforce underage smoking and drinking laws.
- Assure the establishment of and/or collaboration with community partners Coordinated School Health Programming.
- Coordinate the implementation of an identified priority from your local needs assessment for school age youth.

Safe Quality Child Care

Assure access to safe, quality child care for infants and children up to age six, including children with special health care needs.

Healthy People 2010: 16-23

Category: Direct Health

- Provide/assure well-child assessments for all children age up to age 6 in child care settings.

Category: Enabling

- Provide technical assistance and education to child care providers on the care of mildly ill or special needs children.
- Provide technical assistance and education to child care providers on prevention of injury and communicable disease.
- Assure that health information for parents, providers and children in child care settings is available at a reading level and in languages appropriate to the population being served.

- Provide technical assistance for the development of health related policies and procedures in child care settings.

Category: Population Based

- Provide/assure all children up to age 6 in child care settings receive immunizations according to the schedule approved by ACIP, AAP and AAFP.
- Promote public awareness and education to child care providers and families about lead screening, dental sealants, sudden unexpected infant death counseling, and breastfeeding support services.
- Assure/conduct safety assessments in at least three new child care settings annually.
- Collaborate with WIC, local nutritionists and the Child and Adult Care Food Program staff (who visit child care four times a year) to assure healthy and safe food preparation in child care settings.

Category: Infrastructure Building

- Identify and develop the role for a local public health contact person to partner with the local Child Care Resource and Referral and District Regulation and Licensing staff.
- Monitor community data related to child health issues including injuries, communicable disease outbreaks, medication errors, and lead inspections.

Statewide Child Health System Building Program

Healthy People 2010: 1-1, 1-2, 1-4, 1-5, 16-2, 16-3, 16-14, 21-1, 21-2, 21-8

Category: Infrastructure Building

- Secure commitments from major private and public child health organizations to participate in the development of a statewide and coordinated primary, preventive child health delivery system.
- Provide “system” support (training, quality assurance, data collection and analysis) to local health departments related to their role of assuring primary, preventive child health services.
- Provide leadership in the development or statewide adoption of clinical practice standards or best practice model/protocols related to child health.
- Collaborate with the regional Education and Training plan to provide professional development opportunities for child health practitioners.
- Develop a collaborative initiative to obtain health insurance coverage for all children.
- Establish a process for tracking and selecting emerging child health issues that necessitate attention.
- Develop consumer education materials or programs that will increase consumer knowledge about child health topics.
- Monitor child health data and share with appropriate individuals and organizations.

POPULATION SERVED: CHILDREN WITH SPECIAL HEALTH CARE NEEDS

CSHCN Focus Area One: Assure access to timely, complete and accurate information for all families of CSHCN and providers in Wisconsin.

Healthy People 2010: 16-23

Category: Infrastructure Building

- Assure the CSHCN Regional Centers conduct activities, including data collection, that will help achieve favorable outcomes for the appropriate national performance measures.
- Establish a statewide CSHCN Information and Referral System that is available to parents and providers 24 hours a day, via toll-free phone system and Internet.

CSHCN Focus Area Two: Assure the development of a comprehensive, family-centered, community based care coordination system for CSHCN and their families.

Healthy People 2010: 1-4, 1-15, 6-13, 16-22, 16-23

Category: Enabling

- Assure CSHCN receive regular, ongoing medical care within a medical home.
- Assure CSHCN receive specialty and subspecialty services, including care coordination, not otherwise accessible and/or affordable to them.

Category: Infrastructure Building

- Provide education, training, and ongoing technical assistance to increase the capacity of local health departments and other local agencies, such as schools, to provide care coordination services.
- Provide technical assistance to CSHCN Regional Centers, other MCH initiatives and projects, and key regional and community agencies to enhance their capacity to provide care coordination and other services for CSHCN and families.
- Provide technical assistance to facilitate the establishment of formal working relationships between local health departments and the CSHCN Regional Centers to identify, refer, and negotiate care coordination services for CSHCN.

CSHCN Focus Area Three: Develop an infrastructure with key funding and policy making sources to promote technical assistance, health benefits counseling, and advocacy that assures funding for health care interventions for CSHCN.

Healthy People 2010: 16-23

Category: Enabling

- Provide education, technical assistance, and advocacy related to health benefits counseling, to Regional CSHCN Centers and local health departments to assure funding for health care interventions for CSHCN.

Category: Infrastructure Building

- Establish leadership and liaison with key groups such as managed care and insurance providers, Division of Health Care Financing (for Medical Assistance, BadgerCare, and related issues), Social Security Administration (for SSI and Survivor's Benefits related issues) and Office of the Insurance Commission.

CSHCN Focus Area Four: Assure family participation in all aspects of program planning and policy development with special emphasis on developing parent-to-parent support services, care coordination, and providing input into the development of standards of care for CSHCN.

Healthy People 2010: 16-23

Category: Infrastructure Building

- Establish a method to determine family satisfaction with services received.
- Establish a QI mechanism to assure CSHCN and their families receive care coordination and quality care services.
- Assure the development of parent-to-parent support networks and other mechanisms which provide all families with access to parent support services and health benefits counseling.
- Plan and provide for a uniform and ongoing mechanism to gather local, regional, and statewide information which will aid in planning outreach, referral, education, and training for parent-to-parent support activities.
- Assure the development of education and training programs for parents to become better mentors, leaders, and advocates for CSHCN.

CSHCN Focus Area Five: Provide leadership and liaison for development and implementation of standards of care for common chronic CSHCN diseases or conditions.

Healthy People 2010: 1-9, 1-14, 16-23

Category: Population Based

- Provide training and education about the exceptional needs of CSHCN to program staff, agencies, educators, community members, and others working with CSHCN.

Category: Infrastructure Building

- Assure the development of protocols, standards of care and guidelines for best practice, with input from families, to assure quality health care for CSHCN.
- Provide education and training regarding protocols, standards of care and guidelines for best practice to CSHCN Regional Centers, other MCH initiatives and projects, key regional and community agencies, and providers.
- Assure collaboration between families, CSHCN Regional Centers, other MCH initiatives and projects, key regional and community agencies, and providers, to promote standards of care and best practice for CSHCN.

CSHCN Focus Area Six: Assure statewide, family-centered access to early identification, specialty and subspecialty care, and appropriate service interventions that ease transitions from and between NICU's and other sites of diagnosis to local health, social service, preschool/school programming and other supportive community based services.

Healthy People 2010: 1-6, 16-23

Category: Population Based

- Assist in the development of a Universal Newborn Hearing Screening Program.

Category: Infrastructure

- Provide education, training and technical assistance to service providers and parents to assure early identification of and provision of services for infants and CSHCN.
- Collaborate in planning for improved access and inter-program transitions for very young and school age children at the community level, including health, education and social services.
- Establish a statewide plan for early identification and intervention for CSHCN, including transitioning from NICU's to communities.

4.2 Other Program Activities

Discussion of toll-free hotlines

Public Health Information and Referral Services for Women, Children and Families -- Since 1995, the Maternal and Child Health Hotline has provided comprehensive information on the various MCH programs in Wisconsin (total calls received via the MCH Hotline in calendar year 1999 was approximately 7,500). During this time, the need has grown for other state health-focused programs to establish a toll-free hotline and supporting information and referral service. In order to avoid unnecessary duplication, the state combined the needs of these programs into one comprehensive public health information and referral service for women, children and families provided by one agency Gundersen Lutheran Hospital. The purpose of developing a comprehensive hotline system is to streamline the mechanism by which individuals and families can receive information and access specific providers in Wisconsin. This agency combines information and referral services for the following programs:

- Title V MCH Block Grant, including the CSHCN Program and reproductive health(800) 722-2295
- Services Hotline for Women, Children and Families(877) 855-7296
- Supplemental Nutrition Program for Women, Infants and Children (WIC)(800) 722-2295
- Wisconsin Medicaid, including HealthCheck and Healthy Start.....(800) 722-2295
- Wisconsin Birth to 3 Program and Regional CSHCN Centers (First Step Hotline)(800) 642-7837
- Wisconsin Women's Health Program(800) 218-8408

In addition, the State CSHCN Program maintains a toll-free phone number (800) 441-4576 to assist parents and providers regarding children with special health care needs.

The contract for Public Health Information and Referral Services for Women, Children and Families began January 2000, and was awarded to Gundersen Lutheran Hospital, LaCrosse, Wisconsin.

The Statewide Poison Control System was implemented on July 1, 1994, with state General Purpose Revenue (GPR) funds (\$375,000) and a 50% match requirement from each regional poison control center. The program provides Wisconsin citizens with the following services: a toll-free hotline allowing easy access for poison control information; quality interpretation of poison information and needed intervention; and education materials for consumers and professionals. The two regional poison control centers that comprise the Wisconsin Poison System

are: Children's Hospital of Wisconsin, Milwaukee and the University of Wisconsin Hospital and Clinics, Madison. The Statewide Poison Control System received approximately 33,000 human exposure calls on the toll-free hotline number, (800) 815-8855, during July 1, 1998 through June 30, 1999. In addition, other calls were received regarding animal exposures and informational calls.

Relationships with other programs

The MCH program continues a cooperative relationship with the staff at the Regional Office of the Social Security Administration. With the reorganization of DPH and to maintain the formal referral relationship with Disability Determination Service (DDS), language about this activity was incorporated into the MOU with DHCF. This continues the exchange of information between the programs to assure that clients under the age of 16 who are receiving SSI benefits have information about and access to rehabilitation services. Wisconsin Medicaid covers all children in the state who are receiving benefits from the SSI Program.

Support for family leadership continues to be a significant focus of the MCH program with families involved in several initiatives. Specifically, families will provide leadership in the development of parent-to-parent support networks in the regional CSHCN centers that will be formed. The MCH program also continues its role in the planning of a redesign of programs for children receiving long-term care and respite services; both have strong leadership and representation of families of clients and other advocates. In addition, staff of the MCH program are working with key providers, families, and advocates to assure the availability of a statewide system of universal hearing screening for newborns.

4.3 Public Input

In 1992 the MCH Program Advisory Committee was expanded to include a broader membership and more comprehensive role. Currently, 42 members serve on the committee and represent parents and consumers, as well as the public health and medical communities. The committee focuses on broad-based MCH policy and program issues including the MCH Block grant. The committee is actively involved in the state MCH program and advises the Division of Public Health on how it can support and strengthen the MCH program. The committee's current structure and operating procedures are being reviewed in an effort to make the committee even more effective in its advisory role to the MCH program.

Public input for the FFY 2001 MCH Block grant application was obtained through a comprehensive statewide MCH needs assessment. MCH program staff conducted on site, key informant interviews with 74 local health department directors and 11 tribal health agencies. Through this process, agencies identified federal and state MCH performance measures most important to them; local health priorities, community and family strengths; and staff development needs.

The FFY 2001 MCH Block Grant application will be distributed to all local health departments in the state and to all members of the MCH Program Advisory Committee. Copies of the application will be available for public review at the Bureau of Family and Community Health central office in Madison, and at Division of Public Health regional offices in Madison, Milwaukee, Green Bay, Rhinelander and Eau Claire.

4.4 Technical Assistance

See Form 15

V. SUPPORTING DOCUMENTS

- 5.1 Glossary
- 5.2 Assurances and Certifications
- 5.3 Other Supporting Documents
- 5.4 Core Health Status Indicator Forms
- 5.5 Core Health Status Indicator Detail Sheets
- 5.6 Developmental Health Status Indicator Forms
- 5.7 Developmental Health Status Indicator Detail Sheets
- 5.8 All Other Forms
- 5.9 National “Core” Performance Measure Detail Sheets
- 5.10 State “Negotiated” Performance Measure Detail Sheets
- 5.11 Outcome Measure Detail Sheets

5.1 Glossary

Administration of Title V Funds - The amount of funds the State uses for the management of the Title V allocation. It is limited by statute to 10 percent of the Federal Title V allotment.

Assessment - (see “Needs Assessment”)

Capacity - Program capacity includes delivery systems, workforce, policies, and support systems (e.g., training, research, technical assistance, and information systems) and other infrastructure needed to maintain service delivery and policy making activities. Program capacity results measure the strength of the human and material resources necessary to meet public health obligations. As program capacity sets the stage for other activities, program capacity results are closely related to the results for process, health outcome, and risk factors. Program capacity results should answer the question, “What does the State need to achieve the results we want?”

Capacity Objectives - Objectives that describe an improvement in the ability of the program to deliver services or affect the delivery of services.

Care Coordination Services for CSHCN - Those services that promote the effective and efficient organization and utilization of resources to assure access to necessary comprehensive services for children with special health care needs and their families. *[Title V Sec. 501(b)(3)]*

Carryover (as used in Forms 2 and 3) - The unobligated balance from the previous year’s MCH Block Grant Federal Allocation.

Case Management Services - For pregnant women - those services that assure access to quality prenatal, delivery and postpartum care. For infants up to age one - those services that assure access to quality preventive and primary care services. *[Title V Sec. 501(b)(4)]*

Children -A child from 1st birthday through the 21st year, who is not otherwise included in any other class of individuals.

Children with Special Health Care Needs (CSHCN) - (For budgetary purposes) Infants or children from birth through the 21st year with special health care needs who the State has elected to provide with services funded through Title V. CSHCN are children who have health problems requiring more than routine and basic care including children with or at risk of disabilities, chronic illnesses and conditions and health-related education and behavioral problems. **(For planning and systems development)** Those children who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally.

Children With Special Health Care Needs (CSHCN) - Constructs of a Service System

1. State Program Collaboration with Other State Agencies and Private Organizations

States establish and maintain ongoing interagency collaborative processes for the assessment of needs with respect to the development of community-based systems of services for CSHCN. State programs collaborate with other agencies and organizations in the formulation of coordinated policies, standards, data collection and analysis, financing of services, and program monitoring to assure comprehensive, coordinated services for CSHCN and their families.

2. State Support for Communities

State programs emphasize the development of community-based programs by establishing and maintaining a process for facilitating community systems building through mechanisms such as technical assistance and consultation, education and training, common data protocols, and financial resources for communities engaged in systems development, to assure that the unique needs of CSHCN are met.

3. Coordination of Health Components of Community-Based Systems

A mechanism exists in communities across the State for coordination of health services with one another. This includes coordination among providers of primary care, habilitative and rehabilitative services, other specialty medical treatment services, mental health services, and home health care.

4. Coordination of Health Services with Other Services at the Community Level

A mechanism exists in communities across the State for coordination and service integration among programs serving CSHCN, including early intervention and special education, social services, and family support services.

Classes of Individuals - Authorized persons to be served with Title V funds. See individual definitions under “Pregnant Women,” “Infants,” “Children with Special Health Care Needs,” “Children,” and “Others.”

Community - A group of individuals living as a smaller social unit within the confines of a larger one due to common geographic boundaries, cultural identity, a common work environment, common interests, etc.

Community-based Care - Services provided within the context of a defined community.

Community-based Service System - An organized network of services that are grounded in a plan developed by a community and that is based upon needs assessments.

Coordination (see Care Coordination Services)

Culturally Sensitive - The recognition and understanding that different cultures may have different concepts and practices with regard to health care; the respect of those differences and the development of approaches to health care with those differences in mind.

Culturally Competent - The ability to provide services to clients that honor different cultural beliefs, interpersonal styles, attitudes and behaviors and the use of multicultural staff in the policy development, administration and provision of those services.

Deliveries - Women who received a medical care procedure associated with the delivery or expulsion of a live birth or fetal death (gestation of 20 weeks or greater).

Direct Health Services - Those services generally delivered one-on-one between a health professional and a patient in an office, clinic or emergency room which may include primary care physicians, registered dietitians, public health or visiting nurses, nurses certified for obstetric and pediatric primary care, medical social workers, nutritionists, dentists, sub-specialty physicians who serve children with special health care needs, audiologists, occupational therapists, physical therapists, speech and language therapists, specialty registered dietitians. Basic services include what most consider ordinary medical care: inpatient and outpatient medical services, allied health services, drugs, laboratory testing, x-ray services, dental care, and pharmaceutical products and services. State Title V programs support - by directly operating programs or by funding local providers - services such as prenatal care, child health including immunizations and treatment or referrals, school health and family planning. For CSHCN, these services include specialty and subspecialty care for those with HIV/AIDS, hemophilia, birth defects, chronic illness, and other conditions requiring sophisticated technology, access to highly trained specialists, or an array of services not generally available in most communities.

Enabling Services - Services that allow or provide for access to and the derivation of benefits from, the array of basic health care services and include such things as transportation, translation services, outreach, respite care, health education, family support services, purchase of health insurance, case management, coordination with Medicaid, WIC and educations. These services are especially required for the low income, disadvantaged, geographically or culturally isolated, and those with special and complicated health needs. For many of these individuals, the enabling services are essential - for without them access is not possible. Enabling services most commonly provided by agencies for CSHCN include transportation, care coordination, translation services, home visiting, and family outreach. Family support activities include parent support groups, family training workshops, advocacy, nutrition and social work.

Family-centered Care - A system or philosophy of care that incorporates the family as an integral component of the health care system.

Federal (Allocation) (as it applies specifically to the Application Face Sheet [SF 424] and Forms 2 and 3) -The monies provided to the States under the Federal Title V Block Grant in any given year.

Government Performance and Results Act (GPRA) - Federal legislation enacted in 1993 that requires Federal agencies to develop strategic plans, prepare annual plans setting performance goals, and report annually on actual performance.

Health Care System - The entirety of the agencies, services, and providers involved or potentially involved in the health care of community members and the interactions among those agencies, services and providers.

Infants - Children under one year of age not included in any other class of individuals.

Infrastructure Building Services - The services that are the base of the MCH pyramid of health services and form its foundation are activities directed at improving and maintaining the health status of all women and children by providing support for development and maintenance of comprehensive health services systems including development and maintenance of health services standards/guidelines, training, data and planning systems. Examples include needs assessment, evaluation, planning, policy development, coordination, quality assurance, standards development, monitoring, training, applied research, information systems and systems of care. In the development of systems of care it should be assured that the systems are family centered, community based and culturally competent.

Local Funding (as used in Forms 2 and 3)-Those monies deriving from local jurisdictions within the State that are used for MCH program activities.

Low Income - An individual or family with an income determined to be below the income official poverty line defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981. [*Title V, Sec. 501 (b)(2)*]

MCH Pyramid of Health Services - (see “Types of Services”)

Measures - (see “Performance Measures”)

Needs Assessment - A study undertaken to determine the service requirements within a jurisdiction. For maternal and child health purposes, the study is aimed at determining:

- 1) What is essential in terms of the provision of health services;
- 2) What is available, and
- 3) What is missing.

Objectives - The yardsticks by which an agency can measure its efforts to accomplish a goal. (See also “Performance Objectives”)

Other Federal Funds (Forms 2 and 3) - Federal funds other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program. These may include, but are not limited to: WIC, EMSC, Healthy Start, SPRANS, AIDS monies, CISS funds, MCH targeted funds from CDC and MCH Education funds.

Others (as in Forms 4, 7, and 10) - Women of childbearing age, over age 21, and any others defined by the State and not otherwise included in any of the other listed classes of individuals.

Outcome Objectives - Objectives that describe the eventual result sought, the target date, the target population, and the desired level of achievement for the result. Outcome objectives are related to health outcome and are usually expressed in terms of morbidity and mortality.

Outcome Measure - The ultimate focus and desired result of any set of public health program activities and interventions is an improved health outcome. Morbidity and mortality statistics are indicators of achievement of health outcome. Health outcomes results are usually longer term and tied to the ultimate program goal. Outcome measures should answer the question, “Why does the State do our program?”

Performance Indicator - The statistical or quantitative value that expresses the result of a performance objective.

Performance Measure - A narrative statement that describes a specific maternal and child health need, or requirement, that, when successfully addressed, will lead to, or will assist in leading to, a specific health outcome within a community or jurisdiction and generally within a specified time frame. (Example: “The rate of women in [State] who receive early prenatal care in 19__.” This performance measure will assist in leading to [the health outcome measure of] reducing the rate of infant mortality in the State).

Performance Measurement - The collection of data on, recording of, or tabulation of results or achievements, usually for comparing with a benchmark.

Performance Objectives - A statement of intention with which actual achievement and results can be measured and compared. Performance objective statements clearly describe what is to be achieved, when it is to be achieved, the extent of the achievement, and target populations.

Population Based Services - Preventive interventions and personal health services, developed and available for the entire MCH population of the State rather than for individuals in a one-on-one situation. Disease prevention, health promotion, and statewide outreach are major components. Common among these services are newborn screening, lead screening, immunization, Sudden Infant Death Syndrome counseling, oral health, injury prevention, nutrition and outreach/public education. These services are generally available whether the mother or child receives care in the private or public system, in a rural clinic or an HMO, and whether insured or not.

Pregnant Woman - A female from the time that she conceives to 60 days after birth, delivery, or expulsion of fetus.

Preventive Services - Activities aimed at reducing the incidence of health problems or disease prevalence in the community, or the personal risk factors for such diseases or conditions.

Primary Care - The provision of comprehensive personal health services that include health maintenance and preventive services, initial assessment of health problems, treatment of uncomplicated and diagnosed chronic health problems, and the overall management of an individual’s or family’s health care services.

Process - Process results are indicators of activities, methods, and interventions that support the achievement of outcomes (e.g., improved health status or reduction in risk factors). A focus on process results can lead to an understanding of how practices and procedures can be improved to reach successful outcomes. Process results are a mechanism for review and accountability, and as such, tend to be shorter term than results focused on health outcomes or risk factors. The utility of process results often depends on the strength of the relationship between the process and the outcome. Process results should answer the question, “Why should this process be undertaken and measured (i.e., what is its relationship to achievement of a health outcome or risk factor result)?”

Process Objectives - The objectives for activities and interventions that drive the achievement of higher-level objectives.

Program Income (as used in the Application Face Sheet [SF 424] and Forms 2 and 3) - Funds collected by State MCH agencies from sources generated by the State's MCH program to include insurance payments, MEDICAID reimbursements, HMO payments, etc.

Risk Factor Objectives - Objectives that describe an improvement in risk factors (usually behavioral or physiological) that cause morbidity and mortality.

Risk Factors - Public health activities and programs that focus on reduction of scientifically established direct causes of, and contributors to, morbidity and mortality (i.e., risk factors) are essential steps toward achieving health outcomes. Changes in behavior or physiological conditions are the indicators of achievement of risk factor results. Results focused on risk factors tend to be intermediate term. Risk factor results should answer the question, "Why should the State address this risk factor (i.e., what health outcome will this result support)?"

State - As used in this guidance, includes the 50 States and the 9 jurisdictions of the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, the Republic of the Marshall Islands, the Federated States of Micronesia and the Republic of Belau.

State Funds (as used in Forms 2 and 3) - The State's required matching funds (including overmatch) in any given year.

Systems Development - Activities involving the creation or enhancement of organizational infrastructures at the community level for the delivery of health services and other needed ancillary services to individuals in the community by improving the service capacity of health care service providers.

Technical Assistance (TA) - The process of providing recipients with expert assistance of specific health related or administrative services that include; systems review planning, policy options analysis, coordination coalition building/training, data system development, needs assessment, performance indicators, health care reform wrap around services, CSHCN program development/evaluation, public health managed care quality standards development, public and private interagency integration, and identification of core public health issues.

Title XIX, number of infants entitled to - The unduplicated count of infants who were eligible for the State's Title XIX (MEDICAID) program at any time during the reporting period.

Title XIX, number of pregnant women entitled to - The number of pregnant women who delivered during the reporting period who were eligible for the State's Title XIX (MEDICAID) program.

Title V, number of deliveries to pregnant women served under - Unduplicated number of deliveries to pregnant women who were provided prenatal, delivery, or post-partum services through the Title V program during the reporting period.

Title V, number of infants enrolled under - The unduplicated count of infants provided a direct service by the State's Title V program during the reporting period.

Total MCH Funding - All the MCH funds administered by a State MCH program which is made up of the sum of the *Federal* Title V Block Grant allocation, the *Applicant's* funds (carryover from the previous year's MCH Block Grant allocation - the unobligated balance), the *State* funds (the total matching funds for the Title V allocation - match and overmatch), *Local* funds (total of MCH dedicated funds from local jurisdictions within the State), *Other* Federal funds (monies other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program), and *Program Income* (those collected by State MCH agencies from insurance payments, MEDICAID, HMO's, etc.).

Types of Services - The major kinds or levels of health care services covered under Title V activities. See individual definitions under "Infrastructure Building," "Population Based Services," "Enabling Services," and "Direct Medical Services."

5.2 Assurances and Certifications

ASSURANCES -- NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have any questions, please contact the Awarding Agency. Further, certain Federal assistance awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the assistance; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.
3. Will establish safeguards to prohibit employees from using their position for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. Sects. 4728-2763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to non-discrimination. These include but are not limited to (a) Title VI of the Civil Rights Act of 1964 (P.L. 88 Sect. 352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. Sects. 1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. Sect. 794), which prohibits discrimination on the basis of handicaps; (d) The Age Discrimination Act of 1975, as amended (42 U.S.C. Sects 6101 6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office of Treatment Act of 1972 (P.L. 92-255), as amended, relating to non-discrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to non-discrimination on the basis of alcohol abuse or alcoholism; (g) Sects. 523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. Sect. 3601 et seq.), as amended, relating to non-discrimination in the sale, rental, or financing of housing; (i) any other non-discrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other non-discrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. Sects 1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. Sects. 276a to 276a-7), the Copeland Act (40 U.S.C. Sect 276c and 18 U.S.C. Sect. 874), the Contract Work Hours and Safety Standards Act (40 U.S.C. Sects. 327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in flood plains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. Sects. 1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. 7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. Sects 1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers systems
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. Sect. 470), EO 11593 (identification and preservation of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. Sects. 469a-1 et seq.)
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. Sect. 2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by the award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. Sects. 4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply will all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

By signing and submitting this proposal, the applicant, defined as the primary participant in accordance with 45 CFR Part 76, certifies to the best of its knowledge and belief that it and its principals:

- (a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
- (b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission or fraud or criminal judgment in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
- (c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission or any of the offenses enumerated in paragraph (b) of the certification; and
- (d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause, titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion -- Lower Tier Covered Transactions" in all lower tier covered transactions (i.e. transactions with sub-grantees and/or contractors) in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

- (a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
- (b) Establishing an ongoing drug-free awareness program to inform employees about-
 - (1) The dangers of drug abuse in the workplace;
 - (2) The grantee's policy of maintaining a drug-free workplace,
 - (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
 - (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- (c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- (d) Notifying the employee in the statement required by paragraph (a) above, that, as a condition of employment under the grant, the employee will-
 - (1) Abide by the terms of the statement; and
 - (2) Notify the employer in writing of his or her conviction for violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- (e) Notify the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
- (f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d)(2), with respect to any employee who is so convicted-
 - (1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended, or
 - (2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- (g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Division of Grants Policy and Oversight
Office of Management and Acquisition
Department of Health and Human Services
Room 517-D
200 Independence Avenue, S.W.
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled “Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,” generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. The requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, “Disclosure of Lobbying Activities,” in accordance with its instructions. (If needed, Standard Form-LLL, “Disclosure of Lobbying Activities,” its instructions, and continuation sheet are included at the end of this application form.)

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18 if the services are funded by Federal programs either directly or through State or local governments by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable Federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing this certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Service strongly encourages all grant recipients to provide a smoke free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of American people.

5.3 Other Supporting Documents

- Bureau of Family and Community Health Organizational Chart
- Division of Public Health Organizational Chart
- Department of Health and Family Services Organizational Chart
- Quality Criteria
- Quality Criteria Monitoring Tool
- DPH Consolidated Contract Addendum Example
- MCH Consolidated Contract Summary
- Senior Staff Biography
- Needs Assessment Interview Tools
- CSHCN Survey
- MCH Five Guiding Principles Self-Assessment Tool
- DPH Regional Map

5.4 Core Health Status Indicator Forms

Includes Title V ERP forms from SD C1, C2, and C3.

5.5 Core Health Status Indicator Detail Sheets

Includes Title V ERP forms from HSI Detail 1 through 11.

5.6 Developmental Health Status Indicator Forms

Includes Title V ERP forms from SD D1 1-4 and D2 1-8.

5.7 Developmental Health Status Indicator Detail Sheets

Includes Title V ERP forms from SD DHSI Detail 1-17.

5.8 All Other Forms

Form 1 is page iii of the application.

Includes Title V ERP forms from SD 2.1 through 15.2.

5.9 National “Core” Performance Measure Detail Sheets

Includes Title V ERP forms from SD Core 1-18. (Detail Sheets for National/Core Form 11).

Indicator data for the core and negotiated performance measures come from various sources, including state agencies and their retrospective reports. If appropriate, we also report Title V specific data from our MCH Data System (MCH-DS). All projects use the MCH-DS or submit data in a required format. The Division of Public Health initiated a consolidated contract with local health departments for public health services using calendar year funding cycles. This initiative began January 1, 2000. Therefore, Title V and other related program data are reported for the 15-month period, 10/1/98-12/31/99.

Core: All data are for calendar year 1998 (FY99) unless indicated. We do not have CY96 objectives for performance measures because the performance measures were not required then. For performance measures #1, 2, 3, 4, 7, 10, 11, 13, 14, and 17, program staff established objectives for the subsequent years. Year 2000 objectives from Healthy People 2000 (US Department of Health and Human Services, 1990) or Healthier People in Wisconsin: A Public Health Agenda for the Year 2000 (Wisconsin Department of Health and Social Services, 1990) are appropriate for performance measures #5, 6, 8, 9, 12, 15, 16, and 18; they were used or adapted for our year 2000 objectives.

For performance measures #4, 5, 6, 8, 15, 16, and 18, data are collected and reported regularly by various state agencies; we report for CY98. For performance measures #1, 2, 3, 7, 9, 10, 11, 12, 13, 14, and 17, we used program estimates (explained further below) or other reliable estimates from reports maintained by other Wisconsin state agencies.

See Technical Notes for additional information.

5.10 State “Negotiated” Performance Measure Detail Sheets

Includes Title V ERP forms from SD 16 1-12. (Detail Sheets for State/Negotiated Form 11).

5.11 Outcome Measure Detail Sheets

Includes Title V ERP forms from SD Core 19-24. (Detail Sheets for Form 12).

Technical Notes

Additional technical notes included for forms 7, 8, 11, and D2

VI. APPENDICES

Appendix A: DHFS Scorecards, [Section 1.5](#)

Appendix B: Chapter 253, [Section 1.5.1.1](#)

Appendix C: 295 MCH Consolidated Contract Objectives, [Section 1.5.1.2](#)

Appendix D: City of Milwaukee Priorities, [Section 1.5.1.2](#)

Appendix E: Year 06 SSDI Program Materials, [Section 1.5.1.3](#)

Appendix F: April 2000, Wisconsin Medical Journal, [Section 1.5.2](#)

Appendix G: MCH Success Stories, [Section 3.1.1](#)

Appendix H: Letter from Local Health Department, [Section 3.1.2.1](#)

Appendix I: Health Professional Shortage Area Maps, [Section 3.1.2.1](#)

Appendix J: Summary of Development and Implementation of the 5 MCH Guiding Principles, [Section 3.1.2.1](#)