| Priority Needs | Five-Year Objectives | Strategies | Evidence-Based or –Informed Strategy Measures | National and State Performance Measures | National and State Outcome Measures |
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| **Women/Maternal Health** | | | | | |
| Assure Access to Quality Health Services. | Increase the percent of women with a past year preventive medical visit from 78.2% to 82.1% (+5%) by 2025. | Implement training and education on implicit bias and anti-racism in healthcare delivery.<br><br>Identify and develop a mechanism to improve equity issues in clinic-level data collection.<br><br>Provide training opportunities and technical assistance to the Family Foundations Home Visiting Program for home visitors focusing on promoting the annual preventive medical visit for women. | ***Inactive -*** *ESM WWV.1 - Number of Reproductive Health Family Planning partners using marketing tools and materials*<br><br>***Inactive -*** *ESM WWV.2 - Percent of family planning providers trained, who report an increase in knowledge on the relationship between patient outcomes and the annual preventive visit*<br><br>***Inactive -*** *ESM WWV.3 - Percent of Reproductive Health Family Planning agency training attendees who report a practice change after completing implicit bias training*<br><br>ESM WWV.4 - | NPM - Percent of women, ages 18 through 44, with a preventive medical visit in the past year (Well-Woman Visit, Formerly NPM 1) - WWV | NOM - Rate of severe maternal morbidity per 10,000 delivery hospitalizations (Severe Maternal Morbidity, Formerly NOM 2) - SMM<br><br>NOM - Maternal mortality rate per 100,000 live births (Maternal Mortality, Formerly NOM 3) - MM<br><br>NOM - Percent of low birth weight deliveries (<2,500 grams) (Low Birth Weight, Formerly NOM 4) - LBW<br><br>NOM - Percent of preterm births (<37 weeks) (Preterm Birth, Formerly NOM 5) - PTB<br><br>NOM - Percent of early term births (37, 38 weeks) (Early Term Birth, Formerly NOM 6) - ETB<br><br>NOM - Perinatal mortality rate per 1,000 live births plus fetal deaths (Perinatal Mortality, Formerly NOM 8) - PNM<br><br>NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM |

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| | | | Percent of clients served who have complete race and ethnicity data | | NOM - Neonatal mortality rate per 1,000 live births (Neonatal Mortality, Formerly NOM 9.2) - IM-Neonatal<br><br>NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal<br><br>NOM - Preterm-related mortality rate per 100,000 live births (Preterm-Related Mortality, Formerly NOM 9.4) - IM-Preterm Related<br><br>NOM - Percent of women who drink alcohol in the last 3 months of pregnancy (Drinking during Pregnancy, Formerly NOM 10) - DP<br><br>NOM - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations (Neonatal Abstinence Syndrome, Formerly NOM 11) - NAS<br><br>NOM - Teen birth rate, ages 15 through 19, per 1,000 females (Teen Births, Formerly NOM 23) - TB<br><br>NOM - Percent of women who experience postpartum depressive symptoms following a recent live birth (Postpartum Depression, |

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| | | | | | Formerly NOM 24) - PPD |
| Assure Access to Quality Health Services. | Wisconsin will begin working on this universal NPM measure, as is required, following the completion of the next needs assessment cycle in 2026. | Wisconsin will begin working on this universal NPM measure, as is required, following the completion of the next needs assessment cycle in 2026. | No ESMs were created by the State. ESMs were optional for this measure in the 2025 application/2023 annual report. | NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth (Postpartum Visit) B) Percent of women who attended a postpartum checkup and received recommended care components (Postpartum Visit) - PPV | This NPM was newly added in the 2025 application/2023 annual report. The list of associated NOMs will be displayed in the 2026 application/2024 annual report. |
| **Perinatal/Infant Health** | | | | | |
| Improve Perinatal Outcomes. | Increase the proportion of non-Hispanic Black women who ever breastfeed in Wisconsin from 74% to 80% by 2025.<br><br>Increase the percent of infants who are breastfed exclusively through 6 months in Wisconsin from 28% to 33% by 2025. | Work with local and tribal health agencies to increase lactation support in the workplace and early childhood settings.<br><br>Work with local and tribal health agencies to enhance local community coordination to improve continuity of care by strengthening consistent implementation of prenatal, maternity care, and postpartum practices that support breastfeeding.<br><br>Support hospital use of quality improvement strategies that align with the Ten Steps to Successful Breastfeeding and/or Baby-Friendly Hospital Initiative guidelines.<br><br>Identify and implement strategies for community engagement and local stakeholder activities. Implement funding opportunities to support community agencies to advance breastfeeding efforts within specific populations experiencing inequities in breastfeeding initiation and duration.<br><br>Provide training opportunities and technical assistance to the Family Foundations Home Visiting program for home visitors to increase breastfeeding support for Maternal, Infant, and Early Childhood Home Visiting-funded home visiting programs. | ***Inactive -** ESM BF.1 - Number of hospitals in Coffective's Community Match Online Platform*<br><br>ESM BF.2 - Percent of non-Hispanic Black infants ever breastfed<br><br>ESM BF.3 - Percent of non-Hispanic American Indian/Alaska Native infants ever breastfed<br><br>***Inactive -** ESM BF.4 - Percent of Wisconsin hospitals with an mPINC score of 80 or higher* | NPM - A) Percent of infants who are ever breastfed (Breastfeeding, Formerly NPM 4A) B) Percent of infants breastfed exclusively through 6 months (Breastfeeding, Formerly NPM 4B) - BF | NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM<br><br>NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal<br><br>NOM - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (SUID Mortality, Formerly NOM 9.5) - IM-SUID |
| Advance Equity and Racial | Reduce the infant mortality rate in babies born to non-Hispanic Black mothers in Wisconsin from 14.6 to | Strengthen Prenatal Care Coordination as a resource and support during pregnancy through training, resource tools, and quality improvement efforts. | | SPM 1: Infant mortality rate in babies born to non-Hispanic Black mothers | |

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| Justice. | 13.0 per 1,000 live births by 2025. | Support policy and practice changes to integrate doula services into Medicaid coverage.<br><br>Support fetal infant mortality review and maternal mortality review efforts throughout the state and facilitate the implementation of recommendations that emerge from the review teams.<br><br>Implement health and racial equity trainings for internal staff and grantees.<br><br>Support grassroots, community-based organizations serving African Americans of reproductive age. | | | |
| Improve Perinatal Outcomes. | Increase the percent of non-Hispanic Black and Native women receiving prenatal care in the first trimester in Wisconsin from 60% to 66% by 2025.<br><br>Increase the percent of women receiving a quality* postpartum visit from 56% to 67%. (*Quality is defined by those who report receiving a postpartum visit that includes the following services on the Wisconsin PRAMS survey's Question 70: postpartum depression screening, tobacco use, and EITHER contraception OR Birth spacing discussion.) | Support efforts to implement a revised levels of perinatal care assessment in Wisconsin.<br><br>Support Prenatal Care Coordination providers to strengthen postpartum Prenatal Care Coordination services to include depression screening, tobacco use, and reproductive life planning (contraception or birth spacing discussion).<br><br>Disrupt inequities in healthcare access and quality in historically underserved populations.<br><br>Provide training and technical assistance to home visitors within the Family Foundations Home Visiting Program and collaborate with the program to connect non-Hispanic Black and Indigenous women to primary care providers.<br><br>Support screening and appropriate referral and treatment for perinatal mental health disorders.<br><br>Collaborate with Medicaid on a quality improvement project to schedule postpartum visits in advance of delivery.<br><br>Analyze and review the new Pregnancy Risk Assessment Monitoring System (PRAMS) questions on experiences of labor and delivery care in relation to social connection. | | SPM 2: A) Percent of non-Hispanic Black and non-Hispanic Native birthing persons receiving prenatal care within the first trimester; B) Percent of birthing persons receiving a quality postpartum visit | |

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| **Child Health** | | | | | |
| Promote Optimal Nutrition and Physical Activity. | Decrease the number of children in Wisconsin with an overweight or obese classification from 30.5% to 28% (-2.5%) by 2025.<br><br>Increase the percent of children, ages 6 through 11, who are physically active at least 60 minutes per day in Wisconsin from 30.8% to 33.9% (+10%) by 2025. | Support local and tribal health agencies to partner with the University of Wisconsin Extension and FoodWise Programs to support health in children ages 6-11 years old.<br><br>Support local and tribal health agencies to partner with K-5 schools and local partners on school wellness requirements.<br><br>Support local and tribal health agencies to partner with local afterschool/out of school time programs and community organizations to support opportunities for improved physical activity and nutrition in children.<br><br>Integrate community input into technical assistance opportunities, inform future planning efforts, and enhance partnership at the local level.<br><br>Attend Healthy Early Collaborative meetings to support statewide collaboration among stakeholders.<br><br>Formalize a voluntary nutrition and physical activity steering team with the Association of State Public Health Nutritionists to enhance partnerships and capacity.<br><br>Enhance Title V workforce capacity to implement nutrition and physical activity (social, physical and mental) programing to the maternal and child health population through skill building and peer-to-peer learning opportunities.<br><br>Utilize maternal and child health nutrition-related data sources in programs, initiatives and local and state policy, systems and environmental changes in Wisconsin. | ***Inactive -*** *ESM PA-Child.1 - Percent of partners actively involved with the Wisconsin Title V Program's physical activity work connected through the PAN StEM*<br><br>***Inactive -*** *ESM PA-Child.2 - Percent of agencies in their first year of Physical Activity and Nutrition work who indicate an increase in knowledge following training*<br><br>ESM PA-Child.3 - Percent of local and tribal health agencies in Wisconsin receiving Title V funding who chose the physical activity and nutrition objective. | NPM - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day (Physical Activity, Formerly NPM 8.1) - PA-Child | NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS<br><br>NOM - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile) (Obesity, Formerly NOM 20) - OBS |
| Enhance Identification, Access, and Support for Individuals with Special Health Care | Increase the percent of infants in Wisconsin, ages 9 through 35 months, who receive a developmental screening using a parent-completed tool form 43.1% to 47.4% (+10%) by 2025. | Provide training opportunities for families, community professionals, public health, home visitors and healthcare providers that increase their skills/knowledge.<br><br>Provide technical assistance, resources, and/or opportunities to learn from others doing similar work. | ESM DS.1 - Percent of medical providers trained who report using an evidence-based screening tool<br><br>ESM DS.2 - Percent | NPM - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year (Developmental | NOM - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL) (School Readiness, Formerly NOM 13) - SR<br><br>NOM - Percent of children, ages 0 |

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| Needs and their Families. | | Increase knowledge of programing, resources, and tools of others doing similar work.<br><br>Implement the CDC WIC Developmental Milestone Checklist Program with two local and tribal health agencies.<br><br>Support the Adolescent and Child Health Quality Improvement Steering Team.<br><br>Pilot the school-based mental health consultation program in Outagamie County, Wisconsin.<br><br>Participate in the statewide Office of Children's Mental Health Collective Impact Council and the Children's Committee of the Governor's Council on Mental Health.<br><br>Implement the Wisconsin Child Psychiatric Consultation Program Statewide.<br><br>Implement the Health Services and Resources Administration's Pediatric Mental Health Access Program.<br><br>Promote and improve developmental screening, referrals, and early intervention. | of medical providers trained who report a change in knowledge related to developmental screening age interval recommendations<br><br>ESM DS.3 - Percent of community developmental screening training participants who report an increase in knowledge regarding developmental screening | Screening, Formerly NPM 6) - DS | through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS |
| Promote Optimal Nutrition and Physical Activity. | Wisconsin will begin working on this universal NPM measure, as is required, following the completion of the next needs assessment cycle in 2026. | Wisconsin will begin working on this universal NPM measure, as is required, following the completion of the next needs assessment cycle in 2026. | ESM MH.1 - Percent of Regional Center information & referral staff who report competence in explaining medical home concepts<br><br>ESM MH.2 - Percent of family members, health care providers, and community professionals trained on Medical Home- | NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH | NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC<br><br>NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX |

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| | | | related concepts who report a change in knowledge or skills or behavior following the training<br><br>ESM MH.3 - Percent of families who receive at least one Regional Center referral that results in needed services received | | NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS<br><br>NOM - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year (Forgone Health Care, Formerly NOM 25) - FHC |
| **Adolescent Health** | | | | | |
| Foster Positive Mental Health and Associated Factors. | By 2025, decrease the percentage of youth reporting feeling hopeless on the Wisconsin YRBSS from 27% to 24%.<br><br>Decrease the percent of youth reporting being bullied on school property on the Wisconsin YRBS from 24% to 20% by 2025. | Provide technical assistance for the implementation and evaluation of LGBTQ+ support groups and the mental health warm line known as PRISM.<br><br>Support local and tribal health agencies to share resources on anti-bullying policies and best practices with their local school districts, incorporating an equity lens.<br><br>Empower youth and equip providers to provide appropriate, responsive and high-quality health care.<br><br>Pilot the school-based mental health consultation program in Outagamie County, Wisconsin.<br><br>Collaborate with Department of Public Instruction to support the implementation and update of the Youth Risk Behavior Survey (YRBS) to support school-based mental health quality improvement efforts. | | SPM 5: Percent of adolescents, ages 12 through 17, reporting feeling so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities in the last 12 months | |
| Foster Positive Mental Health and Associated Factors. | Reduce the number of 10-19 year-olds hospitalized due to injury from 201 to 195 per 100,000 by 2025. (2017 SID-Adolescent) | Work with local and tribal health agencies to support skills-based and peer-based risk-recognition suicide prevention trainings in multiple settings. | ESM IH-Adolescent.1 - Percent of students who report feeling comfortable seeking help from 1+ adult if they had an important | NPM - Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19 (Injury Hospitalization - | NOM - Child Mortality rate, ages 1 through 9, per 100,000 (Child Mortality, Formerly NOM 15) - CM<br><br>NOM - Adolescent mortality rate ages 10 through 19, per 100,000 |

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| | | | question affecting their life, according to the Wisconsin YRBSS<br><br>ESM IH-Adolescent.2 - Annual number of individuals who receive gatekeeper training (e.g., QPR, Mental Health First Aid) in suicide prevention | Adolescent, Formerly NPM 7.2) - IH-Adolescent | (Adolescent Mortality, Formerly NOM 16.1) - AM<br><br>NOM - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 (Adolescent Motor Vehicle Death, Formerly NOM 16.2) - AM-Motor Vehicle<br><br>NOM - Adolescent suicide rate, ages 15 through 19, per 100,000 (Adolescent Suicide, Formerly NOM 16.3) - AM-Suicide |
| **Children with Special Health Care Needs** | | | | | |
| Enhance Identification, Access, and Support for Individuals with Special Health Care Needs and their Families. | Increase the percent of children with special health care needs in Wisconsin, ages 0 through 17, who have a medical home from 42.8% to 47% (+10%) by 2025. | Develop and disseminate consistent medical home strategies and tools with common messaging that include actionable steps for specific audiences.<br><br>Implement medical home training opportunities for families and community professionals, using the expertise of youth, parent (family) and community professionals as advisors.<br><br>Implement medical home trainings, use quality improvement strategies, and provide technical assistance opportunities for health care providers and systems.<br><br>Provide consultation and support through easily accessible information to families and providers. | ESM MH.1 - Percent of Regional Center information & referral staff who report competence in explaining medical home concepts<br><br>ESM MH.2 - Percent of family members, health care providers, and community professionals trained on Medical Home-related concepts who report a change in knowledge or skills or behavior following the training<br><br>ESM MH.3 - Percent of families who receive at least one | NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH | NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC<br><br>NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX<br><br>NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS<br><br>NOM - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year (Forgone Health Care, |

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| | | | Regional Center referral that results in needed services received | | Formerly NOM 25) - FHC |
| Enhance Identification, Access, and Support for Individuals with Special Health Care Needs and their Families. | Increase the percent of children with special health care needs in Wisconsin, ages 12 through 17, who receive the services and supports necessary to transition to adult health care from 20.5% to 23% (+10%) by 2025. | Develop and disseminate consistent youth health transition strategies and tools with common messaging that include actionable steps for specific audiences.<br><br>Implement youth health transition training opportunities for families and community professionals, using the expertise of youth, parents (family) and community professionals as advisors.<br><br>Implement youth health transition trainings, use quality improvement strategies, and provide technical assistance opportunities for health care providers and systems. | ESM TR.1 - Percent of Regional Center information and referral staff who report competence in explaining youth health transition concepts<br><br>ESM TR.2 - Percent of participants trained on youth health care transition concepts who report a change in knowledge, skills, or intended behavior following the training<br><br>***Inactive -*** *ESM TR.3 - Percent of systems or practices that have a transition policy or guideline (formal written commitment)* | NPM - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care (Transition, Formerly NPM 12) - TR | NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC |
| **Cross-Cutting/Systems Building** | | | | | |
| Cultivate Supportive Social Connections and Community Environments. | Have 10% of Wisconsin Title V State Action Plan strategies promote social connectivity and access to both formal and informal relevant resources by 2025. | Organize current and potential social connection efforts throughout the state by leveraging existing data sources, identifying new and innovative opportunities for data collection.<br><br>Support the work of other performance measure work groups and Title V-funded programs to incorporate Social Connection into their work.<br><br>Support and provide education and awareness efforts to increase Family | | SPM 3: Percent of Wisconsin adults who report that they “usually” or “always” get the social and emotional support that they need. | |

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| | | Health Section staff knowledge, understanding, and importance of Social Connections. | | | |
| Advance Equity and Racial Justice. | Have 100% of Wisconsin Title V Performance Measures demonstrate measurable annual progress in family, youth, and community engagement. | Identify roadblocks to engagement and address them in future training opportunities.<br><br>Increase family, youth, and community member participation in maternal and child health efforts including but not limited to ongoing Needs Assessment activities.<br><br>Incorporate the Community Engagement Assessment Tool within local and tribal health agencies, children and youth with special health care needs Network partners, adolescent health programs, and Reproductive Health Family Planning programs. | | SPM 4: Percent of performance measures with family, youth, and community engagement embedded into program and policies | |