

State Action Plan Table

State: Wisconsin

Implementation method(s) for proposed strategies: 🇺🇸 = Local Public Health Departments; 🇨🇦 = Regional Centers for CYSHCN; 🇺🇸 = Statewide Project						
State Priority Needs	Objectives	Strategies	ESMs	NPMs	SPMs	National Outcome Measures
Women / Maternal						
Health Care Access and Quality	<p>Problem statement: "Too few women ages 18-44 have an annual preventive medical visit."</p> <ul style="list-style-type: none"> • By 2020, work with health care systems and medical practices to promote the accommodation of patient needs. • By 2020, work with patients and health systems to promote the value of the annual preventive visit. • By 2020, work with patients and health care workers to address confusion associated with accessing care. 	<p>Planning Activities:</p> <ul style="list-style-type: none"> • Investigate strategies included in the well-visit intervention planning matrix and prioritized by stakeholders at June 2015 MCH Advisory Committee. • Select strategies to incorporate into a 5-year work plan that includes process measures, specific time-framed activities, and responsible parties. <p>Proposed Strategies (subset):</p> <ul style="list-style-type: none"> • Explore opportunities to extend scope of practice and develop reimbursement strategies for nurse practitioners and other ancillary providers. 🇺🇸 🇺🇸 • Explore opportunities for modifying health system contracts with plans to better accommodate patient needs. 🇺🇸 🇺🇸 	TBD	Well-woman Care (NPM 1)	TBD	<ul style="list-style-type: none"> • Severe maternal morbidity per 10,000 delivery hospitalizations • Low birth weight rate (%) • Preterm birth rate (%) • Infant mortality per 1,000 live births • Perinatal mortality per 1,000 live births plus fetal deaths • Neonatal mortality per 1,000 live births • Preterm-related mortality per 1,000 live births

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State Priority Needs	Objectives	Strategies	ESMs	NPMs	SPMs	National Outcome Measures
		<ul style="list-style-type: none"> Support the work of the Perinatal Quality Collaborative. ●● Promote standards of care through reproductive health networks. ●● Promote educational resources from partner organizations (e.g., Wisconsin Association for Perinatal Care, Wisconsin Alliance for Women's Health). ●● 				
Perinatal / Infant						
Healthy Behaviors	<p>Problem statement: "Too few Wisconsin infants receive breast milk and are breastfed exclusively through 6 months."</p> <ul style="list-style-type: none"> By 2020, work with employers and childcare centers to promote breastfeeding supportive policies and practices. By 2020, work with hospitals and birth centers to promote breastfeeding supportive policies and 	<p>Planning Activities:</p> <ul style="list-style-type: none"> Investigate strategies included in the breastfeeding intervention planning matrix and prioritized by stakeholders at June 2015 MCH Advisory Committee. Select strategies to incorporate into a 5-year work plan that includes process measures, specific time-framed activities, and responsible parties. <p>Proposed Strategies (subset):</p> <ul style="list-style-type: none"> Fund a subset of LHDs to collaborate with community partners to implement and evaluate the 	TBD	Breastfeeding (NPM 4)	None	<ul style="list-style-type: none"> Infant mortality per 1,000 live births Post neonatal mortality per 1,000 live births Sleep-related SUID mortality per 1,000 live births

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	<p>practices.</p> <ul style="list-style-type: none"> • By 2020, work with health plans and health insurance companies to promote breastfeeding supportive policies and practices. • By 2020, work with healthcare providers to provide maternity care that supports breastfeeding. 	<p>following evidence-based strategies: 1) Support workplaces to become breastfeeding friendly, and 2) Support childcare sites to become breastfeeding friendly. 🇺🇸 🇺🇸</p> <ul style="list-style-type: none"> • Explore partnerships with WIC and Wisconsin Breastfeeding coalition. 🇺🇸 • Support the CollIN Social Determinants of Health work to promote breastfeeding among African American mothers through community-based support groups. 🇺🇸 • Promote the Business Case for Breastfeeding as a resource for employers. 🇺🇸 🇺🇸 • Promote hospital staff training on breastfeeding. 🇺🇸 🇺🇸 • Collaborate with partners to promote maternity care practices. 🇺🇸 • Educate pregnant women and their families on maternity care practices that support breastfeeding. 🇺🇸 • Involve fathers in breastfeeding education. 🇺🇸 🇺🇸 				
Safety and	Problem statement: "Too	Planning Activities:	TBD	Safe Sleep	None	<ul style="list-style-type: none"> • Infant mortality

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Injury Prevention	<p>many babies in Wisconsin are not put to sleep alone, on their back, and in a crib, putting them at risk of adverse health outcomes"</p> <ul style="list-style-type: none"> By 2020, work with partners to promote consistent safe sleep information, model safe sleep behaviors, and adopt safe sleep practices and environments for infants. 	<ul style="list-style-type: none"> Investigate strategies included in the safe sleep intervention planning matrix and prioritized by stakeholders at June 2015 MCH Advisory Committee. Select strategies to incorporate into a 5-year work plan that includes process measures, specific time-framed activities, and responsible parties. <p>Proposed Strategies (subset):</p> <ul style="list-style-type: none"> Fund a subset of LHDs to collaborate with community partners to implement and evaluate the following evidence-based strategies: 1) Coordinate and/or provide trainings to implement safe sleep practices with community groups (e.g., parent or family organizations, home visiting agencies, churches, businesses) using common messaging, 2) Coordinate and/or provide trainings to implement safe sleep practices with childcare providers using common messaging, and 3) Promote the use of the safe sleep 		(NPM 5)		<p>per 1,000 live births</p> <ul style="list-style-type: none"> Post neonatal mortality per 1,000 live births Sleep-related SUID mortality per 1,000 live births

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		<p>policies and procedures developed for hospitals and health systems. ●</p> <p>●</p> <ul style="list-style-type: none"> • Fund a subset of LHDs to implement Fetal Infant Mortality Review in collaboration with community partners. ●● • Conduct social marketing to deliver media messages. ●●● • Ensure that birthing hospitals and WIC, child care, and PNCC programs have a policy requiring all staff be trained in and follow AAP safe sleep recommendations. ●●● • Provide education and tools for providers (including PNCC, home visitors, day care, foster care, CYSHCN providers) to have effective conversations about safe sleep. ●●● • Incorporate safe sleep best practices in academic institutions that train medical staff, residency programs, social service staff, and academic staff. ● 				
Mental Health	Problem statement: "Not all	Planning Activities:	TBD	None	Perinatal	

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Factors & Healthy Relationships	<p>women are screened for depression in the perinatal period."</p> <ul style="list-style-type: none"> • By 2020, work with medical providers and community practitioners to assure patients are connected to available depression and/or mental health resources. • By 2020, work with medical providers and healthcare systems to promote health care system processes that support perinatal depression screening, referral, and follow-up. • By 2020, work with communities to reduce the stigma surrounding depression and mental health. 	<ul style="list-style-type: none"> • Investigate strategies included in the perinatal depression screening intervention planning matrix and prioritized by stakeholders at June 2015 MCH Advisory Committee. • Select strategies to incorporate into a 5-year work plan that includes process measures, specific time-framed activities, and responsible parties. <p>Proposed Strategies (subset):</p> <ul style="list-style-type: none"> • Promote a best practice referral process (e.g., warm referral). ● ● ● • Promote ACA requirements for mental health screening. ● ● • Continue to develop online training modules to assist PNCC, home visiting, women's health, public health and other providers in understanding and implementing screening. ● • Work with the WI Perinatal Depression Task Force to identify opportunities that address the void in accessible providers (e.g., options similar to the Child Psychiatric Consultation Program). 			Depression Screening	

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		<ul style="list-style-type: none"> ● Carry out public education campaigns using social media and personal stories. ● ● Develop or promote existing tool kit for improving community awareness. ● 				
Children						
Preventive Screening and Follow-up	<p>Problem statement: "Too few children ages 10 months through 71 months (<6 yrs) receive a developmental screening using a standardized parent-completed tool."</p> <ul style="list-style-type: none"> ● By 2020, work with medical providers, pediatricians, and community partners to promote a standardized screening process. ● By 2020, work with health systems to promote data-related components of a standardized 	<p>Planning Activities:</p> <ul style="list-style-type: none"> ● Investigate strategies included in developmental screening intervention planning matrix and prioritized by stakeholders at June 2015 MCH Advisory Committee. ● Select strategies to incorporate into a 5-year work plan that includes process measures, specific time-framed activities, and responsible parties. <p>Proposed Strategies (subset):</p> <ul style="list-style-type: none"> ● Fund a subset of LHDs to collaborate with community partners to implement and evaluate the following evidence-based strategies: 1) Coordinate and/or provide developmental screening 	TBD	Developmental Screening (NPM 6)	None	<ul style="list-style-type: none"> ● Percent of children in excellent or very good health ● Percent of children meeting the criteria developed for school readiness

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	<p>screening process.</p> <ul style="list-style-type: none"> By 2020, work with medical providers, pediatricians, and community partners to assure knowledge and awareness of referral resources. 	<p>training to medical providers, and 2) Coordinate and/or provide developmental screening training to childcare providers. 🇺🇸 🇺🇸</p> <ul style="list-style-type: none"> Distribute and promote National Resources for consistent messaging to families. 🇺🇸 🇨🇦 🇺🇸 Collaborate with the Waisman Center's Learn the Signs Act Early Grant. 🇺🇸 🇨🇦 🇺🇸 Incorporate developmental screening into the Young Star Childcare Quality Rating system. 🇺🇸 Design a state-wide system to collect and monitor data, similar to the Wisconsin Immunization Registry. 🇺🇸 Develop recommendations for all organizations doing screenings to use a standardized process and referral protocol. 🇺🇸 🇨🇦 Build a system of trainers, including LHDs, to promote a standardized toolkit. 🇺🇸 🇨🇦 🇺🇸 				
Health Care Access and Quality	See the CYSHCN population domain for medical home objectives and strategies that will address all children			Medical Home (NPM 11)		

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State Priority Needs	Objectives	Strategies	ESMs	NPMs	SPMs	National Outcome Measures
Health Care Access and Quality	See the CYSHCN population domain for transition objectives and strategies that will address all children			Transition (NPM 12)		
Children and Youth with Special Health Care Needs						
Health Care	Problem statement: "Too	Planning Activities:	TBD	Medical	None	<ul style="list-style-type: none"> • Percent of

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Access and Quality	<p>many children with and without special health care needs do not receive medical care within the context of a medical home (defined as accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally effective)."</p> <ul style="list-style-type: none"> • By 2020, work with health care and child-serving systems to coordinate care and services within and across systems. • By 2020, work with health care systems to build infrastructure that supports the components of medical home. • By 2020, work with public and private payers to enact policies that finance the components of medical home. 	<ul style="list-style-type: none"> • Investigate strategies included in the medical home intervention planning matrix and prioritized by stakeholders at June 2015 MCH Advisory Committee. • Select strategies to incorporate into a 5-year work plan that includes process measures, specific time-framed activities, and responsible parties. <p>Proposed Strategies (subset):</p> <ul style="list-style-type: none"> • Promote and endorse the concepts of Medical Home using a unified definition, set of tools and messages. ●●● • Develop, promote and sustain practice and system infrastructure through continuous medical home quality improvement approaches with in Wisconsin Health Care Systems. ●● • Promote the Care Coordination Curriculum for families statewide. ● • Promote and implement care coordination with in and across systems and organizations in Wisconsin. ●● 		Home (NPM 11)		<p>children with special health care needs (CSHCN) receiving care in a well-functioning system</p> <ul style="list-style-type: none"> • Percent of children in excellent or very good health • Percent of children ages 19 through 35 months, who have received the 4:3:1:3(4):3:1 :4 combined series of routine vaccinations • Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal

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	<ul style="list-style-type: none"> By 2020, work with community members, families, providers, hospitals, and health systems to assure knowledge and awareness of referral resources. 	Wisconsin. ● ●				influenza <ul style="list-style-type: none"> Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine
Health Care	Problem statement: "Too	Planning Activities:	TBD	Transition	None	<ul style="list-style-type: none"> Percent of

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Access and Quality	<p>few adolescents ages 12 through 17 receive the services and supports necessary to transition to adult health care.”</p> <ul style="list-style-type: none"> • By 2020, work with partners to coordinate services within healthcare systems and between community partners. • By 2020, work with adult and pediatric medical providers to assure knowledge and awareness of transition. • By 2020, work with partners to increase the number of adult providers that serve YSHCN population and participate in transition planning. • By 2020, work with partners to assure family and teen knowledge and support 	<ul style="list-style-type: none"> • Investigate strategies included in the transition intervention planning matrix and prioritized by stakeholders at June 2015 MCH Advisory Committee. • Select strategies to incorporate into a 5-year work plan that includes process measures, specific time-framed activities, and responsible parties. <p>Proposed Strategies (subset):</p> <ul style="list-style-type: none"> • Align activities with the Wisconsin CYSHCN Medical Home Systems Integration Grant. ● • Explore opportunities to collaborate with Medicaid/ACA initiatives to assure they are mindful of youth health transition provisions. ● • Identify opportunities to encourage payers and health systems to support pediatric to adult transition coordination. ●● • Support the Wisconsin Youth Health Transition Initiative work in training and outreach using Got Transition’s Six Core Elements of Health Care Transition, including practice-based 		(NPM 12)		<p>children with special health care needs (CSHCN) receiving care in a well-functioning system</p> <ul style="list-style-type: none"> • Percent of children in excellent or very good health

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	regarding transition.	transition training and Quality Improvement pilot projects. ● ● • Strengthen collaboration across national, state and local agencies through participation on Got Transition Advisory Committee, the cross state agency Community of Practice on Transition (CoT) and county collaborations. ● ● • Support transition training for families and CYSHCN-serving partners at the community level. ● ● ● • Explore the development of a common statewide communication to all sixteen year olds and their families on key steps in transition to adulthood. ● ● ● • Support youth/family cross system coordination by providing information and referral to link individuals to existing supports and services related to transition. ● ●				
Adolescents						
Safety and	Problem statement: "Too	Planning Activities:	TBD	Adolescent	None	• Adolescent

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State Priority Needs	Objectives	Strategies	ESMs	NPMs	SPMs	National Outcome Measures
Injury Prevention	<p>many adolescents ages 10 through 19 experience non-fatal injuries requiring hospitalization related to self-inflicted wounds and self-intoxication."</p> <p>Wisconsin Suicide Prevention Strategy:</p> <ul style="list-style-type: none"> By 2020, work with partners to increase and enhance protective factors. 	<ul style="list-style-type: none"> Investigate strategies included in the self-inflicted wounds / self-intoxication intervention planning matrix and prioritized by stakeholders at June 2015 MCH Advisory Committee. Select strategies to incorporate into a 5-year work plan that includes process measures, specific time-framed activities, and responsible parties. <p>Proposed Strategies (subset):</p>		Injury (NPM 7)		<p>mortality ages 10 through 19 per 100,000</p> <ul style="list-style-type: none"> Adolescent motor vehicle mortality ages 15 through 19 per 100,000 Adolescent suicide ages 15 through 19 per 100,000

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	<ul style="list-style-type: none"> • By 2020, work with partners to increase access to care for at risk populations. • By 2020, work with partners to Implement best practices for suicide prevention within the health care system. • By 2020, work with health care partners to improve monitoring and evaluation of suicide and suicide prevention activities. 	<ul style="list-style-type: none"> • Fund a subset of LHDs to collaborate with community partners to implement and evaluate the following evidence-based strategies: 1) Coordinate and/or facilitate evidence-based suicide prevention practices with community groups, and 2) Promote Zero Suicide principles and practices with health care providers and health care systems. ●● • Fund a subset of LHDs to implement Child Death Review in collaboration with community partners. ●● • Support programs and policies that promote the development of social skills and emotion regulation as key components of children’s health and education. ●● • Support efforts to ensure that private plans meet the parity requirements established by federal and state law. ●● • Work with local coroners, medical examiners, and law enforcement to improve data collection to get better data on high risk groups such as 				

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	<p>Problem statement: "Too many adolescents ages 10 through 19 experience deaths and injuries related to transportation."</p> <ul style="list-style-type: none"> • By 2020, work to implement a more effective graduated driver license law in Wisconsin • By 2020, work with adolescents and parents reduce driving while impaired. • By 2020, work with adolescents and parents to reduce distracted driving. • By 2020, work with adolescents and parents to promote the use of safety measures like seat belts and helmets while engaged in transport. • By 2020, work with 	<p>LGBT persons and veterans. 🇺🇸</p> <p>Planning Activities:</p> <ul style="list-style-type: none"> • Investigate strategies included in the transport-related injury intervention planning matrix and prioritized by stakeholders at June 2015 MCH Advisory Committee. • Select strategies to incorporate into a 5-year work plan that includes process measures, specific time-framed activities, and responsible parties. <p>Proposed Strategies (subset):</p> <ul style="list-style-type: none"> • Fund a subset of LHDs to collaborate with community partners to implement and evaluate the following evidence-based strategy: Implement the TEEN DRIVER PLAN to increase the quantity and diversity of parent/guardian supervised learner practice in different driving environments. 🇺🇸 🇨🇦 • Fund a subset of LHDs to implement Child Death Review in collaboration with community partners. 🇺🇸 🇨🇦 				

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	<p>transportation decision makers to promote safe multi-modal travel options.</p>	<ul style="list-style-type: none"> • Strengthen the Graduated Driver's License Law. ● • Zero Tolerance Laws for Drinking and Driving for drivers who are under the legal drinking age. ● • Expand the use of sobriety checkpoints. ●● • Institute ignition interlocks. ● • Organize and offer alternative transport options (e.g., Drive Safe Programs). ● • Organize school-based programs that require and enforce belt use to and from school premises. ● • Promote Complete Streets policy. ● ● • Foster and develop a "Vision Zero" approach to transport safety. ●● • Develop or foster Safe Communities Coalitions. ●● 				
Health Care	Problem statement: "Too	Planning Activities:	TBD	We are	Adolescent	<ul style="list-style-type: none"> • Percent of

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Access and Quality	<p>few adolescents ages 12-17 have an annual preventive medical visit."</p> <ul style="list-style-type: none"> • By 2020, work with health care systems and medical practices to promote the accommodation of patient needs. • By 2020, work with patients and health systems to promote the value of the annual preventive visit. • By 2020, work with patients and health care workers to address confusion associated with accessing care. 	<ul style="list-style-type: none"> • Investigate strategies included in the well-visits intervention planning matrix and prioritized by stakeholders at June 2015 MCH Advisory Committee. • Select strategies to incorporate into a 5-year work plan that includes process measures, specific time-framed activities, and responsible parties. <p>Proposed Strategies (subset):</p> <ul style="list-style-type: none"> • Work with partner agencies and programs (e.g., MAPPP and PREP) to increase the number of entry points and promote the use of research-based tools to improve youth friendly clinical services such as the Adolescent Centered Environment tool. ●●● • Provide education about adolescent confidentiality practices. ● • Work with school and health classes to improve youth health advocacy. ● • Fund the Providers and Adolescents Communicating for Health (PATCH) Program. ● • Explore opportunities for modifying health system contracts with plans to 		adopting this NPM as a SPM	Well-visits	<p>children and adolescents in very good health</p> <ul style="list-style-type: none"> • Immunization (Percent of children and adolescents who have completed recommended vaccines) • Rate of death in adolescents 12-20 per 100,000 • Rate of suicide deaths among youths aged 15 through 19 per 100,000 • Percent of adolescents in grades 9-12 who used tobacco products in the past month • Percent of adolescents with mental

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		health system contracts with plans to better accommodate patient needs. ● • Create a public health navigator to help patients coordinate care. ●				health problems who receive treatment
Cross-cutting						
Healthy	Problem statement:	Planning Activities:	TBD	Smoking	None	• Severe

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Behaviors	<p>"Wisconsin mothers smoke during pregnancy and children are exposed to smoke and secondhand aerosol from e-cigarettes within the home."</p> <ul style="list-style-type: none"> By 2020, work with health care partners to increase treatment access for priority populations By 2020, work with partners to pass and enforce laws that discourage smoking. 	<ul style="list-style-type: none"> Investigate strategies included in the smoking intervention planning matrix and prioritized by stakeholders at June 2015 MCH Advisory Committee. Select strategies to incorporate into a 5-year work plan that includes process measures, specific time-framed activities, and responsible parties. <p>Proposed Strategies (subset):</p> <ul style="list-style-type: none"> Fund a subset of LHDs to collaborate with community partners to implement and evaluate the following evidence-based strategy: Increase access to smoking cessation services for postpartum women and family members who smoke. ●● Partner with the Tobacco Prevention and Control Program, the Women's Health Foundation, and the University of Wisconsin Center for Tobacco Research and Intervention on statewide initiatives. ●● Explore opportunities to expand coverage of evidence-based smoking cessation services through 		during Pregnancy and Household Smoking (NPM14)		<p>maternal morbidity per 10,000 delivery hospitalizations</p> <ul style="list-style-type: none"> Maternal mortality rate per 100,000 live births Low birth weight rate (%) Very low birth weight rate (%) Moderately low birth weight rate (%) Preterm birth rate (%) Early preterm birth rate (%) Late preterm birth rate (%) Early term birth rate (%) Infant mortality per 1,000 live births Perinatal mortality per 1,000 live births

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		<p>smoking cessation services through Medicaid and health insurance plans. ●</p> <ul style="list-style-type: none"> • Work with providers to improve training and referral (e.g., motivational interviewing, First Breath referrals, Quit Line, cultural competence). ●● • Provide cessation care for whole families when there are multiple smokers in the home. ●● • Educate communities and use Clear Gains materials to support smoke-free housing with community partners. ●● 				<p>plus fetal deaths</p> <ul style="list-style-type: none"> • Neonatal mortality per 1,000 live births • Preterm-related mortality per 100,000 live births • Post neonatal mortality per 1,000 live births • Sleep-related SUID per 100,000 live births • Percent of children in excellent or very good health