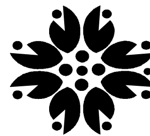
OREGON MATERNAL AND CHILD HEALTH
GOALS, OBJECTIVES AND ACTIVITIES

A Reference for Local Program Planning



OFFICE OF FAMILY HEALTH

Oregon Public Health, Department of Human Services

1st Edition – 2006

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Oregon Maternal And Child Health Goals, Objectives And Outcomes
A Reference for Local Program Planning – 1st Edition 2006

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INTRODUCTION

The Reference for Local Maternal and Child Health Program Planning is a compilation of performance measures, goals, objectives and activities reflecting current priorities and best practices in Oregon and nationally. The material is intended to provide a resource to help communities identify priorities, assess needs, and implement practices for improved population health.

The Reference is organized by population groups and for statewide programs serving the MCH population. Current priority statewide goals are listed first, followed by the national and state MCH Title V Performance Measures. These performance measures provide the overall direction and framework for MCH public health programs across Oregon. The priority Goals and Objectives are based on recent statewide needs assessments and statewide priority setting processes. The Activities and Practices, and Outcomes are the public health practices and evaluation methods effective for achieving the goals.

Local public health providers are encouraged to assess the health status and health needs of their communities and select the goals from these references. Progress towards health improvement across Oregon's populations can be more effective when state and local public health agencies focus on the same goals and outcomes. We welcome your comments and suggestions about this document and about other activities or practices that are currently effective in your communities. An evaluation is included on the last page of this document for your feedback and input on future editions of this Reference.

Katherine Bradley, PhD, RN
Administrator, Office of Family Health

Oregon Maternal And Child Health Goals, Objectives And Outcomes
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For more information: Contact Office of Family Health, Molly Emmons, molly.emmons@state.or.us, 971-673-0234

Perinatal Women

Goals for Oregon Populations

A. Increase access to early and adequate prenatal care
B. Decrease pre-term delivery
C. Decrease low birth weight
D. Decrease prenatal tobacco use
E. Decrease prenatal alcohol or drug abuse
F. Increase breastfeeding to six months
G. Increase access to medical home
H. Decrease HIV infection & transmission
I. Increase access to adequate food and clothing
J. Decrease intimate partner violence

National and State Performance Measures

***MCH Title V National Performance Measures*:**

- Percent of mothers who exclusively breastfeed their infants at hospital discharge
- Percent of live births that are very low birthweight (<1500 grams)
- Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates
- Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester

***MCH Title V State Performance Measures*:**

- Percent of smoking pregnant women who quit smoking during pregnancy and remained quit

Note: These goals for perinatal women cover one year prior to conception to one year after delivery.

Goals and Objectives *Supporting Performance Measures*	**Practices and Activities** *To implement objectives*	**Suggested Outcome Measures** *For health status; process; and/or activity*
Goal A: Increase access to early and adequate prenatal care		
Objective A.1. Increase the percentage of pregnant women who have early and adequate prenatal care.	Provide assistance with prenatal care access through: • Oregon MothersCare (OMC) • Maternity Case Management (MCM) • Outreach, coalition-building, and multi-agency collaboration to identify health care providers who will accept uninsured and Medicaid clients. • Facilitating multi-provider/multi-agency sponsored community clinics to address need.	a. Percentage of babies born to women who begin prenatal care in the first trimester (BC, PRAMS, FCM) b. Percentage of babies born to women who have adequate prenatal care (BC, PRAMS, FN)
Goal B: Decrease pre-term delivery		
Objective B.1. Increase women's knowledge for oral health needs during pregnancy	Provide oral health education through: • OMC • MCM • Direct or contracted prenatal clinical care services with oral health education, referrals, and follow-up.	Percentage of women who have seen a dentist during pregnancy. (PRAMS, FN)

Goals and Objectives *Supporting Performance Measures*	**Practices and Activities** *To implement objectives*	**Suggested Outcome Measures** *For health status; process; and/or activity*
Objective B.2. Increase the percentage of moderate to high-risk pg women that have ongoing case management.	Provide assistance with reducing behaviors and conditions leading to preterm delivery through: • MCM services • Community outreach to assure maximum participation in MCM. • Community education about the warning signs of preterm labor and when to contact health care provider • Coalition-building and multi-agency collaboration to identify oral health professionals who will accept uninsured and Medicaid pregnant clients.	Percentage of babies who are born at 37 wks or later. (BC)
Goal C: Decrease low birth weight		
Objective C.1. All pregnant women will have adequate nutrition during pregnancy	Provide education and assistance regarding nutrition needed during pregnancy through: • MCM services • Community outreach to assure maximum participation in MCM. • Provide education and assistance regarding nutrition needed during pregnancy through Family Planning Clinics and other services to preconceptional and postpartum women to improve nutrition prior to becoming pregnant.	Percentage of low birthweight infants (BC)
Goal D: Decrease prenatal tobacco use		
Objective D.1. Decrease the percentage of babies born to mothers who smoked tobacco during pregnancy	Provide assistance with prenatal smoking cessation, avoidance of second-hand smoke, and education about the harmful effects of tobacco exposure during pregnancy through:	Percentage of women who smoke tobacco during pregnancy (BC, PRAMS, FN)

Goals and Objectives *Supporting Performance Measures*	Practices and Activities *To implement objectives*	Suggested Outcome Measures *For health status; process; and/or activity*
	• MCM services • Community outreach to assure maximum participation in MCM. Community education about the dangers of smoking tobacco during pregnancy • Provide assistance with smoking cessation, through Family Planning Clinics and other services to preconceptional and postpartum women and their family members to decrease smoking prior to becoming pregnant. •	
Goal E: Decrease prenatal alcohol or drug abuse		
Objective E.1. Decrease the percentage of babies whose mothers used/abused alcohol or drugs during pregnancy.	• Provide assistance with prenatal cessation of alcohol or other drugs and education about their harmful effects during pregnancy through: • MCM services • Community outreach to assure maximum participation in MCM. • Community education about the dangers of using alcohol or drugs during pregnancy • Provide assistance with alcohol and/or drug abuse and education about their harmful effects during pregnancy through Family Planning Clinics and other services to preconceptional and postpartum to decrease the incidence of women becoming pregnant while using alcohol or other drugs prior to becoming pregnant.	Percentage of women who abuse alcohol or drugs during pregnancy (BC, PRAMS, FCM)

Goals and Objectives *Supporting Performance Measures*	**Practices and Activities** *To implement objectives*	**Suggested Outcome Measures** *For health status; process; and/or activity*
Goal F: Increase breastfeeding to six months		
Objective F.1. Increase the percentage of babies who are breastfed to six months	Provide education about the benefits of breastfeeding and assistance with breastfeeding through: • MCM services • Community outreach to assure maximum participation in MCM. • Community education about the benefits of breastfeeding • Encouraging and assisting local businesses to become breastfeeding-friendly workplaces • Increased lactation consultant services throughout the community	Percentage of women who continue breastfeeding to at least six months (PRAMS, FN)
Goal G: Increase access to medical home and adequate health care		
Objective G.1. Increase the percentage of pregnant women who have a medical home for themselves and their families	Provide education about the need for and assistance with obtaining a medical home through: • MCM services • Community outreach to assure maximum participation in MCM. • Increased outreach, coalition-building, and multi-agency collaboration to identify health care providers who will accept uninsured and Medicaid clients. • Facilitating multi-provider/multi-agency sponsored community clinics to address need.	Every pregnant woman and her family have a medical home. (FN)

Goals and Objectives *Supporting Performance Measures*	**Practices and Activities** *To implement objectives*	**Suggested Outcome Measures** *For health status; process; and/or activity*
Goal H: Decrease HIV infection & transmission		
Objective H.1. • All pregnant women are tested for HIV.	• Provide education about HIV prevention and treatment and the need for testing through: • MCM services • Community outreach to assure maximum participation in MCM. • Community education about the need for HIV testing during pregnancy	• Percentage of pregnant women who are tested for HIV (BC, PRAMS)
Goal I: Increase access to adequate food and clothing		
Objective I.1. All pregnant women and their families have adequate food and clothing.	Provide assistance with obtaining adequate food and clothing through: • MCM services • Community outreach to assure maximum participation in MCM. • Coalition-building, and multi-agency collaboration to address hunger and food insecurity in the community. • Community education to increase awareness of hunger and food insecurity	Percentage of pregnant women who have adequate nutrition (PRAMS, FN, BRFSS?) Percentage of pregnant women accessing local food banks (FN)
Goal J: Decreased intimate partner violence		
Objective J.1. Increase the safety of pregnant women who are at risk of intimate partner violence.	Provide intimate partner violence education and assistance with obtaining counseling and safety through: • MCM services • Community outreach to assure maximum participation in MCM.	Percentage of pregnant women who are at risk of intimate partner violence who are in a safe environment (PRAMS, FN, BRFSS?). Percentage of pregnant women who visit

Goals and Objectives *Supporting Performance Measures*	**Practices and Activities** *To implement objectives*	**Suggested Outcome Measures** *For health status; process; and/or activity*
	• Coalition-building, and multi-agency collaboration to address intimate partner violence in the community. • Community education to increase awareness of the signs of intimate partner violence.	ER's due to intimate partner violence (Hospital D/C data)

Infants and Children

Goals for Oregon Populations

A. Infants will be breastfed until 6 months of age
B. Infants diagnosed with hearing loss will be enrolled in early intervention before 6 months of age
C. Infants and children will have nurturing caregivers
D. Infants will be placed on their back to sleep
E. Children will have healthy and safe childcare
F. Eliminate children's exposure to second hand smoke (SHS)
G. Prevent early childhood cavities
H. Children will have access to care for optimal health
I. Infants and young children with development delay will receive intervention

National and State Performance Measures

***MCH Title V National Performance Measures*:**

- Percent of newborns screened for metabolic disorders according to current recommendations
- The percent of children with special health care needs 0 to 18 whose families partner in decision making at all levels and are satisfied with the services they receive.
- Percent of children with special health care needs age 0 - 18 who receive coordinated, ongoing, comprehensive care within a medical home.
- Percent of children with special health care needs age 0 - 18 whose families have adequate private and/or public insurance to pay for the services they need.
- Percent of children with special health care needs age 0 - 18 whose families report the community based service systems are organized so they can use them easily.
- Percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life.
- Percent of children (19-35 months) 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diptheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B (4:3:1:3:3)
- Percentage of 3rd graders with sealant on one or more permanent molars
- Death rate per 100,000 from unintentional injuries due to motor vehicle crashes among children aged 14 years and younger
- Percent of mothers who exclusively breastfeed their infants at hospital discharge

- Percent of newborns who have been screened for hearing before hospital discharge.
- Percent of children without health insurance
- Percent of potentially Medicaid children who have received a service paid by the Medicaid Program. (Process)
- Percent of live births that are very low birthweight (<1500 grams)

***MCH Title V State Performance Measures*:**
- Percent of infants diagnosed with hearing loss that are enrolled in early intervention before 6 months of age
- Percent of children that complete the 4th DTaP vaccine between 12-18 months of age.
- Percent of Oregonians living in a community where the water system is optimally fluoridated.
- Percent of health care providers who report confidence in caring for CYSHN and their families
- Percent of families of CYSHN who report costs not covered by insurance were usually or always reasonable.
- Percent of families of CYSHN who reside in rural areas report that needs are usually or always met.

National School Readiness Indicators *follow these tables.*

Goals and Objectives *Supporting Performance Measures*	**Practices and Activities** *To implement objectives*	**Suggested Outcome Measures** *For health status; process; and/or activity*
Goal A: Infants will be breastfed until 6 months of age		
Objective A.1. Increase breastfeeding duration rates among Babies First! participants	• MCM & Babies First! staff will be trained in current best practices related to breastfeeding promotion. Resource: WIC Breastfeeding Module. • Babies First! staff will assess client beliefs, attitudes and barriers regarding continuing breastfeeding to at least 6 months of age by using WIC assessment tool. • The Babies First! Program will implement strategies to support client breastfeeding goals; e.g. effective open-ended questions, affirming statements, and education/counseling strategies.	a. Number of Babies First! clients that are breastfed at 6 months. b. Number of staff that have completed WIC breastfeeding module, or expanded training/certification. c. Were strategies to support client breastfeeding goals implemented?

Goals and Objectives *Supporting Performance Measures*	**Practices and Activities** *To implement objectives*	**Suggested Outcome Measures** *For health status; process; and/or activity*
Goal B: Infants diagnosed with hearing loss will be enrolled in early intervention before 6 months of age		
Objective B.1 All EHDI referrals will receive follow up by Babies First! staff. Objective B.2 Children identified as at risk for late onset or progressive hearing loss will receive a hearing screening every six months up to age 3 years. Objective B.3 Infants diagnosed with hearing loss will receive CaCoon consultation	Educate expectant parents regarding importance of newborn hearing screening and follow-up. Provide case management for clients referred by EHDI. Provide CaCoon consultation to families and infants with hearing loss (birth to 3 years)	a. Number of EHDI referrals that received follow-up. b. Number of EHDI referrals that were lost to follow up. c. Number of infants with hearing loss referred to CaCoon. Data source for all would be EHDI Newborn Hearing Registry, Tracking and Recall system.
Goal C: Infants and children will have nurturing caregivers		
Objective C.1. Increase the proportion of mothers who receive early identification and intervention for maternal depression. Objective C.2. Reduce the percentage of children who are exposed to substance-abusing caregivers. Objective C.3. Increase the percentage of children	• Implement depression. screening in all MCH programs; e.g. Beck Depression Scale or specify target program such as Babies First! • Screen for drug and alcohol abuse; e.g. CAGE tool. • Provide referrals to mental health (MH) and chemical dependency (CD) assessment and treatment as indicated. • Implement Promoting First Relationships curriculum. • Collaborate with local mental health and chemical dependency providers.	a. Number of women screened for depression. b. Number of women referred for MH assessment or treatment. c. Number of women who received MH assessment and or treatment. d. Number of women screened for CD. e. Number of women referred for CD assessment or treatment. f. Number of women who received MH assessment and or treatment. g. NCAST Parent Child Interaction scores

Goals and Objectives *Supporting Performance Measures*	Practices and Activities *To implement objectives*	Suggested Outcome Measures *For health status; process; and/or activity*
who receive growth fostering (cognitive) care giving.	• Provide case management services. • Educate parents and childcare providers on appropriate growth and development and healthy parent- child interaction.	on Babies First! participants.
Goal D: Infants will be placed on their back to sleep		
Objective D.1. Increase number of infants who are placed on their back to sleep. Objective D. 2 Target at risk population: improve percent of African American and Native American infants placed on their back to sleep.	Educational materials on back-to- sleep and safe-sleep environments will be distributed within all maternal child health programs; e.g. WIC, Immunization, Babies First!, CaCoon, Maternity Case Management. Coordination with local hospitals to promote back-to-sleep policies in the hospital setting.	Percent of women who report putting their infant to sleep on their back.
Goal E: Healthy and Safe Childcare		
Objective E.1 Increase the percentage of children who receive healthy and safe childcare. Objective E.2 Assess local childcare health needs. Objective E.3 Develop consultation services and strategies. Objective E.4	Use surveys, focus groups, and/or interviews, to complete childcare needs assessment. Health Consultation and training to child care providers. Develop local childcare team to support health consultation efforts. Provide referrals to child health resources; e.g. pediatric specialists, early intervention, mental/behavioral health and local health department resources. Implement Promoting First Relationships curriculum.	a. Immunization status of children in childcare. b. Childhood injuries that occur in childcare settings (Childcare Division injury database). c. Number of childcare providers receiving consultation. d. Number of trainings provided for childcare providers. e. Number of childcare providers involved in program. f. Staff trained in Promoting First

Goals and Objectives *Supporting Performance Measures*	**Practices and Activities** *To implement objectives*	**Suggested Outcome Measures** *For health status; process; and/or activity*
Develop collaborations between health and childcare providers to improve childcare quality. Objective E.5 Decrease childhood illness and injuries that occur in childcare setting.	Educate childcare providers on appropriate growth and development and healthy parent child interaction.	Relationships (PFR). g. Number of PFR consultations.
Goal F: Eliminate children's exposure to second-hand smoke (SHS)		
Objective F.1 Increase the percentage of children who are not exposed to SHS. Objective F.2. Parents and childcare providers will have access to smoking cessation programs.	All MCH clinicians will be trained in 5A's tobacco cessation protocol. Implement 5A's tobacco cessation protocol in all MCH programs. (Or specify target program for 5A's implementation such as Babies First!) 5A's training for childcare, prenatal and pediatric providers. Referral to Quit Line and other tobacco cessation programs available in local community.	Number of children enrolled in Babies First! exposed to tobacco. (Babies First! annual report)
Goal G: Prevent early childhood caries		
Objective G.1. Increase the percentage of children who have a dental home. Objective G.2 Increase the percentage of children who receive early preventative dental care.	Establish Oral Health Coalition. PHN Early Childhood Cavities Prevention. Resource: Babies First Manual Tooth paste/tooth brush dispensing Educate parents and childcare providers regarding oral health for children and the importance of first dental visit by age 1 Refer to dentist	a. Number of tooth paste/tooth brushes dispensed. b. Number of children that receive an assessment. c. Oral Health Coalition established? d. Number of children with dental home. e. Number of children who receive each activity. f. Childhood caries rate.

Goals and Objectives *Supporting Performance Measures*	**Practices and Activities** *To implement objectives*	**Suggested Outcome Measures** *For health status; process; and/or activity*
Objective G.3 Increase the percentage of children who have access to optimally fluoridated water or receive appropriate fluoride supplementation. Objective G.4 Reduce the percentage of children who have childhood caries.		
Goal H: Children will have access to care for optimal health		
Objective H.1. Increase the percentage of children with a medical home. Objective H.2 Increase the percentage of children receiving preventive medical care. Objective H.3 Increase the percentage of two-year-olds who are adequately immunized. Objective H.4 Increase percentage of infants and young children identified early for health/medical conditions.	Case management. Screenings for immunizations, hearing, vision, growth, and oral health.	a. Number of children identified with abnormal screens. b. Number referred. c. Number who access referral. d. Number of children w/medical home. e. Number of children up to date on well child care. f. Number of Babies First! clients who are up to date on immunizations. (Babies First! report, ALERT registry)

Goals and Objectives *Supporting Performance Measures*	**Practices and Activities** *To implement objectives*	**Suggested Outcome Measures** *For health status; process; and/or activity*
Goal I: Infants and young children with development delay will receive intervention		
Objective I.1 Increase the percentage of infants and young children identified early for developmental delay.	Screening. Referral. Case management. Refer to Early Intervention (EI). PHN provide growth and development fostering consultation for parents of children with delay who do not qualify for EI.	a. Number of children screened. b. Number of children referred to EI. c. Number of children who receive EI. d. Number of Children who receive intervention from PHN.

National School Readiness Indicators [www.gettingready.org]

- **Ready Children**
  1. Physical Well-Being and Motor Development: *% of children with age-appropriate fine motor skills*
  2. Social and Emotional Development: *% of children who often or very often exhibit positive social behaviors when interacting with their peers*
  3. Approaches to Learning: *% of kindergarten students with moderate to serious difficulty following directions*
  4. Language Development: *% of children almost always recognizing the relationships between letters and sounds at kindergarten entry*
  5. Cognition and General Knowledge: *% of children recognizing basic shapes at kindergarten entry*
- **Ready Families**
  6. Mother's Education Level: *% of births to mothers with less than a 12th grade education*
  7. Births to Teens: *# of births to teens ages 15-17 per 1,000 girls*
  8. Child Abuse and Neglect: *Rate of substantiated child abuse and neglect among children birth to age 6*
  9. Children in Foster Care: *% of children birth to age 6 in out-of-home placement (foster care) who have no more than two placements in a 24-month period*

- **Ready Communities**
  10. Young Children in Poverty: *% of children under age 6 living in families with income below the federal poverty threshold*
  11. Supports for Families with Infants and Toddlers: *% of infants and toddlers in poverty who are enrolled in Early Head Start*
  12. Lead Poisoning: *% of children under age 6 with blood lead levels at or above 10 micrograms per deciliter 20*
- **Ready Services – Health**
  13. Health Insurance: *% of children under age 6 without health insurance*
  14. Low Birth weight Infants: *% of infants born weighing under 2,500 grams (5.5 pounds)*
  15. Access to Prenatal Care: *% of births to women who receive late or no prenatal care*
  16. Immunizations: *% of children ages 19-35 months who have been fully immunized*
- **Ready Services - Early Care and Education**
  17. Children Enrolled in an Early Education Program: *% of 3- and 4-year-olds enrolled in a center-based early childhood care and education program (including child care centers, nursery schools, preschool programs, Head Start programs, and pre-kindergarten programs)*
  18. Early Education Teacher Credentials: *% of early childhood teachers with a bachelor's degree and specialized training in early childhood*
  19. Accredited Child Care Centers: *% of child care centers accredited by the National Association for the Education of Young Children (NAEYC*)
  20. Accredited Family Child Care Homes: *% of family child care homes accredited by the National Association for Family Child Care (NAFCC)*
  21. Access to Child Care Subsidies: *% of eligible children under age 6 receiving child care subsidies*
- **Ready Schools**
  22. Class Size: Average teacher/child ratio in K-1 classrooms
  23. Fourth Grade Reading Scores: % of children with reading proficiency *in fourth grade as measured by the state's proficiency tests*

ADOLESCENTS (10-24)

Goals for Oregon Populations

A. Improve access to primary care and preventive health or mental health care for adolescents
B. Increase rates of adolescents 10-24 who receive the recommended annual well-adolescent visit
C. Improve public knowledge and understanding of critical health objectives for adolescent health

National and State Performance Measures

***MCH Title V National Performance Measures*:**

- Decrease the rate of birth (per 1000) for teenagers aged 15-17 (National)
- Decrease the suicide rate per 1,000 youth aged 15-19 years (National)

***MCH Title V State Performance Measures*:**

- Increase the percentage of (8th and 11th) graders who report 3 or more days of vigorous physical activity in the last 7 days (State)
- Decrease the percentage of 11th graders who report having unmet health care needs. (State)

Healthy People 2010 Critical Health Objectives for Adolescents [1]

- Reduce deaths of adolescents and young adults (10-14, 15-19, 20-24)
- Reduce deaths caused by motor vehicle crashes
- Reduce deaths and injuries caused by alcohol- and drug- related motor vehicle crashes
- Increase use of safety belts
- Reduce proportion of adolescents who report that they rode with a driver who had been drinking alcohol
- Reduce the rate of suicide attempts by adolescents
- Reduce homicides (10-14, 15-19)
- Reduce physical fighting among adolescents
- Reduce weapon carrying by adolescents on school property
- Reduce tobacco use by adolescents

1 Healthy People 2010 Critical Indicators for Adolescents: http://nahic.ucsf.edu/index.php/companion/index/

- Reduce binge drinking
- Reduce past-month use of illicit substances (marijuana)
- Reduce proportion of children and adolescents with disabilities who are reported to be sad, unhappy or depressed
- Increase the proportion of children with mental health problems who receive treatment
- Reduce pregnancies among adolescent females
- Increase the proportion of adolescents who abstain from sexual intercourse or use condoms if currently sexually active
- Reduce the number of cases of HIV infection among adolescents and adults
- Reduce the proportion of adolescents and young adults with Chlamydia trachomatis infections
- Reduce the proportion of children who are overweight or obese
- Reduce the proportion of adolescents who engage in vigorous physical activity that promotes cardiorespiratory fitness 3 or more days per week for 20 or more minutes per occasion

Goals and Objectives *Supporting Performance Measures*	**Practices and Activities** *To implement objectives*	**Suggested Outcome Measures** *For health status; process; and/or activity*
Goal A: Improve access to primary care and preventive or mental health care for adolescents		
Objective A.1. Increase the number of adolescent specific clinical public health services	• Conduct needs assessment current public health service delivery targeted for adolescents • Collaborate with community and partners to identify key adolescent health needs in local area • Strategically plan for adolescent health care delivery in community Assist with data analysis and prioritization of health issues	• Assessment document / report • Coalition/partnership meeting minutes • Strategic plan document • Identified health priority(s) • Clinical services / medical encounter data
Objective A.2. Increase the number of schools with a state-certified school-based health center (SBHC)	• Partner with community and health agencies to discuss if SBHCs would compliment local public health service delivery • Operate a SBHC through collaboration with school and health community partners • Implement referral access	• SBHC planning committee minutes / recommendations • Identify medical sponsorship for a SBHC • Certification of SBHC • Documentation of clinical public health services / medical encounters in SBHC

Goals and Objectives *Supporting Performance Measures*	**Practices and Activities** *To implement objectives*	**Suggested Outcome Measures** *For health status; process; and/or activity*
Goal C: Improve public health knowledge and understanding of critical health objectives for adolescents		
Objective C.1. Increase health promotion and education on locally identified adolescent health issues.	• Convene, co-facilitate, or participate on a community or county level prevention coalition or partnership to focus on *<health issue>* • Develop and disseminate health promotion and education messages or information on health care services related to *<health issue>* • Assess burden, develop local data to guide community or county-based planning efforts related to *<health issue>* • Identify and promote the use of evidence-based strategies and activities • Promote positive youth development strategies in the design and delivery of youth-based programs • Assist in data collection, process and outcome evaluations of prevention/intervention activities	• Minutes of meeting • Public health role/action items identified • Messages developed • Number of materials/ messages delivered • Assessment document / report • Local fact sheets *<health issue>* • Resource list of evidence-based practices • Documentation of youth engagement and involvement in program planning • Youth led or directed project(s) • Evaluation reports, data summary or presentations

Nutrition and Physical Activity

Goals for Oregon Populations

Improve healthy eating, daily physical activity, and healthy weight among all Oregonians.

National and State Performance Measures

***MCH Title V National Performance Measures*:**

- Percent of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.

***MCH Title V State Performance Measures*:**

- Percent of adolescents (8th and 11th graders) who report 3 or more days of vigorous physical activity in the last 7 days.

Pregnant and Postpartum Women

Goals and Objectives *Supporting Performance Measures*	**Practices and Activities** *To implement objectives*	**Suggested Outcome Measures** *For health status; process; and/or activity*
Goal: Improve healthy eating, daily physical activity, and healthy weight among Oregon women.		
Objective 1: Increase the percentage of pregnant and postpartum Oregonians who consume at least five daily servings of fruits and vegetables	• Provide nutrition counseling on the importance of fruit and vegetable consumption during WIC certification, recertification and follow-up visits • Provide pregnant women with vouchers to the Farmers Market and independent produce stands through the WIC Farm Direct Nutrition Program • Implement a 5 A Day strategic plan. • Increase promotion of 5 A Day messages I local public health and community programs.	a. Percentage of women reporting adequate servings of fruits and vegetables on 24 hour diet assessment during WIC visits. b. Percentage of pregnant WIC clients utilizing Farm Direct vouchers c. Percentage of adults who consume at least 5 daily servings of fruits and vegetables (ODHS-HS) d. WIC Farmer's Market Nutrition Program e. Redemption rates Number of participating markets

Goals and Objectives *Supporting Performance Measures*	**Practices and Activities** *To implement objectives*	**Suggested Outcome Measures** *For health status; process; and/or activity*
Objective 2 Increase the percentage of pregnant and postpartum women who participate in daily physical activity	Provide nutrition counseling on the importance of physical activity during pregnancy to pregnant and postpartum women during WIC certification, recertification, and follow-up visits.	• Number of pregnant and postpartum WIC clients who report being engaged regularly in at least moderate physical activity for at least 30 minutes per day.
Objective 3 • Increase the percentage of pregnant and postpartum Oregonians who are at a healthy weight	• Provide and promote opportunities for health care providers to expand their knowledge and use of best-practice methods to help individuals reach and maintain healthy weights. • Promote and support breastfeeding initiation and duration in order to decrease the risk of overweight among youth. • Provide education on the need for decreasing sedentary behaviors such television watching which is directly linked to weight gain. • Promote and support state and local legislation and policies that create environments conducive to healthy eating, daily physical activity and healthy weight. • Promote and support worksite wellness programs.	• Percentage of pregnant/postpartum women at a healthy weight. • Percentage of mothers who breastfeed - In hospital - At six months • Percentage of worksites with policies promoting healthy weight: o Breastfeeding o Physical o Activity o Healthy Food Choices
Objective 4 Provide appropriate, consistent messages about the importance of nutrition, physical activity and maintaining a healthy weight to all pregnant and postpartum women	• Provide education and assistance regarding nutrition, physical activity and maintaining a healthy weight during pregnancy and post pregnancy through: - MCM services - WIC - Family Planning	• Percentage of clients and staff stating they've received consistent nutrition and physical activity messages from each program.

Goals and Objectives *Supporting Performance Measures*	Practices and Activities *To implement objectives*	Suggested Outcome Measures *For health status; process; and/or activity*
Objective 5 Improve staff health and efficacy and enthusiasm for treating patients and clients	• Utilize small grant opportunities to improve nutrition and physical activity in worksite environments • Support efforts for healthier lifestyles by having staff participate in worksite wellness activities like: -10,000 step programs - Brown bags on nutrition and physical activity topics - Stair walking contests - Know your numbers campaign • Promote policies that improve nutrition and physical activity and promote healthy lifestyles • Implement a healthy food policy during Work meetings and gatherings (see American Cancer Society, "Meeting Well" document http://www.hawaii.edu/foodskills/acs.htm	• Percentage of staff reporting improved nutrition and physical activity opportunities in the workplace. • Percentage of staff reporting healthy alternatives served at meetings • Percentage of staff reporting overall improvement in nutrition and fitness levels.

Children and Adolescents

Goals and Objectives *Supporting Performance Measures*	Practices and Activities *To implement objectives*	Suggested Outcome Measures *For health status; process; and/or activity*
Goal: Improve healthy eating, daily physical activity, and healthy weight in Oregon children and adolescents		
Objective 1 Increase the percentage of children and adolescents in Oregon who consume at least five daily servings of fruits and vegetables	• Increase promotion of 5 A Day messages in local public health, community, and school nutrition and health programs through increased access to training, technical assistance and funding. • Encourage funding and support to increase the number of elementary and middle schools with variety bars offering fruits and vegetables	a. Number of servings of fruits and vegetables consumed by 8th and 10th graders in a seven day period b. Percentage of Oregon schools with variety bars (ODE)

Goals and Objectives *Supporting Performance Measures*	Practices and Activities *To implement objectives*	Suggested Outcome Measures *For health status; process; and/or activity*
	purchased locally whenever possible. • Provide a variety of appealing fruits and vegetables and juices within the school environment • Limit the amount of less healthy (competitive) food and beverage choices within the school environment	
Objective 2 Increase the percentage of Oregon children and adolescents who participate in daily physical activity	• Promote and support daily physical activity in communities by increasing the opportunities for physical activity at neighborhood community centers and through parks and recreation programs. • Support and promote development of walking and biking trails and lanes, and walkable sidewalks • Promote and support Walk and Bike to School Day and Safe Routes to School efforts • Create and Support School Health Advisory Councils • Participate in Oregon's Healthy Kids Learn Better School Health approach • Utilize resources like the School Health Index for elementary school and middle/high school to provide guidance for self-assessment and planning • Enhance the school environment to create opportunities throughout the day • Provide extracurricular opportunities for recreation to all students • Provide education about the importance of physical activity in school curriculum • Require physical education classes for all students five days per week	OHT Q72-77, 30-35) a. Number of 8th and 11th graders who participated in daily moderate physical activity for at least 30 minutes. b. Number of 8th and 11th graders who participated in daily vigorous physical activity for at least 20 minutes. c. Number of Oregon schools requiring daily physical education for all students. d. Number of Oregon schools, local health departments, and community partners participating in Walk and Bike to School Day. (WBTS Day data) e. Number of Oregon schools, local health agencies, and community partners participating in Safe Routes to School projects. (ODHS-HS)

Goals and Objectives *Supporting Performance Measures*	**Practices and Activities** *To implement objectives*	**Suggested Outcome Measures** *For health status; process; and/or activity*
Objective 3 Increase the proportion of children and adolescents who view television two or fewer hours per day	• Provide education through curriculum and educational materials like posters on the importance of limiting television viewing to two hours or less a day. • Promote and support TV Turn-off Week	a. Percentage of 8th and 11th graders reporting watching 2+ hours of TV on an average school day (ODHS-HS) b. Number of local agencies, libraries and Oregon schools participating in TV turn-off week (Kaiser Permanente TV Turn-off data)
Objective 4 Provide appropriate, consistent messages about the importance of nutrition, physical activity and maintaining a healthy weight to children and adolescents	Provide education and assistance regarding nutrition, physical activity and maintaining a healthy weight through: • School curriculum • School-based Health Centers • Coordinated School Health Efforts • Medical appointments • Family Planning	

Additional Resources: Nutrition, Physical Activity, and Obesity Prevention Toolkit:
http://egov.oregon.gov/DHS/ph/npa/toolkit.shtml

Oral Health

Goals for Oregon Populations

A. Increase Early Childhood Caries Prevention activities.
B. Increase the use of dental sealants.
C. Increase the percentage of residents with access to optimally fluoridated water.
D. Increase access to a dental home.

National and State Performance Measures

***MCH Title V National Performance Measures*:**

- Percent of children aged 6-8 who receive dental sealants.

***MCH Title V State Performance Measures*:**

- Percent of Oregonians living in a community where the water is optimally fluoridated
-

Goals and Objectives *Supporting Performance Measures*	**Practices and Activities** *To implement objectives*	**Suggested Outcome Measures** *For health status; process; and/or activity*
Goal A: Increase early childhood caries prevention		
Objective A.1. Increase the percentage of children under the age of three who have a dental home.	• Collaborate with dental care organizations and dental providers to coordinate a referral system. • Collaborate with oral health coalitions addressing access to oral health care. • Promote, to caregivers and medical and dental providers, a dental visit by age one.	a. Percentage of children under the age of three who have seen a dentist. (TOTS)
Objective A.2. Increase the percentage of pregnant women who have a dental home.	• Coordinate services through OMC. • Establish an oral health referral system.	a. Percentage of women who saw a dentist during pregnancy. (PRAMS) b. Percentage of women who were advised to see a dentist during their pregnancy. (PRAMS)

Goals and Objectives *Supporting Performance Measures*	Practices and Activities *To implement objectives*	Suggested Outcome Measures *For health status; process; and/or activity*
Objective A.3. Increase the percentage of young children who receive early preventive care.	• Coordinate with Early Childhood Cavities Prevention Coalition to ensure that medical providers receive training on ECCP. • Public Health Nurses implement the Early Childhood Caries Prevention approach as outlined in the ECCP Provider Training packet. • Collaborate with other programs to provide education about oral health, e.g. WIC. • Dispense toothbrushes to all caregivers of young children and toothpaste for children over the age of two.	a. Number of medical providers who receive ECCP training. b. Percentage of young children who receive an ECCP assessment and appropriate follow-up. c. Documentation of education provided. d. Number of toothbrushes and toothpaste dispensed.
Objective A.4. Increase the percentage of young children who have access to optimally fluoridated water or receive appropriate fluoride supplementation.	• Provide access to fluoride supplementation to children over the age of 6 months. • Promote optimal water fluoridation.	a. Number of young children given a referral for fluoride supplementation. b. Number of young children receiving a prescription for fluoride supplementation. c. Materials that promote optimal water fluoridation. d. Policy statement in support of optimal water fluoridation.
Goal B: Increase the use of dental sealants		
Objective B.1. Increase the percentage of school-age children who receive dental sealants.	• Collaborate with local groups and coalitions to establish school-based/linked dental sealant programs. • Collaborate with programs that serve pre-school age children to promote oral hygiene to increase the number of children's teeth that are eligible for dental sealants, i.e. caries free.	a. Percentage of school-age children who have dental sealants. (Smile Survey) b. Number of teeth not eligible to receive sealants due to decay. (dental sealant program data) e. Number of school-based/linked dental sealant programs. f. Percentage of school-age children who are screened for dental sealants. (dental sealant program data)

Goals and Objectives *Supporting Performance Measures*	**Practices and Activities** *To implement objectives*	**Suggested Outcome Measures** *For health status; process; and/or activity*
Objective B.2. Increase the percentage of school-age children who have access to optimally fluoridated water or appropriate fluoride supplementation.	• Provide access to fluoride supplementation to all children. • Promote optimal water fluoridation. • Participate in the King Fluoride tablet and rinse program by coordinating with local elementary schools.	a. Number of children given a referral for fluoride supplementation. b. Number of children receiving a prescription for fluoride supplementation. c. Materials that promote optimal water fluoridation. d. Policy statement in support of optimal water fluoridation. e. Number of children participating in King Fluoride Program. f. Number of schools or classrooms participating in King Fluoride Program. Participation/coordination with water fluoridation coalition(s).
Goal C: Increase access to community water fluoridation		
Objective C.1. Increase the percentage of residents who have access to optimally fluoridated community water.	• Collaborate with local groups and coalitions to promote optimal water fluoridation. • Promote optimal water fluoridation by providing information to customers.	a. Participation with groups and coalitions that promote water fluoridation. b. Policy statement in support of optimal water fluoridation. c. Materials available that promote optimal water fluoridation.
Goal D: Increase access to a dental home		
Objective D.1. Increase the percentage of children who have a dental home.	• Collaborate with dental care organizations and dental providers to coordinate a referral system. • Collaborate with oral health coalitions addressing access to oral health care. • Promote, to caregivers and medical and dental providers, a dental visit by age one.	a. Percentage of children referred successfully into a dental home.
Objective D.2. Increase the percentage of pregnant women who have a dental home.	• Coordinate services through OMC. • Collaborate with dental care organizations and dental providers to coordinate a referral system.	a. Percentage of women who saw a dentist during pregnancy. (PRAMS) ntage of women who were advised to see a t during their pregnancy. (PRAMS)

Child Injury Prevention

Goals for Oregon Populations

A. Increase the number of children ages 0-6 who are properly restrained in child safety seats and booster seats.
- Objective A.1 – Improve access by low-income families to low-cost child safety seats and booster seats in the local community.
- Objective A.2 – Increase the number of clients who receive both classroom and hands on education on proper use of child safety seats and booster seats, especially clients who speak a language other than English.

B. Increase the number of children ages 0-15 who wear helmets while biking and riding on skates, skateboards and inline skates.
- Objective B.1 – Improve access by low-income children to low-cost bike and skate helmets.

C. Increase the number of children ages 5-14 who walk and bike to school.
- Objective C.1 – Collaborate with schools and organizations on the local level to provide pedestrian and bike safety education to students.

National and State Performance Measures

MCH Title V National Performance Measure

- Death rate per 100,000 from unintentional injuries due to motor vehicle crashes among children aged 14 years and younger

Goals and Objectives *Supporting Performance Measures*	**Practices and Activities** *To implement objectives*	**Suggested Outcome Measures** *For health status; process; and/or activity*
Goal A: Increase the number of children ages 0-6 who are properly restrained in child safety seats and booster seats.		
Objective A.1 Improve access by low-income families to low-cost child safety seats and booster seats in the local community	▪ Identify community partners and resources for providing low-cost child safety seats. ▪ Screen low-income families for child safety seats/booster seats and provide information on where to access seats.	Process: - Partners and resources are identified and a plan is in place to screen clients. - Number of families screened and number of seats distributed.
Objective A.2 Increase the number of clients who receive both classroom and hands on education on proper use of child safety seats and booster seats, especially clients who speak a language other than English.	▪ Identify community partners that have staff who are nationally certified Child Passenger Safety Technicians and will provide community child safety seat clinics. ▪ Distribute information on date/location of child safety seat clinics and provide education on correct use of child restraints.	-Percent of clients that receive child safety seat education. -Number of child safety seat clinics offered in community
Goal B: Increase the number of children ages 0-15 who wear helmets while biking and riding on skates, skateboards and inline skates.		
Objective B.1 Improve access by low-income children to low-cost bike and skate helmets.	▪ Identify community partners and resources for providing low-cost helmets. ▪ Screen low-income families for helmets and provide information on where to access helmets.	Process: - Partners and resources are identified and a plan is in place to screen clients. - Number of families screened and number of seats distributed.
Goal C: Increase the number of children ages 5-14 who walk and bike to school.		
Objective B.1 Collaborate with schools and organizations on the local level to provide pedestrian and bike safety education to students.	▪ Identify community partners and schools. ▪ Encourage bike safety and pedestrian safety education at schools with walking/biking populations.	- Partners and schools are identified. - Percent increase by school number of students who walk or bike to school annually.

Oregon Family Planning Program

Statewide Program Goals

A. Assure continued high quality clinical family planning and related preventive health services to improve overall individual and community health.

- Objective A.1 – Increase or maintain agency methods and techniques for improving reproductive health services in the community
- Objective A.2 – Increase or maintain the number of clients served who are considered hard-to-reach such as males, people with limited English proficiency, adolescents or other vulnerable or at-risk populations
- Objective A.3 – Increase or maintain funds available for services by increasing the percent of funds received from billing insurance

B. Reduce risk of unintended pregnancy in local community

- Objective B.1 -- Increase or maintain the percent of clients leaving the clinic with an equally or more effective method of birth control than reported at the outset of the visit.
- Objective B.2 – Increase or maintain the percent of visits at which Emergency Contraception is dispensed prophylactically

Program data sources (contact Oregon Family Planning Program):

Ahlers Family Planning Client Visit Data
Ahlers Family Planning Billing Data

National and State Performance Measures

***MCH Title V National Performance Measures*:**

- The rate of birth (per 1000) for teenagers aged 15-17

***MCH Title V State Performance Measures*:**

- Percent of births that are intended

Goals and Objectives *Supporting Performance Measures*	**Practices and Activities** *To implement objectives*	**Suggested Outcome Measures** *For health status; process; and/or activity*
Goal A: Assure continued high quality clinical family planning and related preventive health services to improve overall individual and community health		
Objective A.1 Increase or maintain agency methods and techniques for improving reproductive health services in the community	▪ Arrange for a COPE© assessment for your agency through the state family planning office ▪ Develop and implement a continuous quality improvement (CQI) program to measure change in identified problems and issues	Process: - Assessment of the agency is completed, issues are identified - A CQI plan is in place to implement and measure services or agency changes
Objective A.2 Increase or maintain the number of clients served who are considered hard-to-reach such as males, people with limited English proficiency, adolescents or other vulnerable or at-risk populations	▪ Assess which segment(s) of the community is in need, such as males, migrant community, etc. ▪ Create a plan based on assessed underserved communities, including outreach and/or services ▪ Plan can include hiring staff that represents the identified population, addressing limited English proficiency needs, etc.	Percent of [target population group] that receives family planning services (start with a baseline and monitor over time). . (Ahlers client data and, where available, community demographic data)
Objective A.3 Increase or maintain funds available for services by increasing the percent of funds received by billing third party insurance	▪ Develop and implement a plan to increase agency capability of billing insurance or other third party resources (TPRs)	Percent of agency family planning program revenue from third party insurance payors (start with a baseline and monitor over time). (Use agency billing data)
Goal B: Reduce risk of unintended pregnancy in local community		
Objective B.1 Increase or maintain the percent of clients leaving the clinic with an equally or more effective method of birth control than reported at the outset of the visit.	▪ Provide client-centered counseling; expand education to include switching to a more effective method ▪ Expand choice of methods available at clinic to include more of the highly effective methods (i.e. IUD insertion training or adding the NuvaRing)	Percent of clients whose methods of birth control upon exiting servicesare equally or more effective than the method with which they entered services (start with a baseline and monitor over time). (Ahlers Client Data) (Exclude clients who are pregnant, seeking pregnancy or not sexually active)

Goals and Objectives *Supporting Performance Measures*	**Practices and Activities** *To implement objectives*	**Suggested Outcome Measures** *For health status; process; and/or activity*
Objective B.2 Increase or maintain the percent of visits at which Emergency Contraception (EC) is dispensed prophylactically	▪ Develop and implement a protocol to offer EC at each visit for client's future use ▪ Increase supply inventory to include additional quantities of EC ("Plan B")	Percent of visits at which EC is dispensed for future use (start with a baseline and monitor over time). (Ahlers Client Data)

Oregon Immunization Program

Statewide Program Goals

- Increase coverage levels for children (19 to 35 months of age for four DTaP, three Polio, one MMR)
- Increase coverage levels for seventh graders for D/T, Polio, MMR, Hep B series
- Increase coverage levels for Pneumococcal immunizations among adults age 65 and older, and ages 18-64 years with medical risk factors

National and State Performance Measures

***MCH Title V National Performance Measures*:**

- Percent of children, 19-35 month olds, who have completed immunizations for Measles, Mumps, Rubella, Polio, Diptheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B (4:3:1:3:3)

***MCH Title V State Performance Measures*:**

- Percent of children that complete the 4th DTaP vaccine between 12-18 months of age.

Focus Area	Suggested Immunization Activities by Core Public Health Function			State Resources
	Assessment	Assurance	Policy Development	
Using a CQI process, improve at least one AFIX measurement, (e.g.; single antigen rate, series rate, late start rate, missed opportunities rate, etc…) in one target population (eg. LHD, delegate, or private partner practice; hospital)	• Assess baseline for chosen measure. (eg. rates for 4th DTaP, missed shots, birth dose hep B, adult PPV23) • Identify current efforts to target population • Determine current provider processes that influences rate (eg. recall for 4th DTaP, doctor order required for birth dose) • Identify key factor to focus on (eg. assess reminder / recall system, promote	• Educate providers and staff on key factor issues • Implement change in immunization practice • Provide annual feedback to clinic or hospital staff	• Participate in AFIX Certificate of Commitment • Partner with hospital or clinic to develop and implement standing orders • Develop and implement new appointment protocol • Develop and implement reminder/recall protocol	• Consultation with AFIX staff to review measurements and strategies to focus improvements • Annual AFIX Assessment for LHD • AFIX Assessment for selected private practices upon request • Best Practices "TIPS" sheet • OPIC 4th DTaP promotion

Focus Area	Suggested Immunization Activities by Core Public Health Function			State Resources
	Assessment	Assurance	Policy Development	
	standing orders) Define improvement goal			
ALERT Promotion	• Assess level of awareness and use of ALERT in your community: do they understand the benefits? • Assess how well ALERT is integrated with private clinic practice to limit missed shots and avoid over-immunization	• Provider/School ALERT promotion • Help providers expand range of data reported • Reward ALERT users • Assist with e-transfer • Develop a demonstration project to show increase in rates for clinics that use ALERT consistently	• Assist providers with development of procedures and training for staff use of ALERT • Assist school systems with development of procedures for school use of ALERT	• List of providers and their level of participation in ALERT • List of schools accessing ALERT through the web • ALERT Video for clinics • ALERT Clinic Training Manual • Speakers for community meetings • On-site web demos TA for e-transfer
Vaccine Accountability with Private Partners	• Compare current unaccountability rate to baseline • Assess current vaccine handling and management processes	• Educate providers on accountability issues • Conduct provider storage and handling checks and trainings	• Create or adopt Standard Operating Procedures (SOPs) for vaccine management • Work with providers to develop SOPs	• List of current VFC providers, including mailing labels • Model SOPs • Speakers
Community-wide AFIX Project	• Determine current provider ALERT participation as prerequisite for AFIX • Identify providers who may benefit from AFIX	• Recruit providers to participate in AFIX assessments • Participate in feedback sessions • Host an AFIX Exchange	• Assist providers in development of policies based on AFIX results	• AFIX assessments of identified private providers • Feedback for providers at LHD-DHS co-hosted feedback session
Developing and maintaining coalitions	• Identify agencies interested in partnering on immunization to develop or expand your coalition • Assess local issues	• Host or assist with a coalition meeting • Develop immunization resource list and distribute to new partners	• Develop by-laws for coalition • Develop local immunization standards with coalition partners	• Co-host VFC-coalition meeting • Speakers
Standards for pediatric, adolescent and/or	• Assess LHD's ability to meet immunization	• Implement imm. practice changes in LHD	• Develop LHD plan to address targeted	Resource guide – available Spring 2006 for use in

Focus Area	Suggested Immunization Activities by Core Public Health Function			State Resources
	Assessment	Assurance	Policy Development	
adult immunizations	standards • Identify 1-2 standards to target (e.g, simultaneous vax, screening at each appt)	• Create tip sheet for private providers to improve ability to meet standards	standard(s)	providers' offices

Oregon Women, Infants and Children (WIC) Program

Overall Mission/Purpose: *To impact the success of the WIC family by targeting emerging health issues as identified through national and state data sources.*

Statewide Program Goals

1. Decrease the risk of obesity among WIC participants by increasing physical activity awareness.
2. Increase the percentage of WIC participants who consume at least five daily servings of vegetables and fruits.
3. Increase client participation in 2nd nutrition education contacts.
4. Increase breastfeeding duration rates among WIC participants.

***MCH Title V National Performance Measures*:**

Percent of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile

Goal 1: Decrease the risk of obesity among WIC participants by increasing physical activity awareness.
Activity 1: (Required by October 31, 2005) Assess client awareness regarding physical activity and identifying client barriers to getting adequate physical activity by using state provided assessment tool. Activity 2: (Required by June 30, 2006) Using results from staff and client surveys, identify/develop and implement at least one clinic activity to promote increased physical activity and increase awareness of the prevalence of overweight increase among staff and clients. Activity 3: (Optional) Participate in an organized "Turn off the TV Week" campaign April 2006. Activity 4: (Optional) Participate in a community event that promotes physical activity.

Goal 2: Increase the percentage of WIC participants who consume at least five daily servings of vegetables and fruits.

Activity 1: (Required by October 31, 2005)
Assess client attitudes and behaviors regarding fruit and vegetable consumption using state provided tool.

Activity 2: (Required during September 2005)
Develop and implement **client**-centered activity/event during September 2005 in recognition of 5 A Day Month. (Examples include: Bulletin Boards, Newsletters, and Classes).

Activity 3: (Required by June 30, 2006)
Use client fruit and vegetable survey results to develop or modify individual or group nutrition education activities to promote fruit and vegetable consumption.

Activity 4: (Optional)
Develop and implement a staff activity/event during September 2005 in recognition of 5 A Day Month. (Snacks at staff meeting, staff in service tasting new fruits and vegetables).

Goal 3: Increase client participation in 2nd nutrition education contacts.

Activity 1: (Required by September 30, 2005)
Assess client attitudes, needs, and barriers to attendance related to 2nd nutrition education using state provided tool.

Activity 2: (Required by December 31, 2005)
Compare results of client and staff surveys to State NE minimum standards and develop guidelines for quality nutrition education in your agency. Minimum standards will be set in the areas of availability/accessibility, topic, content, delivery methods, marketing, assessment, and evaluation.

Activity 3: (Required by January 31, 2006)
Contact your Nutrition Consultant to review your agency's guidelines, then plan and schedule 2nd NE offering in preparation for multiple month FI issuance.

Activity 4: (Required)
Assure staff who teach NE classes complete the Providing Group Nutrition Education module and the appropriate Level 2 training

modules.

Activity 5: (Optional)
Explore the options for developing innovative partnerships for providing NE to clients in your agency.

Goal 4: Increase breastfeeding duration rates among WIC participants.

Activity 1: (Required by December 31, 2005)
WIC staff will have completed role-appropriate sections of the revised Breastfeeding Module.

Activity 2: (Required by December 31, 2005)
WIC staff will assess client beliefs, attitudes and barriers regarding continuing breastfeeding to least 6 months of age by using state provided assessment tool.

Activity 3: (Required by June 30, 2006)
The WIC agency will implement at least one strategy to support client breastfeeding goals.

Activity 4: (Optional)
The agency will implement the Breastfeeding Mother-Friendly Employer project and receive designation from the Oregon Department of Human Services.

Outcomes, Measures and Indicators Resources

- Healthy People 2010: http://www.healthypeople.gov/document/HTML/tracking/OD16.htm
- Title V Performance Measures:
  https://perfdata.hrsa.gov/mchb/mchreports/Search/core/measureindicatemenu.asp
- DHS Performance Measures: http://www.oregon.gov/DHS/publications/pm_reports/
- Oregon Benchmarks: http://egov.oregon.gov/DAS/OPB/obm_pubs.shtml
- Healthy People 2010 Critical Indicators for Adolescents: http://nahic.ucsf.edu/index.php/companion/index/
- National Survey of Children's Health (SLAITS) – Data Resource Center: www.nschdata.org
- National School Readiness Indicators: www.gettingready.org

Oregon Data Sources

- Oregon Vital Statistics: http://www.oregon.gov/DHS/ph/chs/index.shtml
- Pregnancy Risk Assessment Monitoring System (PRAMS): http://www.oregon.gov/DHS/ph/pnh/prams/index.shtml
- Oregon Healthy Teen Survey: http://www.oregon.gov/DHS/ph/chs/youthsurvey/index.shtml
- Adolescent Suicide Attempt Data System: http://www.oregon.gov/DHS/ph/chs/data/arpt/04v2/chp8toc.shtml
- Oral Health: Smile Survey: http://egov.oregon.gov/DHS/ph/oralhealth/resources/research.shtml
- Behavioral Risk Factor Survey System: http://egov.oregon.gov/DHS/ph/chs/brfs/index.shtml
- ODOT Transportation Safety Division Data: http://www.oregon.gov/ODOT/TS/index.shtml
- DHS ODPE Injury Data: http://oregon.gov/DHS/ph/ipe/index.shtml

Evaluation and Suggestions

Was this material useful in assessment or planning for community Maternal and Child Health programs and policies?

What worked?

What didn't work?

Suggestions for improvement of the Reference for Local MCH Program Planning:

Suggestions for other practices and activities to be included the Reference:

Submit the evaluation and suggestions in email or fax to:

Molly Emmons, MCH Project Specialist, Office of Family Health, Oregon DHS-Public Health
Email: molly.emmons@state.or.us
Fax: 971-673-0240

Phone: 971-673-0234