

PREPARED TEMPLATES

Goal 1: Families of children with special health care needs will partner in decision-making at all levels and will be satisfied with the services they receive.

Objective 1: By September 30, 2005, determine the level of satisfaction families with CSHCN have with the services they receive.	Outcome Eval 1: Report results from HCP family satisfaction survey analysis regarding family satisfaction.
Activity 1: Identify the sub-populations of families of CSCHN in region you would like to survey. Survey families to discern baseline level of satisfaction with the care they receive.	Process Eval 1: Obtain current level of family satisfaction with services as a baseline for future comparisons.
References: HCP family satisfaction survey.	
Future Objectives:	
Objective 2: By September 30, 2005 increase by _____%, family participation in family support and advocacy resources/training	Outcome Eval 2: Percentage of increase in the families that report participating in family support and advocacy resources/training
Activity 1: Public education to families with CSHCN on information and support available on the “Parent to Parent List Serv”*, how to access and support for utilizing it’s services. Active participation of Regional Family Coordinator on the “Parent to Parent List Serv”. Encourage parents to utilize the “Parent to Parent List Serv”*	Process Eval 1: Report the number of hits on the “parent-to-parent” list serve for your region / area at beginning and end of contract year.
Activity 2: Encourage parents to attend the HCP sponsored “Family-to-family” (F ₂ F) health information training.	Process Eval 2: Report the number of families from your region attending “F ₂ F Health Network” trainings during this contract year
References: F ₂ F training agenda and schedule for October 1, 2004 through September 30, 2005. Parent to Parent List Serv: www.p2p-co.org	
Future objectives: Address how well families are participating in decision-making; develop strategies on how to increase family satisfaction after identifying what are the significant areas needing improvement (from survey results).	

Goal 2: All children with special health care needs will receive coordinated, ongoing, comprehensive care within a medical home.

<p>Objective 1: By September 30, 2005, increase by _____ the number of PCP's that consult with HCP RO compared to previous year.</p>	<p>Outcome Eval 1: The number of providers with whom HCP regional offices provided consultation increased from <u>X_____number</u> to <u>X_____number</u> from the previous year.</p>
<p>Activity 1: Review IRIS data entry procedures with team members and establish last year's starting baseline for number of consultations/encounters RO had with primary care physicians/practice settings for resources, referrals, care coordination, and other HCP services.</p> <p>Activity 2: Contact primary care practices throughout region and complete the "Title V Assessment of Practice Needs- A Practice Inquiry and Options for Menu of Support"* Document contacts with PCP offices as community encounters in IRIS.</p> <p>Activity 3: Survey PCP practices on their desire to know more about best practices and resources r/t Universal Newborn Hearing Screening, NB Metabolic, developmental, and/or early vision screening.</p> <p>Activity 4: FOR RO's WHO CONDUCT HCP SPECIALTY CLINICS: Send out "Reverse Referral"* forms as part of pre-clinic activities. Document in IRIS when completed form is received and other pre-clinic or post clinic consultations with PCP.</p>	<p>Process Eval 1: Report number of practices/providers that RO has consulted in the region using IRIS community and individual client encounters. Use same method at end of 2005 fiscal year to see if activities increased by _____ number.</p> <p>Process Eval 2: Number of community encounters with PCP practice settings. Report the results of completed assessments.</p> <p>Process Eval 3: Number of surveys completed and report of results</p> <p>Process Eval 4: Number of "reverse referral" forms sent out to PCP's prior to a child's HCP Specialty Clinic visit.</p>
<p>References: Title V Assessment of Practice Needs- A Practice Inquiry and Options for Menu of Support"* "Reverse Referral Form"*</p>	
<p>Future Objectives:</p>	

Goal 2: continued.

<p>Objective 2: Increase the frequency with which IFSP's are shared with PCPs.</p>	<p>Outcome Eval: The number of IFSPs sent by Part C to PCP's..</p>
<p>Activity 1: Contact part C Agencies to determine interest in collaborative project to increase participation of PCP's in IFSP process..</p> <p>Activity 2: Use/develop system for Part C to document number of IFSPs sent to PCPs (For example: # IFSPs sent by Co-Hears to PCP's) and establish baseline number of IFSPs sent to PCPs for previous year.</p> <p>Activity 3: Develop joint presentation with Part C to give to PCP's on Part C and HCP services. Contact PCP's/practices and give presentation.</p>	<p>Process Eval 1: Report the number of Part C agencies in your region contacted and willing to participate in project by IRIS community encounters.</p> <p>Process Eval 2: Report baseline number.</p> <p>Process Eval 3: Report number of PCPs contacted by IRIS community encounter information.</p>
<p>References: Medical Home Learning Collaborative web site: www.medicalhomeimprovement.org , from this site there are links to AAP and Family Voices web sites.</p>	
<p>Future Objectives:</p>	

Goal 3: All families of children with special health care needs will have adequate private and/or public insurance to pay for the services they need.

<p>Objective 1: By September 30, 2005 contact X__ number of stakeholders in their region by HCP office to define private and/or public insurance and third party payer resources available and identify gaps in services.</p>	<p>Outcome Eval 1a: The number of regional stakeholders contacted.</p> <p>Outcome Eval 1b: Report on current resources and/or gaps in services. Report improvements and lack of improvements and reports are shared with the regional stakeholders and those who provide services for CSHCN.</p>
<p>Activity 1: Schedule and facilitate a region task force with stakeholders to define resources available and identify gaps in services.</p> <p>Activity 2: Use regional task force to define a regional/county work plan with the goal of improving insurance and community resources for health care services for CSHCN.</p> <p>Activity 3: Collaborate with public insurance programs (Medicaid providers, Medicaid, HMOs, EPSDT, CHP+, CICIP) to improve enrollment for children who qualify and who are currently uninsured. Collect county enrollment numbers by program, when available, and compare to previous year.</p>	<p>Process Eval 1: The number of stakeholders contacted by using IRIS community encounters. Report on activities completed.</p> <p>Process Eval 2: The regional/county work plan . Process for monitoring progress and reporting on annual basis is developed.</p> <p>Process Eval 3: County enrollment numbers are increased for programs. Report community or</p>

	program changes that result in increased or decreased enrollment numbers.
References: Colorado Health Care Policy and Financing (CHP+, CACP, Medicaid, EPSDT); www.chcpf.state.co.us , Medicaid School Health Services Program; Colorado Covering Kids and Families; www.cchn.org/ckf , Colorado Rural Health; www.coruralhealth.org/crhc/index.html , Rural Health Clinics; www.cdphe.state.co.us/hf/static/rhc.htm , ClinicNet; www.ccmu.org/ppt/LessonsfromTrenches-ClinicNet.ppt .	
Future Objectives:	

Goal 3: continued.

Objective 2: Increase the number of CSHCN with insurance and/or resources to pay for health care services.	Outcome Eval 2: The number of children in the county / region with insurance and resources for health care.
<p>Activity 1: Identified CSHCN working with HCP who are uninsured.</p> <p>Activity 2: Identify number of children who are uninsured and receiving health care from a FQHC. Work with FQCH(s) within the region to identify number of children who are uninsured and receiving health care services from the clinic.</p>	<p>Process Eval 1: Document number of CSHCN who are uninsured using payer report in IRIS.</p> <p>Process Eval 2: Document the number of children who attend the FQHC and are not insured. Report community program changes that effect changes in enrollment numbers.</p>
References: Colorado Community Health Network; www.cchn.org	
Future Objectives: Identify and enumerate barriers to families with CSHCN receiving adequate public or private insurance to pay for services.	

Goal 4: All children will be screened early and continuously for special health care needs.

<p>Objective 1: By September 30 2005, increase the number of infants that complete needed second hearing screening follow up in your region to 75%.</p>	<p>Outcome Eval 1: The percent of infants with documented completion of needed second hearing screening.</p>
<p>Activity 1: Public education about recommended infant hearing screening follow up.</p> <p>Activity 2: Regional Office Audiology Coordinator and team collaborate with birthing hospitals in their region to complete infant hearing screening protocols for the hospital.</p> <p>Activity 3: Offer and conduct trainings for hospital hearing screening coordinators to improve screening techniques and follow up.</p>	<p>Process Eval 1: Number of community encounters and contacts made.</p> <p>Process Eval 2: The number of birthing hospitals with appropriate protocols.</p> <p>Process Eval 3: The number of trainings conducted as documented in IRIS community encounters and number of hospital coordinators that attended.</p>
<p>References: Colorado Infant Hearing Guidelines: Screening, Audiologic Assessment, and Intervention at: http://www.cdphe.state.co.us/ps/mch/hcp/completecihac.pdf</p>	
<p>Future Objectives:</p>	

Goal 5: Community-based service systems will be organized so families can use them easily.

<p>Objective 1: By September 30, 2005 make X___ number of community encounters with partners who provide support services for CSHCN.</p>	<p>Outcome Eval 1: The number of community partners and contact activities achieved during the year.</p>
<p>Activity 1: Identify and update directories of existing and potential partners that provide services for CSHCN.</p> <p>Activity 2: Participate in local meetings of community agency resource teams or the Community Inter-agency Coordinating Council.</p> <p>Activity 3: Invite representatives from community agencies serving CSHCN to offer trainings during a HCP Regional, Staff or Team meeting twice during the contract year.</p> <p>Activity 4: Participate in Community Resource Fair(s) to share information on HCP services and resource and referral information that is known to the team.</p>	<p>Process Eval 1: Report the list of contact persons in directory.</p> <p>Process Eval 2: Number of meetings attended by HCP team members using Community Encounters in IRIS.</p> <p>Process Eval 3: Number of trainings documented using IRIS Community Encounters.</p> <p>Process Eval 4: Number of Community Resource Fair activities documented using IRIS Community Encounters.</p>
<p>References:</p>	
<p>Future Objective: Identify gaps in the community based service systems.</p>	

Goal 6: All youth with special health care needs will receive the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.

<p>Objective 1: By September 30 2005, the number of youth between 14 and 21 in the HCP caseload that have discussed with their doctor(s) the shift to an adult provider(s) will increase by ____%</p>	<p>Outcome Eval 1: The percent of increase in number of youth between 14 and 21 on caseload who have discussed medical services transition with their doctor(s).</p>
<p>Activity 1: Identify youth who are close to or qualify for adult services and have not discussed with their doctors the shift to adult provider by surveying youth and families to determine who could receive assistance. Use transition survey questions* and/or add these questions to HCP Family Satisfaction survey.</p> <p>Activity 2: Discuss with youth and families the need to begin steps toward transition to adult services. Offer support and information, to build confidence, knowledge and empower youth and families to approach their doctors.</p> <p>Activity 3: Follow up contact or repeat survey with youth and parent(s) regarding status of having discussion regarding transition with their doctors.</p>	<p>Process Eval 1: List of families of youth between the ages of 14 and 21 in caseload who have not discussed the shift to adult provider with their doctors.</p> <p>Process Eval 2: The number of youth and parents (from list developed from survey) that team members contacted and provided support and information services. Report how youth and parents were empowered to approach their doctors in the region.</p> <p>Process Eval 3: Recorded outcomes of families who discussed transition to adult providers with doctors.</p>
<p>References: Transition Information and Resources, Division of Specialized care for Children, University of Illinois at Chicago Health Sciences Center. Transition resources including information sheets for families, worksheets for parents and youth, teaching sheets, timelines, health care checklists and other resources; http://hctransitions.ichp.edu/resources.html; Transition Timelines for Children and Adolescents with Special Health Care Needs; http://depts.washington.edu/healthtr</p>	
<p>Future Objectives:</p>	

Goal 6: continued.

Objective 2: Increase contacts with educational transition coordinator(s) and transititeam(s) in region.	Outcome Eval 1: Number of contacts with transition coordinator and transition team during the contract year.
Activity 1: Identify transition coordinator and build relationships with the transition team. Activity 2: Visit transition program.	Process Eval 1: Acquire a list of transition team including transition coordinator and resources that team uses. Process Eval 2: Acquire transition team protocol utilized.
References:	
Future Objectives: Improve HCPs involvement with transition team and planning.	

Goal 7: The regional model of operation for HCP will provide high quality, efficient services to families, providers, and state and local partners.

Objective 1: Develop and implement a plan for filling vacant positions on the regional office multidisciplinary team.	Outcome Eval 1: Decrease local vacancies.
<p>Activity 1: Hiring managers will utilize scope of work and job descriptions for each specialty to assess in hiring positions.</p> <p>Activity 2: Acquire survey data for each discipline by region.</p> <p>Activity 3: Market vacant positions through email broadcasts, newsletters, and professional association notifications.</p>	<p>Process Eval 1: Local offices will acquire completed job descriptions and salary surveys from HCP team leaders.</p> <p>Process Eval 2: Utilize salary surveys from CDPHE, websites and other public resources to acquire salary range for advertised position.</p> <p>Process Eval 3: Notify other HCP team leaders and State HCP Office when they can broadcast information on job openings.</p>
References:	
Future Objectives:	
Objective 2: Improve workforce competencies for priority areas.	Outcome Eval 2: Report from priority areas on work force competency.
<p>Activity 1: Conduct annual needs assessment of HCP workforce.</p> <p>Activity 2: Evaluate training priorities relative to local goals, MCH goals, and constituency needs.</p> <p>Activity 3: Deliver training toward improving priority competencies.</p>	<p>Process Eval 1: Identify workforce competency areas, which need to be improved.</p> <p>Process Eval 2: Use workforce survey to identify training priorities and constituency needs.</p> <p>Process Eval 3: Number of HCP team members who receives training on identified priority competencies.</p>
References:	
Future Objectives:	

Early Childhood Passenger Safety

Goal: Reduce Motor Vehicle Morbidity and Mortality of Children 0-8 years old.		
Sample long-term objective: By September 30, 2010, decrease the motor vehicle fatality rate for 0-8 year olds in _____ county by 5% (from x/100,000 to y/100,000). By September 30, 2005, decrease the motor vehicle hospitalization rate for 0-8 year olds in _____ county by 5% (from x/100,000 to y/100,000). Sample Short Term Objective: By September 30, 2005, increase proper usage of car seats and booster seats by ____% in _____ county.	Outcome Evaluation: Use motor vehicle death rates for 0-8 year olds from COHID* to track county rate. Note: the motor vehicle death rate is not as sensitive a measure as the motor vehicle hospitalization rate, especially in counties with a smaller population. Use motor vehicle injury hospitalization rates for 0-8 year olds from COHID* to track county rate. Pre-post surveys regarding car seat knowledge and usage completed by parents participating in the program activities and/or baseline and follow-up observational surveys.	Outcome/Progress Report:
Activities	Process Evaluation	Outcome/Progress Report
1.1 Collaborate with community partners to create or strengthen a forum to address infant and child passenger safety. This could mean using an existing group to address the issues or starting a new coalition if necessary.	Documentation of meeting schedule, minutes, list of partners, etc.	
1.2 Create and provide booster seat display boards, information packets or other social marketing strategy to highlight the new booster seat law to be displayed in settings of high visibility (i.e. primary health care offices, WIC offices, <u>immunization clinics</u> , child care centers, elementary schools, <u>faith-based settings</u> , <u>hospitals</u> , etc).		
1.3 <u>Assess community partners for staff formally trained in infant and child passenger safety. If necessary, send MCH staff or community partners(s) to the 4-day NHTSA training on child passenger safety in order to provide safety checkpoints and/or fitting stations.</u>		

1.4 Work with community partners to provide child passenger safety check-point(s) or fitting station(s) to assess seatbelt usage and assist parents with correct car seat/booster seat installation.	Number of car/booster seat checks completed	
1.5 Work with community partners to obtain low cost car and booster seats. Provide free and low cost car and booster seats to parents who need assistance.	Number of free and/or low cost car seats and booster seats distributed.	
<p><u>Resources:</u></p> <p>Primary MCH Contact for this goal area:</p> <ul style="list-style-type: none"> • Rachel Hutson, Early Childhood Nurse Consultant, rachel.hutson@state.co.us, 303-692-2365 <p>For More Information Contact:</p> <ul style="list-style-type: none"> • Barb Bailey, CDPHE Injury Prevention Specialist, 303-692-2589 or 800-886-7689-ext.2589, barbara.bailey@state.co.us. • Holly Hedegaard, CDPHE Injury Epidemiologist, 303-692-3005, holly.hedegaard@state.co.us <p>On-line Resources:</p> <ul style="list-style-type: none"> • The following resources are available on-line at: http://www.cdphe.state.co.us/pp/injepi/injuryepihom.html • <i>Injury in Colorado</i>. Denver, CO: Colorado Department of Public Health and Environment; 2002. Chapter Three: Motor Vehicle Traffic, pp 45-55. • <i>Traffic Safety Facts: Colorado Children Ages 4 to 8</i>, a four-page report. • More MV passenger safety resources are available at: http://www.cdphe.state.co.us/ps/bestpractices/topicsubpages/injury.html <p>*Injury data is available on-line at www.cdphe.state.co.us/cohid, however users must obtain a password to run data queries. To request a password, follow the instructions posted on the COHID website. The data for this specific age group can also be obtained through a data request to Holly Hedegaard, CDPHE Injury Epidemiologist.</p>		

Local health department contact for this goal area:

Name: _____

Phone: _____ **Email:** _____

Health and Safety in Child Care

Goal: Increase Health and Safety in Child Care		
Sample Long Term Objective: By September 30, 2010, ____% of licensed child care facilities will improve health and safety ratings using a recognized rating system.	Outcome Evaluation: Statewide data sources currently unavailable. Potential local data sources include information obtained through the Early Childhood Environmental Rating Scale (ECERS) and the Infant Toddler Rating Scale (ITERS) or other recognized rating system. Number and percentage of centers receiving child care health consultation services. Other potential outcome evaluation measures: Pre-post surveys regarding health and safety knowledge or child care center staff.	Outcome/Progress Report:
Sample short term objective: By September 30, 2005, improve health and safety in child care by providing child care health consultation services for ____ number of centers in _____ county.		
Activities	Process Evaluation	Outcome/Progress Report
1.6 Send MCH staff person(s) to Healthy Child Care Colorado training for Child Care Health Consultants.	Documentation of training participation.	
1.7 Establish child care health consultation relationship/contract/MOU with X number of child care centers.	Documentation of signed contracts or MOUs	
1.8 Provide monthly consultation to child care providers.	Log of consultation dates and notes of consultation visits.	
1.9 Provide needed trainings for child care providers (universal precautions, medication administration, etc).	Log of classes, dates and participants. (File proper paperwork with the Colorado Office of Resource and Referral Agencies for medication administration class participants.)	
1.10 Provide phone consultation to child care providers as needed.	Log of phone consultation.	

Resources

Primary MCH Contact for this goal area:

- **Rachel Hutson, Early Childhood Nurse Consultant, rachel.hutson@state.co.us, 303-692-2365**

Contact for More Information:

- Linda Satkowiak, Director, Healthy Child Care Colorado, 303-290-9088 x208, lsatkowiak@corra.org

On-line Resources:

- CDPHE Healthy Child Care Colorado webpage: <http://www.cdphe.state.co.us/ps/hcc/healthyhom.asp>
- Colorado Office of Resource and Referral: <http://www.corra.org>
- National Resource Center for Health and Safety in Child Care: <http://nrc.uchsc.edu>
- American Academy of Pediatrics: <http://www.aap.org>
- The Children's Hospital: <http://www.tchden.org>

Local health department contact for this goal area:

Name: _____

Phone: _____ **Email:** _____

Adolescent Motor Vehicle

Goal: Reduce Adolescent Motor Vehicle Morbidity and Mortality		
<p>Sample long-term objectives (select at least one): By September 30, 2010, decrease the motor vehicle fatality rate for 15-19 year olds in _____ county by X% (from x/100,000 to y/100,000).</p> <p>By September 30, 2010 decrease the motor vehicle injury rate for 15-19 year olds in _____ county by X% (from x/100,000 to y/100,000).</p> <p>Sample short-term objective: By September 30, 2005, increase seatbelt use among adolescents at 5 (specified) high schools by 10% (from ___% baseline to ___%).</p>	<p>Outcome Evaluation: Use calendar year motor vehicle death rates for 15-19 year olds from COHID* to track County rate. Note: the motor vehicle death rate is not as sensitive a measure as the motor vehicle hospitalization rate, especially in counties with a smaller population.</p> <p>Use calendar year motor vehicle hospitalization injury rates for 15-19 year olds from COHID to track County rate.</p> <p>Conduct pre and post seatbelt use observations at 5 specified high schools and report results (% seatbelt usage baseline and following intervention—could do an additional post-intervention observation).</p>	<p>Outcome/Progress Report:</p>
<i>Activities</i>	Process Evaluation	Outcome/Progress Report
<p>1.1. Involvement of Community Partners</p> <ul style="list-style-type: none"> • Collaborate with community partners to create or strengthen a forum to address seatbelt use among adolescents. This could mean partnering with an existing coalition or meeting with stakeholders (law enforcement, non-profits, parents, insurance companies, teens, etc.) who have an interest in improving teen motor vehicle safety. 	<p>Documentation of meeting schedule, minutes, list of partners, etc.</p>	
<p>1.2 Enforcement of Seatbelt Laws:</p> <ul style="list-style-type: none"> • Develop campaign with local law enforcement officials to increase enforcement of seatbelt laws for 15-19 year olds. (i.e. Click It or Ticket Campaign) 	<p>Local law enforcement reports number of teens stopped for seatbelt violations.</p>	

<p>1.3 Increase Seatbelt Use:</p> <ul style="list-style-type: none"> • Conduct community social marketing campaign to promote seatbelt use among teens (use teen radio stations, billboards, etc.). • Develop and implement a parent education campaign related to seatbelt use and other teen driving issues (underage driving, new drivers transporting groups of teens, and other local issues.) • Conduct youth-led motor vehicle safety/seatbelt use campaign in 5 high schools. 	<p>Number of social marketing messages tracked and evaluated, i.e. number of ads placed, number of packets distributed, number of teens reached, etc.</p> <p>Parent education campaign developed and implemented (e.g. brochures developed and # mailed with insurance notices to parents of 16-year-old drivers; PSAs targeting parents developed, shown and evaluated; # presentations to PTAs, service clubs, other groups with parents, etc.)</p> <p>A “seatbelt use campaign” is designed by youth and implemented in the 5 schools (example is at www.drivesmartcoloradosprings.com)</p>	
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Resources

Primary MCH Contact for this goal area:

- Jason Vahling, Adolescent Health Program Manager, jason.vahling@state.co.us, 303-692-2946

For More Information Contact:

- Barb Bailey, CDPHE Injury Prevention Specialist, 303-692-2589 or 800-886-7689-ext.2589, barbara.bailey@state.co.us.
- SallieThoreson, CDPHE Injury Epidemiologist, 970-248-7161, sallie.thoreson@state.co.us.
- Holly Hedegaard, CDPHE Injury Epidemiologist, 303-692-3005, holly.hedegaard@state.co.us

On-line Resources:

- Best Practices website at CDPHE at <http://www.cdphe.state.co.us/ps/bestpractices/bestpracticeshom.asp>
- The Injury and Suicide Prevention Program at CDPHE at <http://www.cdphe.state.co.us/pp/injuryprevention/injuryprevhom.asp>.
- Task Force on Community Preventive Services at <http://www.thecommunityguide.org/mvoi/default.htm>.
- National Highway Traffic Safety Administration at <http://www.nhtsa.dot.gov>.
- *Injury in Colorado*. Denver, CO: Colorado Department of Public Health and Environment; 2002. Chapter Three: Motor Vehicle Traffic, pp 45-55 at www.cdphe.state.co.us/pp/injepi/InjuryinColorado/injuryincolorado.html.
- National Safety Council at www.nsc.org
- Insurance Institute for Highway Safety at www.highwaysafety.org

*Injury data is available on-line at www.cdphe.state.co.us/cohid, however users must obtain a password to run data queries. To request a password, follow the instructions posted on the COHID website. The data for this specific age group can also be obtained through a data request to Holly Hedegaard, CDPHE Injury Epidemiologist.

Local health department contact for this goal area:

Name: _____

Phone: _____ Email: _____

Suicide Prevention

Goal: Reduce Adolescent Suicide Morbidity and Mortality.		
<p>Sample long-term objectives (select at least one): By September 30, 2010, decrease the number of deaths due to suicidal behavior for 10-19 year olds in _____ county by X% (from x/100,000 to y/100,000).</p> <p>By September 30, 2010, decrease the number of hospitalizations due to suicidal behavior for 10-19 year olds in _____ county by X% (from x/100,000 to y/100,000).</p> <p>Sample short-term objective: By September 30, 2005, provide education regarding suicidal risk factors, warning signs and resources available to X% of the community in X county.</p>	<p>Outcome Evaluation: Use calendar year suicide death rates for 10-19 year olds from COHID* to track County rate.</p> <p>Use calendar year suicide hospitalization injury rates for 10-19 year olds from COHID* to track County rate.</p> <p>Number of community members receiving education related to suicide and suicide prevention</p>	<p>Outcome/Progress Report:</p>
Activities	Process Evaluation	Outcome/Progress Report
<p>1.1 Involvement of Community Partners</p> <ul style="list-style-type: none"> • Assess community agencies/coalitions currently working on youth suicide prevention efforts. Develop steps to coordinate/collaborate with other partners. • If no coalition exist, convene stakeholders (mental health, public health, parent/family survivors, youth, EMS, youth serving agencies, school districts and hospitals) • Create a plan for addressing suicidal behavior 	<p>Document meeting schedule, minutes, list of partners etc.</p> <p>Document meeting schedule, minutes, list of partners etc.</p> <p>Identify goals, objectives and parties responsible for implementing the strategic plan</p>	

<p>1.2 Increase public awareness and education regarding youth suicide prevention (in conjunction with stakeholders)</p> <ul style="list-style-type: none"> • Provide public awareness materials from the Office of Suicide Prevention to area schools, health fairs, clinics, recreation centers etc. * • Use Public Service Announcements for local radio, television stations and print media (already created)* • Plan and host a community awareness presentation. 	<p>Document distribution of materials.</p> <p>Track ads through clipping services, media logs etc</p> <p>Document the event to include the number of attendees.</p>	
<p>1.3 Increase gatekeeper training (a gatekeeper is an individual who might be in contact with a youth at risk for suicide)</p> <ul style="list-style-type: none"> • Send X number of public health representatives to a gatekeeper training program 	<p>Document attendance.</p>	
<p>Resources</p> <p>Primary MCH Contact for this goal area: Jason Vahling, Adolescent Health Program Manager, jason.vahling@state.co.us, 303-692-2946</p> <p>For More Information Contact:</p> <ul style="list-style-type: none"> • Cindy Hodge, Office of Suicide Prevention, Program Manager, 303-692-2539, Cynthia.hodge@state.co.us • Holly Hedegaard, CDPHE Injury Epidemiologist, 303-692-3005, holly.hedegaard@state.co.us <p>On-line Resources:</p> <ul style="list-style-type: none"> • www.cdphe.state.co.us/pp/Suicide/suicidehom.asp <p>*Injury data is available on-line at www.cdphe.state.co.us/cohid, however users must obtain a password to run data queries. To request a password, follow the instructions posted on the COHID website. The data for this specific age group can also be obtained through a data request to Holly Hedegaard, CDPHE Injury Epidemiologist.</p>		

Local health department contact for this goal area:

Name: _____

Phone: _____ **Email:** _____

Immunizations

Goal: Achieve and maintain effective vaccination coverage levels for universally recommended vaccines among children Immunization Rates (HP 2010)		
<p>Sample long-term objective: By September 2010, increase to 90% the proportion of young children 19-35 months who receive all vaccines that have been recommended for universal administration.</p> <p>Sample short-term objective: By September 30, 2006, _____% of immunization providers in _____ County will utilize and demonstrate compliance with the recommended strategies to improve immunization coverage from the Revised Standards for Child and Adolescent Immunization Practices developed by the National Vaccine Advisory Committee (NVAC) and published by the National Immunization Program (NIP)</p> <p>Sample short-term objective: By September 30, 2005, the agency will have developed a system for collecting baseline information regarding childhood vaccination rates from the agency clinics, community health centers, schools when appropriate and private providers in the community.</p>	<p>Outcome Evaluation: Data source not available at this time Utilize future state/county data sources when available</p> <p>County-wide assessment of immunization providers utilization of strategies to improve vaccination coverage from the Revised Standards for Child and Adolescent Immunization Practices developed by the National Vaccine Advisory Committee (NVAC) and published by the National Immunization Program (NIP) completed as both a pre and post measure</p> <p>Data system has been developed for collecting baseline and ongoing countywide assessment of childhood immunization rates from public health, community health centers, schools and private providers.</p>	<p>Outcome/Progress Report:</p>

Activities	Process Evaluation	Outcome/Progress Report
1.1 Assessment of current community provider activities and planning <ul style="list-style-type: none"> • Assess which agencies/coalitions are addressing child and adolescent immunizations • Assess which providers are providing vaccinations • Conduct meetings with stakeholders/coalition (physicians, midlevel providers, school nurses, childcare centers, faith based settings) 	Document assessment activities. Community stakeholder group has met, membership is documented, and a plan of action with defined roles for each member is completed	
1.2 Make available the Revised Standards for Child and Adolescent Immunization Practices developed by the National Vaccine Advisory Committee (NVAC) and published by the National Immunization Program (NIP) to all immunization providers and community stakeholders/coalition	Number of trainings and copies of the Revised Standards for Child and Adolescent Immunization Practices developed by the National Vaccine Advisory Committee (NVAC) that were disseminated – percentage of providers reached.	
1.3 Implementation of strategies to improve vaccination coverage <ul style="list-style-type: none"> • Systems are used to remind parents/guardians, patients, and healthcare professionals when vaccinations are due and to recall those who are overdue • Office or clinic-based patient records reviews and vaccination coverage assessments are performed annually • Healthcare professionals practice community-based approaches 	Number and proportion of reminder systems utilized by immunization providers in the county Number of Immunization providers patient record reviews and vaccination coverage assessments completed annually Document activities of community stakeholder group/coalition to improve immunization rates in the community.	

Resources

Primary MCH Contact – Cathy White, RN, MSN School Age and Youth Child Health Nurse consultant, 303-692-2375, cathy.white@state.co.us

For More Information Contact:

- Joni Reynolds, Immunization Nurse Consultant at joni.Reynolds@state.co.us/ phone 303 692-2363

On-line Resources:

- Copy of the **Revised Standards for Child and Adolescent Immunization Practices** go online at <http://www.cdc.gov/nip/recs/rev-immz-stds.htm>
- **Standards for Child and Adolescent Immunization Practices** article published in Pediatrics go online at <http://www.cdc.gov/nip/recs/rev-immz-stds.htm>

Local health department contact for this goal area:

Name: _____

Phone: _____ **Email:** _____

Physical Activity and Nutrition

Goal: Reduce Overweight/Obesity Among School Age Children and Youth Through Healthy Nutrition and Physical Activity		
<p>Sample Long Term Objectives: By 2010, reduce the proportion of high school students who are overweight or obese to 5% (from the 2000 Colorado YRBS baseline of 7.1%)</p> <p>By 2010, reduce the percentage of overweight children ages 5 – 14 by 3%, as measured by the Colorado Child Health Survey.</p> <p>Sample Short Term Objectives: By September 2005, ascertain baseline data for children and youth for:</p> <ul style="list-style-type: none"> a) recommended physical activity levels (e.g. vigorous physical activity for at least 20 minutes at least 3 times a week) b) compliance with nutritious dietary intake (e.g. 5 fruits and vegetables a day, adequate consumption of dairy products, limited soda pop) 	<p>Outcome Evaluation: <i>Colorado Youth Risk Behavior Survey (YRBS 2000) data used for state baseline and the Colorado Combined Youth Survey (combines YRBS and Colorado Youth Survey) can be used for future measurement</i></p> <p><i>Colorado Child Health Survey</i> data will be available in 2004 to establish baseline and for future measurement</p> <p>Future data sources include <i>Colorado Combined Youth Survey</i> and <i>Colorado Child Health Survey</i></p>	<p>Outcome/Progress:</p>

Activities	Process Evaluation	Outcome/progress
1.1 Assessment of current community and school activities and policies related to physical activity and nutrition for school age children and youth as part of a school and/or community health team/stakeholders group.	Document assessment of activities and policies, both as baseline and changes by the end of the year.	
1.2 Actively participate in creating a plan to increase activities and develop and/or improve policies in the community and schools related to physical activity and improved nutrition. (Utilize the School Site Resource Kit: Implementation Guide for the Colorado Physical Activity and Nutrition state Plan 2010 www.cdphe.state.co.us/pp/copan/schoolsite.html)	A plan is created with school and community priorities for policy development and activity changes that will promote recommended physical activity and improved nutrition.	
1.3 Utilize agency staff and community experts to educate school staff, parents, and community leaders about the issues affecting the health of children related to obesity, lack of physical activity, and recommended nutrition.	Documentation of education offerings, presenters, and attendance list	
1.4 Engage in social marketing activities that encourage families to increase physical activity, eat more healthy foods, and reduce television viewing (See Colorado Physical Activity and Nutrition State Plan 2010 www.cdphe.state.co.us/pp/copan/stateplan.html)	Provide documentation of social marketing activities, promotions, and education offerings	
1.5 Assure training and current information for health care providers on child and adolescent overweight/obesity, and encourage providers to address this issue. www.nutrition.gov	Documentation of provider training, educational materials/brochures disseminated, etc.	

Resources:

Primary MCH Contact – Cathy White, RN, MSN School Age and Youth Child Health Nurse Consultant, 303-692-2375, cathy.white@state.co.us

Contact for more information:

- Joan Brucha, COPAN School Site Task Force Coordinator, 303-692-514, joan.brucha@state.co.us
- Debi Lemke, Nutrition Coordinator, 303-692-3010, debi.lemke@state.co.us

On-line Resources:

- Physical Activity and Nutrition State Plan 2010 at www.cdphe.state.co.us/pp/copan/stateplan.html
- Adolescent Health In Colorado 2003 at www.cdphe.state.co.us/ps/adolschool/adolehealthreport.asp
- School Site Resource Kit at www.cdphe.state.co.us/pp/copan/schoolsite.html

Local health department contact for this goal area:

Name: _____

Phone: _____ **Email:** _____

MCH Performance Indicator (SPM 2): The percent of pregnancies that are unintended.

Contact Person: Karen Trierweiler, Women’s Health Section Director, karen.trierweiler@state.co.us, or (303) 692-2481.

Goal 1: Decrease the proportion of pregnancies that are unintended.

Objective 1 (Long-term)	Outcome Evaluation	Outcome/Progress
Decrease the unintended pregnancy rate in County (or Region) X from a baseline of ___% in CY01 to ___% in 2005.	The unintended pregnancy rate in County (or Region) X as measured by Pregnancy Risk Assessment Monitoring System (PRAMS) data.	
Activity	Process Evaluation	
1.1 Analyze PRAMS and/or Vital Statistics data to determine the high-risk groups at risk for unintended pregnancy in County.	1.1 Data analyzed and high-risks groups identified.	
1.2. Conduct focus groups with high-risk groups to determine community-specific strategies for the target population OR utilize focus group information collected from other counties with similar high-risk groups (Contact the WHS for these data.).	1.2. Focus groups conducted OR focus group data obtained.	
1.3. Analyze focus group results to determine if the short-term objectives are relevant.	1.3. Focus group results analyzed.	

Short-Term Objective #1: Increase Awareness among Men	Outcome Evaluation	Outcome/Progress
Increase knowledge among at least 30-75 (INSERT #) high-risk males (ie., men seen in STD clinics, family planning clinics, probation or criminal justice systems) about contraception, STIs, partner communication and the role of men in decreasing unintended pregnancy as measured by a score of 80% on a session post-test by 9/30/05.	The number of class participants scoring at least 80% on a session post-test.	
Activity	Process Evaluation	
1.1. Develop or procure high-risk male curriculum. (Contact WHS for curriculum.)	1.1 Curriculum determined.	
1.2. Train staff in implementing curriculum.	1.2. Staff trained.	
1.3. Develop and pilot post-test.	1.3. Post-test developed and tested	
1.4. Determine population to be trained.	1.4 Population identified.	
1.5. Implement classes.	1.5. Classes implemented.	
1.6. Compile and analyze post-test data.	1.6 Post-test data compiled and analyzed.	

Short-Term Objective #2: Increase Knowledge among Health Care Providers	Outcome Evaluation	Outcome/Progress
Increase knowledge among at least 30-100 (INSERT #) primary and 30-100 (INSERT #) ancillary health care providers about effective contraceptive methods (ie., DMPA, IUDs, Evra, NuvaRing, EBC) as measured by a score of 80% on a session post-test by 9/30/05.	The number of training participants scoring at least 80% on a session post-test.	
Activity	Process Evaluation	
2.1. Identify family practitioners, Ob/Gyns, internists, pediatricians, mid-level and ancillary health care providers (WIC, NFP, HCP, PN+, STD clinic staff, social services staff, etc.) needing training.	2.1. Providers identified.	
2.2. Develop training curriculum OR contact WHS for assistance in obtaining curricula.	2.2. Curriculum developed.	
2.3. Implement trainings.	2.3. Trainings implemented.	
2.4. Compile and analyze post-test data.	2.4. Post-test data compiled and analyzed.	

Short-Term Objective #3: Parental Involvement	Outcome Evaluation	Outcome/Progress
Increase knowledge and skills among 25 -100 (INSERT #) parents of middle and high-school children regarding communicating with their children about sexuality and pregnancy prevention as measured by a score of 80% on a session post-test by 9/30/05.	The number of participants scoring at least 80% on a session post-test.	
3.1. Identify/develop training curriculum (Parent Power or other curricula are available to be adopted – contact WHS for assistance.)	3.1. Curriculum developed/identified.	
3.2. Determine target groups to be trained.	3.2 Target groups for training identified.	
3.3 Implement training.	3.3 Implement training.	
3.4. Compile and analyze post-training questionnaires.	3.4 Post-training questionnaires compiled and analyzed.	

Short-Term Objective #4: Family Planning Promotion	Outcome Evaluation	Outcome/Progress
Ninety-percent of childbearing-aged women and men who access the local health department for any type of service will receive information and/or referral to family planning services by 9/30/05.	The percentage of childbearing-age women and men accessing health department programs who receive information about family planning.	
Activity	Process Evaluation	
4.1. Orient health department staff about family planning.	4.1. Staff oriented.	
4.2. Develop/provide client information card and family planning resource referral sheet.	4.2. Materials provided.	
4.3. Implement process whereby women and men of childbearing age receive referral information.	4.3. Process implemented.	
4.4 Compile data for evaluation.	4.4. Data compiled.	

MCH Performance Indicator (SPM 9): Percent of women with inadequate weight gain during pregnancy.

Contact Person: Candace Grosz, Women’s Health Section Program Manager, candace.gross@state.co.us or (303) 692-2482.

Goal 1: Improve perinatal outcomes		
Objective	Outcome Evaluation	Outcome/Progress
Decrease the percentage of pregnant women with inadequate weight gain from ___% to ___% by 2005.	Percentage of women with inadequate weight gain reported in PRAMS data.	
Activity	Process Evaluation	
1.1 Determine percentage of pregnant women with inadequate weight gain in ___ County for the previous 5 years by reviewing PRAMS data.	1.1 Review of PRAMS data re: prenatal weight gain for last 5 years is completed. Baseline and trend are determined.	
1.2 Attend CDPHE training on use of the “Healthy Baby is Worth the Weight” campaign materials.	1.2 Training completed.	
1.3 To provide at least 100 prenatal health care providers (physicians, nurse practitioners, nurse midwives, nurses, registered dietitians, health educators, and other office staff) with tools and training to provide assessment and counseling to women regarding inadequate pregnancy weight gain. “A Healthy Baby is Worth the Weight” materials and campaign activities will be used.	1.3 Collect pre and post training questionnaires as provided by WHS-CDPHE from 100 prenatal care providers and submit forms to WHS. Report the numbers of providers trained and other data as described on PWG evaluation materials.	
1.4 To inform local agency staff from Prenatal Plus and WIC programs (estimated at 20 persons in addition to providers described in Objective #1) about “A Healthy Baby is Worth the Weight” campaign by providing tools and training.	1.4 Collect pre and post training questionnaires as provided by WHS-CDPHE from 20 WIC and PN+ staff members and submit forms to WHS. Report the numbers of providers trained and other data as described on PWG evaluation materials.	
1.5 To strengthen clinical practice in 10 prenatal care settings by documenting any changes in clinical practices for measurement, counseling, and documentation of weight gain among pregnant women after receiving “A Healthy Baby is Worth the Weight” materials and training.	1.5 In a 2-3 page narrative report, summarize the impact of the campaign activities to change clinical practice re: prenatal weight gain 10 sites based on interviews and responses to pre and post training questionnaires as provided by WHS-CDPHE. Include recommendations for expansion of campaign activities, any revisions to materials, etc.	
1.6 To distribute materials and provide counseling for at least 500 pregnant women who are receiving care from the prenatal care providers, WIC, and PN+ staff participating in the project.	1.6 Report the number of pregnant women who receive counseling and materials, and other data as described on PWG evaluation materials.	

MCH Performance Indicator (NPM 18): The percentage of infants born to pregnant women receiving prenatal care beginning in the first trimester.
Contact Person: Debbie Kasyon, Women’s Health Section, deborah.kasyon@state.co.us or (303) 692-2497.

Goal 1: Increase first trimester enrollment into prenatal care.

Objective 1 (Long-term)	Outcome Evaluation	Outcome/Progress
Increase the first trimester enrollment rate from a baseline of _____% in FFY 2003 to _____% by 2008 in _____ County.	First trimester enrollment rate in _____ County as measured by birth certificate data.	
Activity	Process Evaluation	
1.1 Analyze first trimester enrollment data – Cohid, vital statistics – to determine the groups of women at highest risk for not accessing prenatal care in _____ county.	Data analyzed and high-risk groups identified.	
1.2 Review CDPHE first trimester care document to review effective strategies for working with the identified population(s). <i>(Document is available at www.cdphe.state.co.us/ps/bestpractices/bestpracticeshom.asp)</i>	Document and strategies reviewed.	

Short-Term Objective #1: Increase Provider Capacity	Outcome Evaluation	Outcome/Progress
By September 30, 2005, increase the number of client appointments available with prenatal care providers for Medicaid and/or uninsured clients, from _____ to _____.	The number of appointments available for Medicaid/uninsured clients.	
Activity	Process Evaluation	
1.1 Analyze current community resources for PN care to determine existing system capacity.	1.1 Community resources analyzed and gaps identified.	
1.2. Identify local providers currently accepting Medicaid/uninsured clients for prenatal care to determine their capacity for accepting additional clients.	1.2. Providers identified.	
1.3. Meet with providers to establish a quota and mutually agreed upon referral system that emphasizes rotation of client referrals.	1.3. Meeting held and quota & mutually agreed upon referral system established.	
1.4. Refer clients to identified providers.	1.4 Referrals made.	
1.5. Follow-up with clients to ensure referral was completed.	1.5. Follow-up completed.	

Short-Term Objective #2: Increase Awareness of the Importance of Early Prenatal Care through Outreach to High Risk Community.	Outcome Evaluation	Outcome/Progress
By September 30, 2005, provide outreach to the _____ population through distribution of _____ brochures and _____ contacts with community groups.	Number of brochures distributed and contacts made.	
Activity	Process Evaluation	
2.1. Identify culturally appropriate outreach materials.	2.1. Materials identified/developed.	
2.2. Determine target areas to distribute printed materials.	2.2 Target areas identified.	
2.3 Distribute printed materials to appropriate community agencies and at local community events such as cultural festivals, health fairs, etc.	2.3 Materials distributed.	
2.4 Evaluate effectiveness of campaign by tracking client referral information on local health department intake forms.	2.4 Campaign effectiveness evaluated by tracking referral source to P.E.	

Short-Term Objective #3: Access to Care	Outcome Evaluation	Outcome/Progress
By September 30, 2005, increase the percentage of pregnant women, from _____ % to _____%, who apply for P.E.	The percentage of patients who apply for P.E.	
Activity	Process Evaluation	
3.1. Meet with community members, including members of the undocumented community, to determine barriers to enrolling in P.E.	3.1 Meeting held.	
3.2. Based on results of community meeting, evaluate current system to identify barriers and areas for improvement.	3.2. Evaluation completed and barriers/areas of improvement identified.	
3.3. Make changes, based on community meeting and evaluation of current system. Activities that could increase applications for P.E. include: increased hours for accepting P.E. applications, applications accepted at multiple sites).	3.3. Changes implemented.	
3.4. Review number of applications received to determine if changes were successful.	3.4 Review completed and the percent of change documented.	

Goal 1:		
Objective 1:	Outcome Evaluation:	Outcome/Progress:
Activities:	Process Evaluation:	
1.1		
1.2		
1.3		
1.4		