 **Workgroup: Child Health**

**Priority 3:**  **Developmentally appropriate care and services are provided across the lifespan**

1. What measures and objectives in the plan ***should absolutely be kep****t* for 2018-2019?
   1. Where is there core MCH work reflected that MCH can directly and positively impact?
   2. Where is there good potential, progress, infrastructure, existing systems to build?
   3. Where are there strong opportunities for collaboration for gains/impact in a short time?
2. What measures and objectives in the plan ***should be removed/replaced***for 2018-2019?
   1. Where has been accomplished, progress been made, and/or where have goals been met (we are in sustainability mode)?
   2. Are there any objectives that are duplicative or too similar to have as separate objectives? Can we streamline to create efficiencies?
   3. What is no longer appropriate/necessary for MCH as lead/prioritize and/or in a good place with other partners (we don’t have to do it all)?
   4. Where has there been a clear lack of progress/movement for a number of reasons (remove from plan for now until we have groundwork in place, resources, etc.)?

| **Performance Measure and Objectives** | **Recommended changes with notes of explanation, including possible new collaborative opportunities**  ***Note change: + or circle PM or obj. to keep; strikethrough to remove*** |
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| **NPM 6:** Developmental screening (Percent of children, ages 10 through 71 months, receiving a developmental screening  using a parent-completed screening tool) |  |
| **NPM 7:** Child Injury (Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents ages 10 through 19) |  |
| **SPM 3:** Percent of children 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes/day |  |
| 3.1 Increase the proportion of children aged 1 month to kindergarten entry statewide who receive a parent-completed developmental screening annually. |  |
| 3.2 Provide annual training for child care providers to increase knowledge and promote screening to support healthy social-emotional development of children. |  |

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| --- | --- |
| 3.3 Increase by 10% the number of children through age 8 riding in age and size appropriate car seats per best practice rec. by 2020. |  |
| 3.4 Increase the proportion of families receiving education and risk assessment for home safety and injury prevention by 2020. |  |
| 3.5 Increase the percent of home-based child care facilities implementing daily routines involving at least 60 minutes of daily physical activity per CDC recommendations to decrease risk of obesity by 2020. |  |
| 3.6 Increase the percent of children and adolescents (K-12 students) participating in 60 minutes of daily physical activity. |  |

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   2. What is MCH investing in/working on that ties to a priority/measure that isn’t reflected?
   3. What activities are partner organizations leading that MCH must be involved in/with?

| **Recommended Performance Measure or Objective to Add** | **Explanation** | **Lead or Partner Organization** |
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**Priority 7:**  **Services are comprehensive and coordinated across systems and providers**

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| **NPM 11:** Medical home (Percent of children with and without special health care needs having a medical home) |  |
| 7.1 Increase family satisfaction with the communication among their child’s doctors and other health providers to 75% by 2020. |  |
| 7.2 Increase the proportion of families who receive care coordination supports through cross-system collaboration by 25% by 2020. |  |
| 7.3 Develop an outreach plan to engage partners, providers, and families in the utilization of a shared resource to empower, equip, and assist families to navigate systems for optimal health outcomes by 2020. |  |

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**Priority 2:**  **Services and supports promote healthy family functioning**

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| **SPM 2:** Percent of children living with parents who have emotional help with parenthood |  |
| 2.1 Increase opportunities to empower families and build strong MCH advocates by 2020. |  |
| 2.2 Increase the number of providers with capacity to provide trauma-informed care by 2020. |  |
| 2.3 Increase the number of families receiving home visiting services through coordination and referral services by 5% annually. |  |

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**Priority 6:**  **Professionals have the knowledge and skills to address the needs of maternal and child health populations**

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| 6.3 Implement collaborative oral health initiatives, identify baseline measures, and expand oral health screening, education, and referral by 2020. |  |

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