Nutrition Education and Marketing Plan Guidance

Policy 12.01A

For questions, please contact the Nutrition Coordinator, Breastfeeding Coordinator, or Program Operations Coordinator

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What is NEMP?

The purpose of the Nutrition Education and Marketing Plan (NEMP) is to establish nutrition priorities, including breastfeeding and support, and focus activities to improve participant health and nutrition outcomes. As a public health program, we also need to coordinate services through various programs within the Department of Health to work toward common goals. Annually within SDWIC-IT, staff shall complete a NEMP with a minimum of three (3) goals: Marketing, Nutrition and Breastfeeding. This document is meant to explain the steps to successfully set and implement WIC NEMP goals that play a part in the overarching goals of the DOH and its health programs.

Logistics

- *ALL RESOURCES FOR NEMP CAN BE FOUND ON THE KNOWLEDGE BASE AT http://sdwic.org/knowledge/ocfs-annual-plans*
- NEMP Committee members will serve as the point-of-contact for each region. A list of the NEMP Committee members can be found *on Knowledge Base (sdwic.org/knowledge/) under the OCFS Annual Plans folder.* Nutrition staff will serve as the lead in the development of each clinic's plan and will refer to the NEMP Committee members for guidance.
- **All staff** must be involved in development, implementation, & evaluation of the NEMP.
- A timeline for the review process can be found on Knowledge Base under the OCFS Annual Plans folder. Based on this timeline, clinic staff will work directly with the NEMP Committee members to complete changes throughout the year.
- Clinics who serve ≤25 clients or have the same staff serving multiple sites are able to combine with other clinics for the NEMP with Central Office approval. An approved list of clinic combinations is included in Appendix A NEMP Clinic Combinations. For more information on how to document this in your NEMP, please see Entering NEMP into SDWIC-IT.

Community Health Needs Assessment

The first step to goal setting is identifying the greatest need in your community. This entails evaluating your community through a Community Health Needs Assessment (CHNA). Throughout the CHNA you will be looking at national data down to your state, organization, and local community. There are numerous sources of excellent data to review pertaining to the clientele that community health offices serve. All of the tools provided will help determine where you can make the biggest impact on the health of the families you serve and your community through your local NEMP goals and joint strategies.

After the CHNA you should have the answers to these questions:

- How healthy are our clients?
- What does the health status of our community look like?
- What are the concerning issues among our clients?
- How do lifestyle behaviors of our clients contribute the community's overall health status?
- What factors impact the health and quality of life of our community?
- How does the health status of our community compare to that of ten years ago; to that of other communities; to that of the state and the nation?

1. **Please start by reviewing the Department of Health Plans. If multiple DOH programs start working toward common goals, we will be able to have a greater impact by the state as a whole. These plans can be found at http://sdwic.org/knowledge/ocfs-annual-plans**
   - Department of Health Strategic Plan
   - Maternal Child Health Goals and Strategies
   - Office of Chronic Disease Prevention and Health Promotion Measures
   - WIC Goals and Objectives

2. **Review the NEMP from last year so you can review data to evaluate your previous goals. This will assist in deciding if goals are met or need to move forward through the next NEMP.**
   - A printed version of the NEMP can be found by running a report in the **Admin Module:** *SDWIC-IT/Admin Module/Reports/NEMP Planning and Tracking Log*
     - Choose the year you would like to review and your clinic
     - Please see the Evaluation section for more information on goal evaluation in SDWIC-IT.

3. **Collect WIC Needs Assessment Data**
   - NEMP Needs Assessment data describes the percentage of clients who received a given risk code in the current year and the past two years. This will be the data source you will need to use when evaluating your 2018 and 2019 Nutrition Goal and Joint Strategy.
   - This data can be found by running a report in the **Clinic Module** *SDWIC-IT/Clinic Module/Reports/Administration/NEMP Needs Assessment*
     - Click on **Reports**
     - Click on **Administration**
     - Click on **NEMP Needs Assessment**

4. **Review Participant survey to help NEMP meet needs of clients**
   - Review the needs of the state as a whole and of your Region to see how your clients describe their needs. State and Regional data can be found on Knowledge Base. If you want your clinic information, it can be obtained through SDWIC-IT by going to *Clinic/Reports/Administration/Participant Survey Summary*.

5. **Describe Your Community**

   To conduct a CHNA, it is necessary to understand the population characteristics of your community. Appendix B, Table 1 is a list of examples to guide you in your CHNA and a blank column for you to fill in electronically if you prefer to do so. A Word document can be found on Knowledge Base titled *Community Health Needs Assessment* to edit for your clinic. http://sdwic.org/knowledge/ocfs-annual-plans

   A list of reliable data sources and potential uses can be found in Appendix B, Table 2. These sources include the statewide initiatives of the DOH and its programs as well as data collected within our DOH programs, statewide data, and national data. If other data sources are obtained, please send to the Nutrition Coordinator, Breastfeeding Coordinator, or Program Operations Coordinator to review prior to use. Required data for goal setting includes use of the NEMP Needs Assessment Report for the Nutrition goal, Breastfeeding Initiation and Duration

Report for the Breastfeeding goal, and the Potential Eligible data for the Marketing goal. Please see Appendix B, Table 2 for the location of these data sources.

6. **Review available Audio & Visual resources**

Review statewide NEMP and state approved nutrition education materials and prototypes (Policy & Procedure Manual 12.01B Audio Visual Resource Catalog). This will give you an idea of what resources are already available.

- Materials may include:
  - Posters, table tents, mobiles, displays
  - Handouts
  - DVD's
  - Educational flip charts
  - Relevant National initiative materials
  - Referral sources and ideas
- Central Office will provide monthly newsletters and specific nutrition education information for:
  - March: National Nutrition Month
  - August: National Breastfeeding Month
  - September: Fruit and Vegetable Month
- Materials and prototypes will be developed annually with input from the Nutrition Education and Marketing Plan Committee based on State's determined highest priority areas, and made available to the clinics.
- Other Central Office approved materials, such as materials from National initiatives and other South Dakota programs will be made available.
- If you find there is something you would like to do that would need additional resources, please work with the Nutrition Coordinator, Breastfeeding Coordinator, or Program Operations Coordinator to see if it would be possible.

Guidance on Material use:

- Posters
  - A poster can be the focus of the Nutrition Education Message
  - The poster should be displayed in an area clearly visible to the client
  - Post a sign to identify the key idea from the poster. It could be done in the form of a question, such as "Did you know that…."
  - Change posters frequently to provide variety
- Bulletin Boards and Displays
  - The bulletin board and displays should be displayed in an area that is clearly visible to the client
  - The bulletin board or display can be the focus of the supplemental nutrition education message

- Clinics can point out the bulletin board or display by explaining one or two ideas or asking the client to complete an activity
- Post a sign to identify the key idea from the bulletin board or display
- Keep the bulletin board simple
- Keep one concept – not too many ideas
- Organize pictures and letters so the main idea can easily be seen
- Keep statement brief, for easy reading by client

- Art work ideas
  - Use the clip art found on your computer in Microsoft Word. Use colored printer if available
  - Other places to get art are coloring books or purchased clip art books
  - Use purchased bulletin board accents
  - Use bulletin board borders
  - Draw attention to the bulletin board
  - Use bright colors for the background, letters, borders
  - Bright colors attract attention
  - Bright colors and large pictures and letters are easier to see
  - Keep size of items (artwork, letters, pictures) on bulletin board in proportion to size of board
  - Make 3 dimensional – rather than using a paper item use a real item like a stick, balloon, or a bag
  - Use a variety of colors, textures, and objects
  - Assure information is accurate: Have the Nutrition staff review the bulletin board before it is used
  - Do not use copyrighted materials without permission
- DVD's
  - When a DVD is selected as a type of nutrition education material, it must be used for general information for all WIC clients
  - Running the DVD on a continual basis allows clients to receive all or at least part of the nutrition information while in the clinic
  - WIC clients should be made aware the DVD is part of the nutrition information
  - This could be done in various ways, i.e. a sign that says "Now Showing….." or use the DVD as the focus of the nutrition education message for the month
  - Have clients view the DVD after explaining one or two main points addressed in the DVD
  - Other ways a DVD can be used:
    - In waiting rooms
    - Individual counseling
    - Group counseling

Setting Goals, Joint Strategies, and Action Steps:

After looking at the participant and demographic data and deciding what areas need addressing, it is time to set goals, joint strategies, and the actions steps. Statewide goals and joint strategies have been established to make our efforts more effective.

Goals

- There must be a minimum of 3 goals for the NEMP
  - Breastfeeding,
  - Nutrition, and
  - Marketing.
- **Please see the memo for the current year for any required goal topics from the central office or contact the Nutrition Coordinator, Breastfeeding Coordinator, or Program Operations Coordinator.**
- Goals are general. A few examples of an overall, general goal related to our public health programs are listed below in the **Goal Examples** section. Great examples of general overall goals and SMART "Key Performance Indicators" (which are our "Joint Strategies") can also be found in the DOH Strategic Plan online at http://doh.sd.gov/strategicplan/ or in the shared drive at *M:\DOH\OFCHS\Local Site Folders\OCFS Annual Plans*.
- If there is a specific need in the community that you serve that falls outside of the State goals, you can add an additional goal under "Other".

Goal Examples

- Increase breastfeeding duration
- Reduce iron deficiency anemia
- Increase the number of women getting prenatal care in the 1st trimester
- Increase vaccination rates
- Reduce tobacco use and second hand smoke exposure among WIC participants
- Increase retention rate for children ages 1-4 on WIC

Joint Strategies

- Each goal should have at least 1 Joint Strategy (JS) which has been set at the state level.
- The JS needs to be SMART which stands for specific, measurable, attainable, realistic, and time sensitive. An example of how to set a SMART JS is included in Appendix C. JSs must have a date for completion (i.e. By December 31, 2017), must state what it is trying to achieve (increase by X% or increase case load to XX), and must state what the beginning measurement or starting point is (from XX % or XX monthly participation). JS should be realistic for the allotted time period.
- ****Note if combining with another clinic, data from both sites must be included in your joint strategy.**

Action Steps

- Action Steps (AS) are the activities your clinic plans to implement in order to reach the JSs to support the overall Goals. When planning your AS, the expectation is to use activities that are outside your normal day-to-day routine of services, education and referrals. For example, it is expected that through our positions in WIC we are doing things like "Provide families with information on healthy eating and exercise" so this should **NOT** be included as an action step. Providing a positive atmosphere with up-to-date nutrition and breastfeeding information in our waiting rooms and offices is also part of the clinic environment policy. As such, bulletin boards and posters will not be included as AS for the NEMP. Creating new educational materials or posters to use for nutrition education may be acceptable. Please contact the Breastfeeding Coordinator, Nutrition Coordinator or Program Operations Coordinator if you are questioning a possible AS for your clinic.
- At least 3 AS must be listed for each JS. One AS will be provided by the NEMP Committee as a required action step for all clinics to complete, leaving 2 AS per JS for clinics to develop or choose from the provided list in Appendix D, Appendix E, or Appendix F based on their Community Health Needs Assessment.
- AS should be specific and include **what** will be done, **who** will do it, **where** and **when** it will take place, what **materials** will you use (e.g. brochures, posters, displays, etc.), what methods will take place for **evaluation** including what data will be used or information will be collected and when will the evaluation take place.
- For more information on available materials, see #6 in the Community Health Needs Assessment section.
- Evaluation of AS must be done **at a minimum of quarterly** with date of evaluation and a description of the evaluation entered into SDWIC-IT under Evaluation Method (see Entering NEMP into SDWIC-IT under Activity Log).

Evaluation

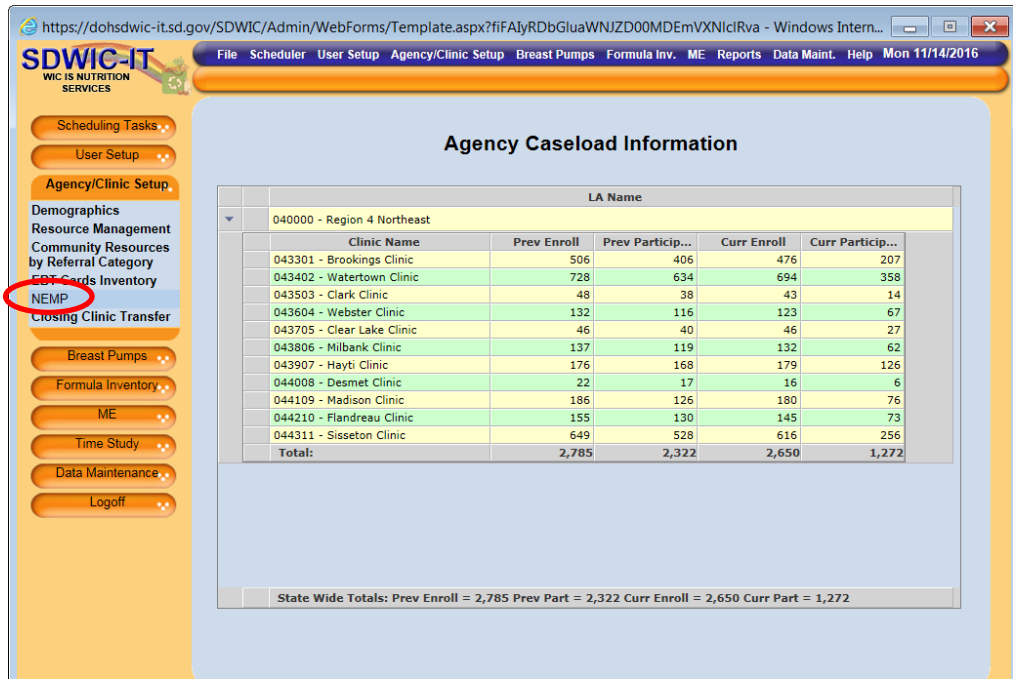
- The Central Office and clinics will review applicable data for goals, joint strategies and action steps at least quarterly to see if goals are being met and to ensure accurate and relevant data is being collected. Clinics should be keeping track of their AS throughout the year to make it easier to evaluate how they went at the end of the year and if they were impactful to the JS and overall Goal. This can be captured in the Evaluation Method section in each line of the Activity Log for AS.
- Overall Goal evaluation will take place between January and July following the year of implementation. In the Goal Evaluation section of NEMP, provide explanation and data of what happened throughout the year (e.g. progress made toward achieving the goal with applicable data and possible reasons for lack of success, if known) and your plan going forward into the next year.
- Evaluation should include data to support what you have accomplished along with other information such as: noting materials, displays, table tents, etc. that clients responded well to,

or did not seem to care for; materials or topics that clients requested they would like to see more or less of; impact and ease of use of audio-visual materials; marketing activities that worked or did not work, how the data was collected (i.e. reports, spreadsheets) etc.

- Here are examples of appropriate evaluation responses:
  - The Potential Eligibles Children 1-4 data shows we have increased the number of children we are serving to 77% in 2016 from 75% in 2015. This is an increase of 2%, but short of our goal by 3%. We plan to continue working toward the current goal of 80% through continuing the Harvest of the Month program and implementing new action steps outlined in next year's NEMP.
  - The Breastfeeding Initiation and Duration data shows we have met our goal to increase breastfeeding duration of 6 months to 40%. We believe this has increased due to the completion of our action steps of all CPA staff completing CLC training and referring 98% of clients to the Breastfeeding Peer Counselor (tracked in "CLC Referrals" spreadsheet and reviewed monthly). As this is a goal we desire to continue to improve, our goal will be to increase to 45% next year.

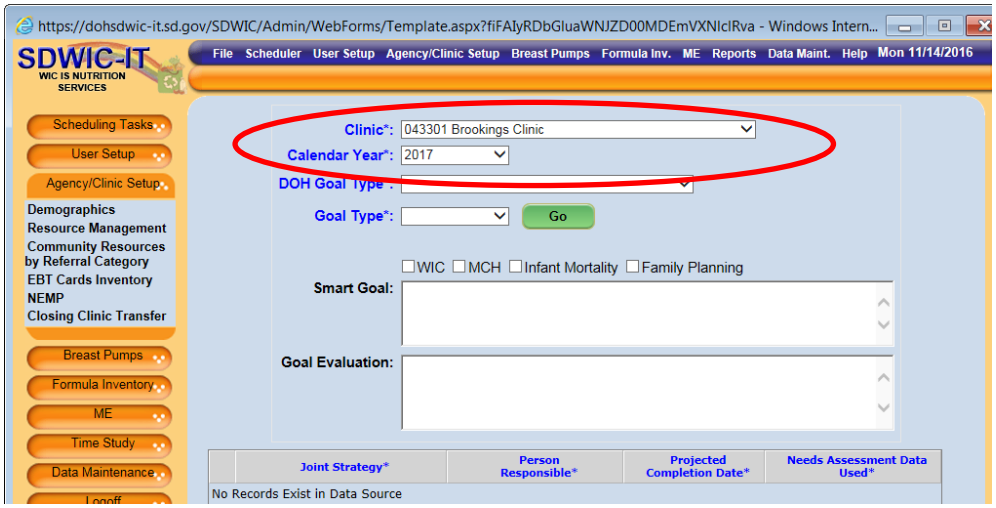
Entering NEMP into SDWIC-IT

- To access the NEMP plan for your county go to https://dohsdwic-it.sd.gov/sdwic/sdwic.aspx. Select ADMIN, choose your county from the dropdown list, and press OK.
- In the ADMIN window, select Agency/Clinic Setup and choose NEMP from the list.

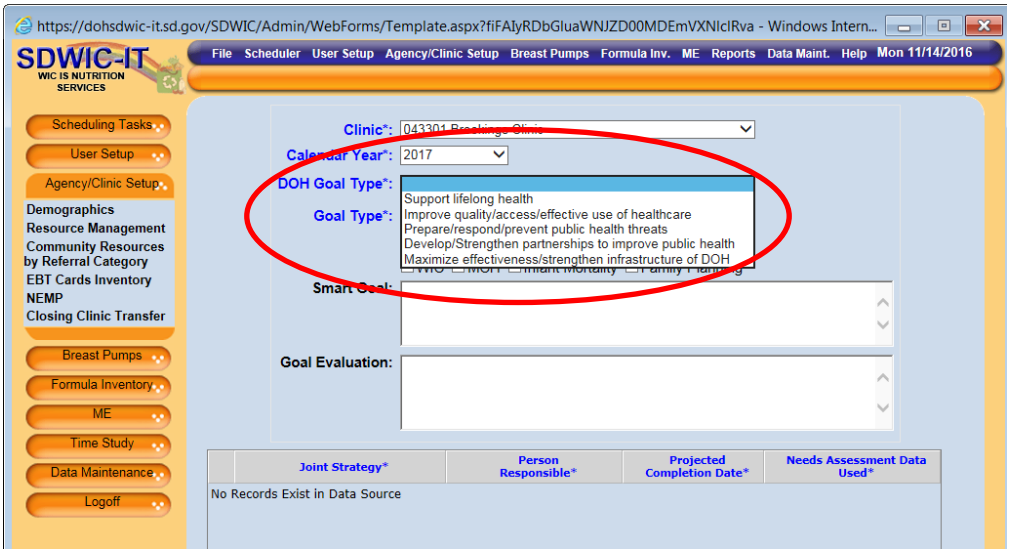


- **Select Clinic Name**

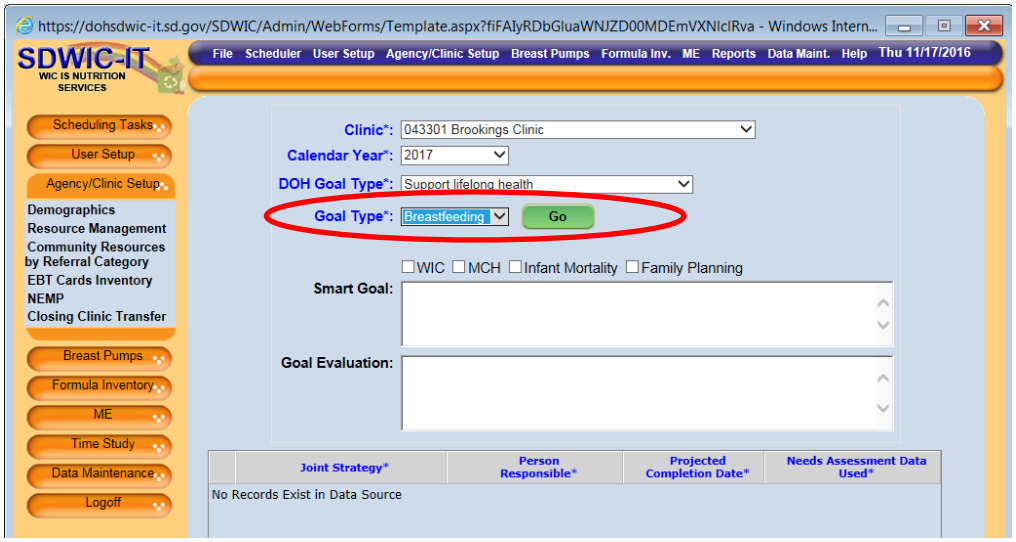
- **Select Calendar Year**



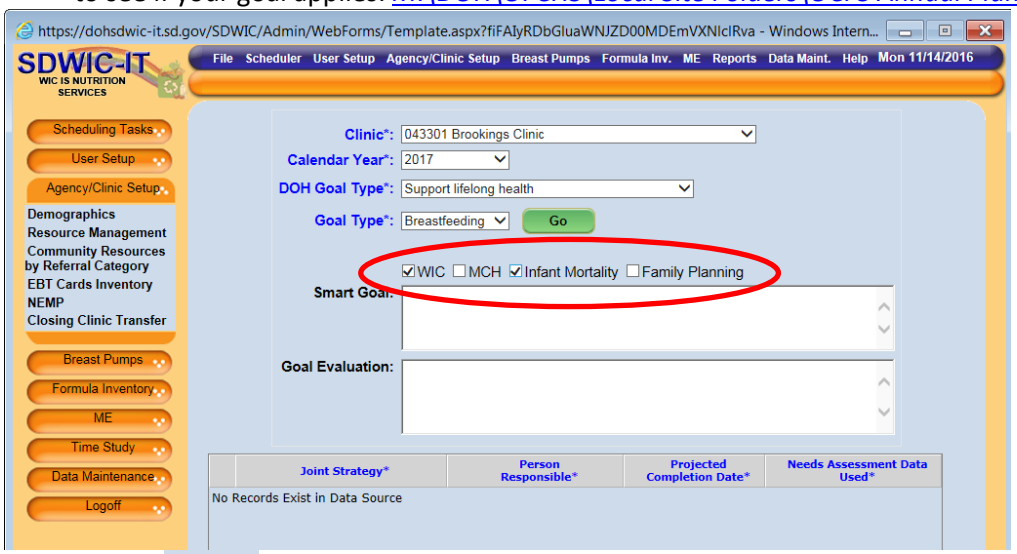
- **DOH Goal Type**: This section refers to the DOH Strategic Plan goals. A copy of the DOH Strategic Plan can be found on the DOH website (http://doh.sd.gov/strategicplan/) or saved in *M:\DOH\OFCHS\Local Site Folders\OCFS Annual Plans\Data*.
  Select the goal type you feel fits the goal you have chosen to complete.



- **Goal Type:** Select the goal type you would like to complete for WIC including Breastfeeding, Marketing, Nutrition or Other



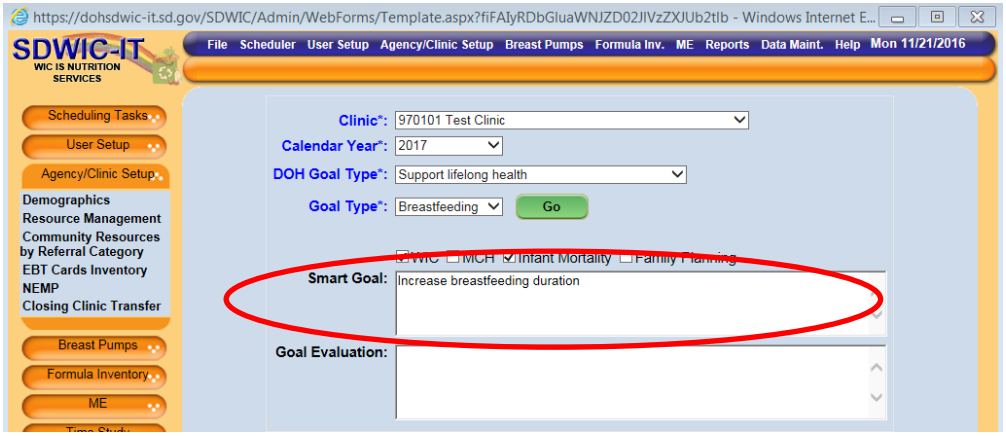
- **Plan check-boxes**: Select which plan(s) the goal applies to.
  - Each program using SDWIC-IT to house their plan is listed as a check-box option. Goals such as Breastfeeding may overlap between plans (i.e. Infant Mortality) and, therefore, may have multiple boxes checked for a single goal.
  - The WIC check box must be checked for all goals of the NEMP.
  - NOTE: MCH is NOT a separate plan to complete. This checkbox is meant to track goals that apply to the overall MCH goals for tracking purposes. Please review the MCH goals to see if your goal applies: *M:\DOH\OFCHS\Local Site Folders\OCFS Annual Plans*



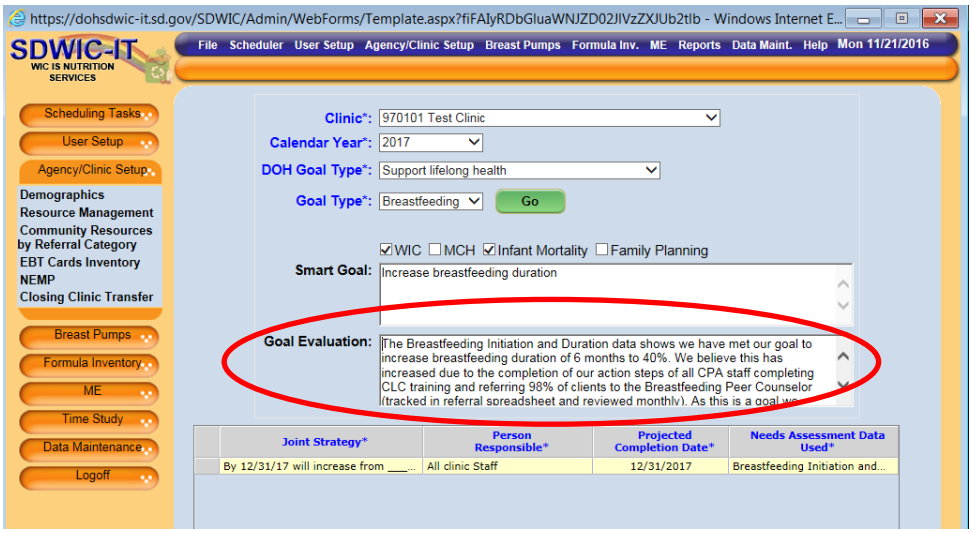
- **Click the green** Go **button.**

Goal:

- The overall Goal will be added to this section. For assistance with the Goal, please refer to the Setting Goals, Joint Strategies, and Action Steps section.
- If combining with another clinic for the NEMP, this must be listed in the Goal section. The largest clinic should list the clinics they are combining with and the smaller clinics should list which plan their data is located in.
  - Example: Belle Fourche creates NEMP and states in Smart Goal area this includes Buffalo and Newell clinics.
  - Note: Buffalo and Newell clinics should put in their NEMP Smart Goal section that they are included in the Belle Fourche plan and to refer to it for information.

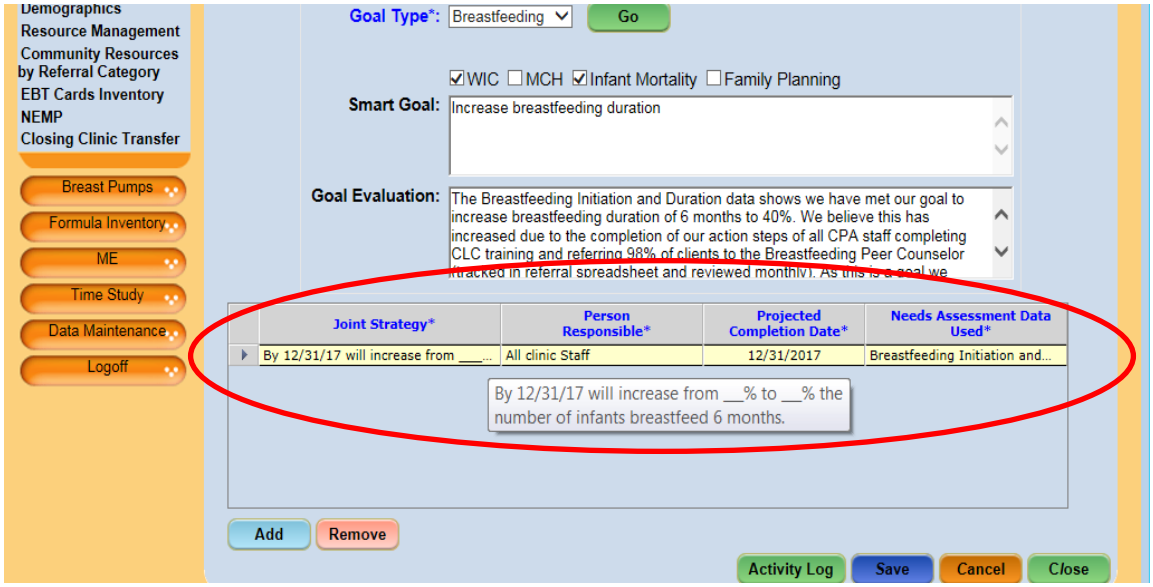


- **Goal Evaluation:** This section will be completed during the evaluation process from January – July the year following implementation. For examples of the information to include here, please

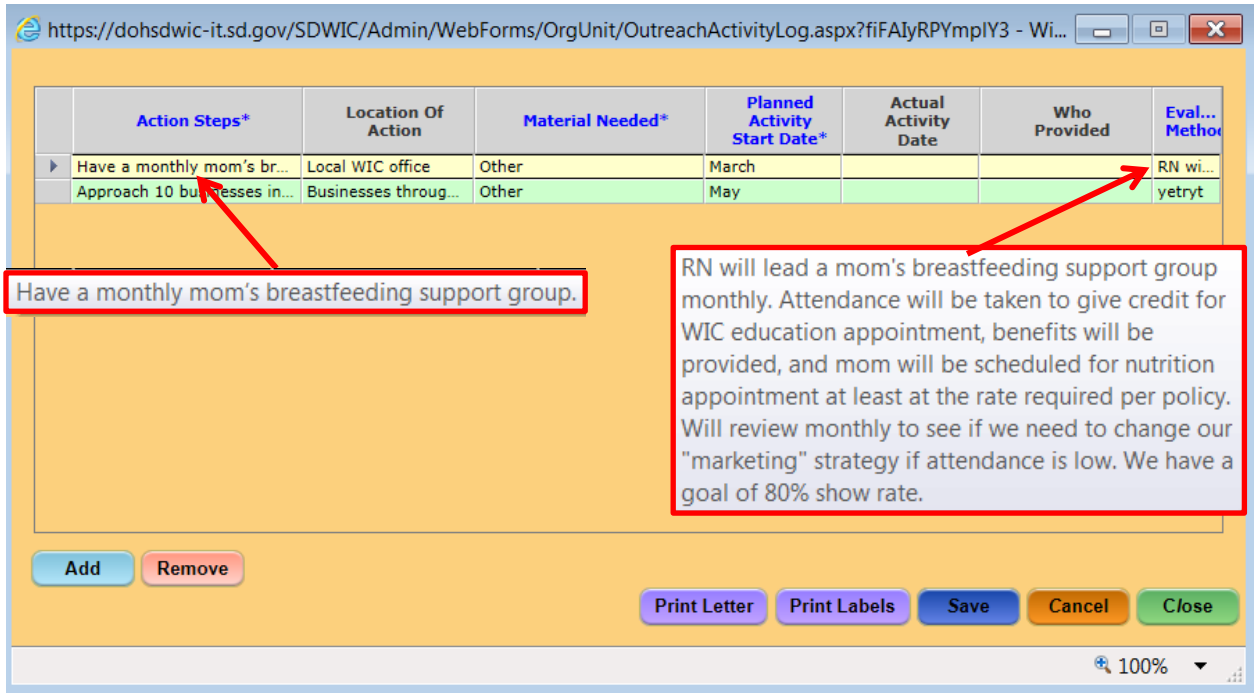


see the Evaluation section.

- **Joint Strategy:**
  - **Click the** Add **button**
  - **Joint Strategy**: Add the appropriate information created in the Joint Strategies section. ****Note if combining with another clinic, the JS must include both sites.**
  - **Person Responsible**: Joint Strategies should include all clinic staff and additional regional staff, if applicable.
  - **Projected Completion Date**: Must be on or before December 31st.
  - **Needs Assessment Data Used**: Community Health Needs Assessment (CHNA) **information and data** used to support a Joint Strategy should be listed here including where the starting data came from and any additional data that will be used for evaluating the goal. Ensure the timeframe of the data is listed (Example 2016 Potential Eligible report). Enter in a narrative explaining the demographic information gathered from the CHNA which applies to that goal. For example, information that would affect Breastfeeding rates, such as hospitals not promoting breastfeeding, would go under the Breastfeeding goal.
    ****Note if combining with another clinic, data from both sites must be included.**
  - **Click** Save **to save information.**



- **Activity Log:**
  - **Select the Row** of the Joint Strategy you would like to add Action Steps to.
  - **Click on the** Activity Log **button**
  - **Click on the** Add **button**
  - **Action Steps:** Enter one action step per line. For more information, see Action Steps.
  - **Location of action**: Where will this take place
  - **Material Needs**: For example, brochures, posters, displays, etc.
  - **Planned Activity Start Date**: List the activity start date. If the action step is one you plan on doing throughout the calendar year, such as tracking the use of the fruit and vegetable CVV, then it would start when the annual NEMP starts in January.
  - **Actual Activity Date**: List the actual activity start date once completed.
  - **Who Provided**: This will be filled in by clinic staff once the action step has been completed.
  - **Evaluation Method**: list the planned evaluation method to be used by the clinic. This must include **when** and **how** the evaluation will take place. Evaluation of Action Steps must be done **at a minimum of quarterly** with date of evaluation entered into this section in SDWIC-IT.
  - **Click** Save **to save information**
  - **Click** Close **to save information and close the Activity Log**
  - **Click** Cancel **to close the Activity Log without saving**
  - **NOTE examples of Action Steps and Evaluation Methods sections are in the screenshot below.



Appendix A: NEMP Clinic Combinations

- Region 1
  - Belle Fourche, Buffalo & Newell
  - Faith, Isabel, Dupree & Timberlake
  - Bison & Lemmon
- Region 2
  - Kimball & Chamberlain
  - Bonesteel & Burke
  - Kadoka & Wanblee
  - Pierre & Murdo
  - Highmore & Miller
- Region 3
  - Eureka & Leola
  - Bowdle, Gettysburg & Ipswich
- Region 4
  - DeSmet & Hayti
  - Howard & Madison
- Region 6
  - Lake Andes & Platte
  - Viborg & Parker

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Appendix B: Community Health Needs Assessment (CHNA) Resources

Table 1. Community Health Needs Assessment Overview

Resources/Assets	
Describe the strengths/weaknesses of county resource network system. Think of the services you routinely recommend that women or children should utilize or receive (dental care, immunizations, well child visits, Head Start, Birth-to-3, Teddy Bear Den, food pantry, mental health). *Is there a local resource or do they need to travel to receive those services? *Is there transportation available to get them there? *Is there a lack of resources in a certain area? (healthy food options)	
Are there breastfeeding education and support services available? What gaps exist in breastfeeding services and resources within your local agency and the community that can be addressed through peer counseling and what improvements in your program are needed?	
Are childbirth education services available?	
Outside of WIC, what nutrition education services are available in the community?	
What are some of the common resources that many of your clients utilize that you could partner with to provide services, put on events, etc.? (e.g. Head Start, SNAP-Ed, a local dental provider, local daycare provider)	
How "healthy" is your community for physical activity and healthy eating? (e.g. sidewalks, access to the gym for walking, lighting, parks/playgrounds, community garden, farmers markets)	
Risk factor behaviors and conditions	
Tobacco use (5,6D)	
Obesity rates (5,14,Reports through SDWIC-IT)	
Alcohol or Drug use (1,5,6A,12)	
Other health related behaviors (5)	
Child health	
Infant mortality rate (6D)	

Low birth weight rates (5, 6D)	
Proportion of women who receive late or no prenatal care (6D)	
Breastfeeding rates (2,3,10,13,14,Reports through SDWIC-IT)	
Teen pregnancy rate (5,6D)	
Demographics and socioeconomic status	
Population size (trends in growth and density)(4,5,6D)	
Racial and ethnic composition (4,5,6D)	
Changes in cultural or ethnic diversity of the county/service area, including socioeconomic or cultural changes within already existing groups(4)	
Socioeconomic status (4,5,6D)	
Academic attainment (4,5)	
Unemployment rate (5,11) *Job availability? DOL	
Age structure (4,6D)	
Gender (4,5)	
Access to Healthcare	
Any openings/closings of area hospitals or clinics?	
Any changes in Doctor or Medical Providers?	
Any changes in dental care in the area? Have dental clinics opened/closed in the area? (5)	
Health Staffing shortages by Health Professional Shortage area (HPSA), Primary Care HPSA, Dental HPSA (5)	
Physicians (M.D.s and D.O.s), Primary care per 10,000 population (5)	
Are the Doctors being replaced with Physician Assistants or Nurse Practitioners?	
Percent uninsured (4,5) Uninsured adults (Ages 18+) Uninsured children (≤17)	
Percent Medicaid and Medicare (11)	
Social environment	
Major change in the agriculture industry—Drought, Flooding, Prices for animals and crops	
Increases in the number of military or other special population eligible for WIC within the counties served by the clinic	
Violent crime rate (5)	

Child abuse rate	
Housing affordability rate (5)	
Health status of overall population and priority population (uninsured, low-income and minority groups)	
Leading causes of death (age-adjusted rates if available) (6D)	
Infectious disease	
Sexually transmitted infection rates (chlamydia, gonorrhea, syphilis) (5, 6D-under Sexually Transmitted Disease>Sexually Transmitted Disease statistics>STD Reports>South Dakota Monthly Disease Summaries)	
HIV incidence rate (Family planning stats, 6D-under HIV/AIDS>HIV/AIDS Surveillance Reports>South Dakota HIV/AIDS Surveillance Report [reports listed by year])	

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Table 2. Data Sources

State and National Data Websites	
1-America's Health Rankings https://assets.americashealthrankings.org/app/uploads/2017annualreport.pdf	
2-CDC Breastfeeding Data – Breastfeeding Report Card https://www.cdc.gov/breastfeeding/data/reportcard.htm	
3-CDC Breastfeeding Data – mPINC https://www.cdc.gov/breastfeeding/data/mpinc/state_reports.html	
4-Census Bureau https://www.census.gov/quickfacts/table/PST045216/00	
5-County Health Rankings http://www.countyhealthrankings.org/	
6-Department of Health – Risk Factors and Vital Statistics ▪ A. Behavioral Risk Factor Surveillance System ▪ B. SD Youth Risk Behavior Survey ▪ C. SD Youth Tobacco Survey ▪ D. SD Vital Statistics (birth, death, marriage, etc.) https://doh.sd.gov/statistics/	
7-Early Care and Education State Indicator Report https://www.cdc.gov/obesity/strategies/ece-state-indicator-report.html	
8-National Healthcare Quality and Disparities Report https://nhqrnet.ahrq.gov/inhqrdr/South%20Dakota/benchmark/summary/All_Measures/All_Topics	
9-The Compendium of Publicly Available Datasets and - Other Data-Related Resources (Compendium) is a free resource that compiles in one place descriptions of and links to 132 public datasets and resources that include information about health conditions and other factors that impact the health of minority populations. http://www.minorityhealth.hhs.gov/npa/templates/browse.aspx?lvl=1&lvlid=46	
10-Pregnancy Risk Assessment Monitoring System (PRAMS) https://doh.sd.gov/statistics/prams.aspx	
11-South Dakota KIDS COUNT http://www.usd.edu/business/south-dakota-kids-count	
12-Surgeon General's Report on Alcohol, Drugs, and Health https://addiction.surgeongeneral.gov/	
WIC Data	
13-Breastfeeding Initiation and Duration Report http://sdwic.org/knowledge/ocfs-annual-plans	This data should be used to set and evaluate your Breastfeeding goal.
14-PEDNSS & PNSS Resource will be added when available	

15-Potential Eligibles (All and breakdown by category) http://sdwic.org/knowledge/ocfs-annual-plans	This data should be used to set and evaluate your Marketing goal.
Reports through SDWIC-IT	
NEMP Needs Assessment: Displays risk code data at the state, clinic level and the Local Agency level **Clinic/Reports/Admin/Needs Assessment** ***Your Clinic** ***Year**	This data should be used to set and evaluate your Nutrition goal.
Participant Survey Summary: Displays the Participant Survey summary totals at state, clinic, local agency and statewide level **Clinic/Reports/Admin/Participant Survey Summary** ***State or LA or Clinic** ***Survey: (Year) WIC Participant Survey**	
Reasons Breastfeeding Ended: Provides the number of clients for each reason why breastfeeding has ended **Clinic/Reports/Breast Pumps/Reasons Breastfeeding Ended** ***State/LA or LA/Clinic** ***Date From to Date Thru (Can look at a full year of data)**	
Client Risk Factor By Category: Provides a list of the number and percentage of clients with each risk factor. **Clinic/Reports/Nutr and Health Summary/Client Risk by Category** ***State or LA**	
Client Risk Factors by Risk: Provides the number of clients by category that have a health risk. The report will display all risk codes. **Clinic/Reports/Nutr and Health Summary** ***Start Date & End Date (Can look at full year of data)** ***State or Region**	
Hemoglobin Daily Summary Report: If you suspect low Hgb. in your clinic **Clinic/Reports/Nutr and Health Summary/ Hemoglobin Daily Summary Report** ***State, LA, or Clinic** ***Start Date & End Date (Can look at a full year of data)**	

High Risk Report: Lists all clients who are considered high risk and are categorized by state, local agency or clinic within a specific date range. **Clinic/Reports/Nutr and Health Summary/High Risk Report** ***State, LA, or Clinic** ***Cert Date From & Cert Date Thru (Can look at full year of data)**	
Family count by Primary Language: Provides a count of families by primary language at the state or local agency level. Languages included are English, Spanish, Arabic, French, Russian, Vietnamese, Korean and other. Used to determine staffing needs. **Clinic/Reports/Participation/Families Count by Primary Language** ***State or LA (Clinics are listed in LA Report)**	
Pregnant Women Expected Delivery Date: Provides a list of Pregnant Women by EDD date range entered. Used for outreach and to make sure follow-up appointments are scheduled. **Clinic/Reports/Participation/Pregnant Women Expected Delivery Date** ***State, LA or Clinic** ***Expected Date From & Expected Date Thru**	
Clients Scheduled Outside the 10/20 Day Limit: Displays a list of all clients scheduled outside the required 10/20 day limit at the clinic, local agency or state level. **Clinic/Reports/Scheduler/Clients Scheduled Outside 10/20 Day Limit** ***State, LA or Clinic** ***Date From & Date to (**Can look at year full of data)	
Show Rate: Compares show and no-show rates by appointment type for a clinic and/or LA. Information provided includes appointment type, number of clients who showed and did not show, the total number of clients for each appointment type (show/no show), the no show rate percentage, and the number of walk-ins. **Clinic/Reports/Scheduler/Show Rate** ***LA or Clinic** ***Date from & Date thru**	

Pre-defined Reports within SDWIC-IT	
****Pre-defined Reports are very versatile. The following is 1 example of how they can be used. If you would like further examples of how this report can be used, please contact the Nutrition Coordinator, Breastfeeding Coordinator, or Program Operations Coordinator.**	
Risk Code Assignment: This will give you the number of total participants that are assigned each risk code at this point in time. FREQUENCY will be reported but NOT percentages. **Clinic/Miscellaneous/Pre-defined Reports** ***Frequency Table** ***State, LA or Clinic** ***Major Characteristics: Risk Code** ***Page 2: Risk Factor: Type in desired risk factor WITHOUT PERIOD (i.e. 11401; not 114.01)** ***Title for Report** ***Submit** **Then run the Priority Enrollment By Category:** **Clinic/Reports/Caseload/Priority Enrollment By Category** ***LA** ***Year** ***Month – previous full month** **Add up the categories for which this code is assigned to (i.e. 11401 is assigned to IBE, IBP, IFF, C1-C4)** **Divide Frequency of risk code from Pre-defined Report by total caseload for all applicable categories.**	

Back to Community Health Needs Assessment

Appendix C: Developing Program Goals and Measurable Joint Strategies

Developing Program Goals and Measurable Joint Strategies

Program goals and joint strategies establish criteria and standards against which you can determine program performance. You will need to identify the goals and joint strategies of the program component or intervention you plan to evaluate.

Goal	Joint Strategy
A broad statement about the long-term expectation of what should happen as a result of your program (the desired result). Serves as the foundation for developing your program joint strategies. **Criteria:** 1) Specifies the problem or related health risk factors; 2) Identifies the target population(s) for your program.	Statements describing the results to be achieved, and the manner in which they will be achieved. You may need multiple joint strategies to address a single goal. **Criteria:** SMART attributes are used to develop a clearly-defined joint strategy.

Attributes of SMART joint strategies:

- **Specific:** includes the "who", "what", and "where". Use only one action verb to avoid issues with measuring success.
- **Measurable:** focuses on "how much" change is expected.
- **Achievable:** realistic given program resources and planned implementation.
- **Relevant:** relates directly to program/activity goals.
- **Time-bound:** focuses on "when" the objective will be achieved.

Examples of SMART joint strategies:

By (month/year), (X%) of providers who reported incorrect gonorrhea treatment in County Z will be contacted within 1 month.

By (month/year), increase the percentage from (X%) to (Y%) of providers in County Z that fully adhere to the CDC-STD treatment guidelines for appropriate treatment of gonorrhea.

Note: Joint Strageties are **different from** listing **Action Steps**. *Joint Strategies* are statements that describe the results to be achieved and help monitor progress towards program goals. *Action Step* are the actual events that take place as part of the program.

Example: Activity versus Joint Strategies

Goal: Reduce gonorrhea rates among male adolescents in County Z.

Action Step: Educate providers on appropriate treatment for gonorrhea.

SMART joint strategy: By (month/year), (X%) of providers who reported incorrect gonorrhea treatment in County Z will be contacted within 1 month.

Back to Setting Goals, Joint Strategies, and Action Steps

Appendix D: Breastfeeding Goal Guidance

Examples			
Goal	Joint Strategy	Action Steps	Evaluation Methods
Increase breastfeeding duration rate	By December 31, 20XX increase the percentage of ever-breastfed infants at 3 months from XX% to XX% (All Xs indicate numbers that can vary from plan to plan.) (Must use NEMP DATA Spreadsheet,> "Breastfeeding tab" found at OCFS Annual Plans & Data on Knowledge Base.)	▪ **REQUIRED**: Provide follow up contact with breastfeeding clients between 0 – 1 month of age to see how breastfeeding is going and offer assistance if needed. ▪ Refer clients interested in or currently breastfeed to Breastfeeding Peer Counselor. ▪ Visit with the local providers (list specific providers) in the community to inform them about WIC services and of avialble Certified Lactation Consultants by (date) ▪ Assist at least 1- 5 local businesses to take the Breastfeeding Friendly Business Initiative Pledge by December 20XX	▪ On a set day of each month run a pre-defined report for participants to contact (Miscellaneous: Pre-defined Reports: Type of report – select "Client Listing;" Organization level – select "Clinic;" on page 2 Age of client select "month; between 0 & 1," on page 3 "WIC Client Category select IBE Infant BF exclusively and IBP Infant BF Partially); from reports can note number of participants to contact and status of contact (left message, reached, phone disconnected, offered assistance, etc.) ▪ Track referrals ▪ Evaluation could be something about who you met with and how you felt the meeting went and if you should meet with different staff next time ▪ Track the number of businesses approached and pledged, who you talked to, think about different ways to approach those that do not pledge and follow up with them. Evaluate by checking

			www.HealthySD.gov/Breastfeeding
		▪ Provide each breastfeeding mom with Breastfeeding-Friendly Mom's Kit. ▪ Provide breastfeeding education classes to PG and PP WIC mothers. ▪ Visit with the local providers (list specific providers) in the community to inform them of available Certified Lactation Consultants in April 20XX ▪ Provide the "Things to Consider When Preparing to Feed Your Infant: Breastfeeding" handout to all new pregnant clients at initial contact in New Pregnant Packet. ▪ Provide an incentive such as a breastfeeding tracking bracelet to mom's who attend breastfeeding class. (Would need to use county money to purchase if you have it or put in request for funding to Central Office if this will be used for educational purposes (i.e. part of a group class. Funding from Central Office is not guaranteed and AS will need to be replaced if funding is not available.)	▪ Track number given and number of PG which reports use ▪ Track number of classes provided/attendance. ▪ Evaluation could something about who you met with and how you felt the meeting went and if you should meet with different staff next time ▪ Track handouts provided/reviewed ▪ Track manually in each office how many are issued each month

Appendix E: Nutrition Goal Guidance

Examples			
Goal	Joint Strategy	Action Steps	Evaluation Methods
Increase child retention	By December 31, will increase participation in C1-C4 clients on the WIC Program from X% to X%. (All Xs indicate numbers that can vary from plan to plan.) (Must use NEMP DATA Spreadsheet, "Nutrition" tab found at OCFS Annual Plans & Data on Knowledge Base.)	▪ **REQUIRED**: Will meet with the staff at XX (name of program) Head Start and create a plan for coordination of services. ▪ Provide nutrition education to parents and children attending XXX (Head Start, Daycare, events in the community etc.) which can also count as a low-risk nutrition education visit if they are enrolled in WIC. ▪ Implement Harvest of the Month as a nutrition class by June 20XX. ▪ Between May 20XX and August 20XX, X% of WIC participants will attend cooking demonstrations through put on by local SNAP-Ed Nutrition Educators featuring vegetables. ▪ Promote use of Cash Value Benefit through implementing grocery store tours as WIC nutrition education visits. ▪ Will create a fun new group discussion lesson plan that encourages parent/child interaction and education provided directly to the child when possible. ▪ Contact local nutrition related entities and establish group of X-X community members and	▪ Evaluation would include meeting minutes with who you met with, how you felt the meeting went and the plan for coordination of services and any additional assistance or supplies you need from the Central Office to support your plan ▪ Location it was provided, how many attended, short opinion survey for parents on: convenience, if they would do it again, topic covered, etc ▪ Was lesson plan created and where to find it. Track attendance and client feedback. ▪ Track attendance of cooking demonstrations ▪ Track CVB redemptions ▪ Date lesson plan created, number of client who attended the class in 2019, 2 question satisfaction survey from clients ▪ Track completion of the grocery store tours/participation

		professionals to work on coordination of services by December 20XX. ▪ Will use new educational tools from Heart Buttons (https://www.heartbuttoncounseling.com/) to provide client-centered, emotional based nutrition education. ▪ Will add telenutrition services to XXX clinic. ▪ Will increase the use of wichealth.org as a nutrition education option from XXX(# of lessons) lessons completed in 20XX (year) to XXX in 20XX. ▪ Set up a mock grocery cart filled with WIC eligible food examples to be displayed in office for nutrition education.	▪ Implementation, how many clients it was used with, client feedback, staff feedback ▪ Implementation, how many clients it was used with, client feedback. ▪ Data pulled from wichealth.org stats ▪ Implementation, how many clients it was used with, client feedback, staff feedback

Appendix F: Marketing Goal Guidance

Examples			
Goal	Joint Strategy	Action Steps	Evaluation Methods
Increase eligible Participants enrolled in WIC	By December 31, XXXX (year), XXX (clinics for this plan) will increase the percentage C1-C4 clients on the WIC Program from X% to X% (list data for each site included in this plan). (All Xs indicate numbers that can vary from plan to plan.) (Must use NEMP DATA Spreadsheet "Marketing" tab" found at OCFS Annual Plans & Data on Knowledge Base.)	▪ **REQUIRED**: Distribute WIC marketing material (current "Pass WIC On" or Child Under 5 poster) to at least 3 businesses/organizations in the community (ex: local clinic, daycares, domestic violence shelter, food pantry, etc.) ▪ Attend 1 Health fair to promote WIC ▪ Promote WIC food packages through bulletin board or poster creation of what is included in WIC food package and examples of other healthy foods you can purchase with the money saved by using WIC.	▪ List date of health fair ▪ Date and Number given out ▪ Poster creation, where and how it was used

State Approved Marketing Materials

- Central Office will provide marketing tools for clinics to publicize the WIC program. These are available for order by clinics through the DOH Distribution Center (Located in Sturgis) through Launchpad.
  - WIC Brochure Healthy Choices for Healthy Families brochures (WIC 026)
  - Pass WIC On (WIC 031)
  - South Dakota WIC Marketing Program posters (WIC 037)
  - Do you Have a Child Under 5 posters (WIC 010)
  - WIC's Role in Reducing Poor Health Outcomes posters (WIC 045 and WIC 046)

- When Public Service Announcements (PSAs) are developed they will be provided to clinics through WIC Memorandums. PSAs created by the central office can be found in M:\DOH\OFCHS\WIC\Media\PSA's.

Refer to the following marketing ideas for action steps:
Action steps specific and tailored to your community. See Action Steps for more information.

Schools

- Distribute WIC information in local schools including elementary, high school, universities, vocational and schools that provide adult education
- Market WIC to Family and Consumer Science classes and give the instructor WIC brochures
- Provide WIC information to new staff at schools
- Provide WIC information to Head Start program
- Distribute WIC information to alternative schools
- Market to fraternity and sorority facilities and organizations
- Contact career learning centers
- Provide WIC information to parents at teacher in-services
- Market to college counselors
- Provide WIC information to after-school programs
- Participate in Health Fairs
- Allow medical, nursing, dietetic students/ interns to gain practice hours in our clinics

Businesses

- Set up informational display at local quick stop business
- Work with local supermarkets for distribution of WIC marketing flier in the grocery bags
- Provide a "services available" display for break room of businesses who employ young parents
- Provide a presentation about services to the employers and/or employees of a large business or corporation
- Provide WIC information to local community Chamber of Commerce
- Promote WIC to loan officers at the bank, i.e. agriculture loan officers
- Place WIC posters in various businesses

Health Care Facilities

- Target WIC Program marketing to physicians and the medical community
- Provide WIC information to local hospitals and medical clinics
- Provide WIC information to nursing homes to reach young employees or grandparents
- Promote WIC at prenatal classes
- Provide WIC information to childbirth classes
- Market WIC to medical students
- Offer to do a bulletin board about WIC and its services at healthcare facilities
- Provide WIC information to a Wellness Center
- Place WIC Program marketing materials in local pharmacies
- Educate other health care workers about WIC services available
- Place WIC Program marketing materials in Family Planning clinics

- Offer WIC information to hospital chaplains
- Coordinate with physicians on WIC services and breastfeeding support

Clinics

- Post WIC office schedules in clinic
- Promote WIC along with other activities such as Immunizations, Bright Start, Well Baby, Baby Care, etc.
- Have a special event at the clinic and give out WIC information
- Promote National Nutrition Month, Fruit and Vegetable Month and WIC foods that support these activities
- Promote World Breastfeeding Week
- Set up booth at craft fairs to promote WIC Program
- Set up a display at a local health fair or other large community gathering
- Promote WIC in a community parade
- Market WIC at Farm and Home Show
- Coordinate activities with Extension Services, Expanded Foods & Nutrition Education (EFNEP) and Family Nutrition Program (i.e. cooking classes, recipes, etc.)
- Consider use of volunteers for distribution of program promotional information in the community
- Meet with the local Interagency Networks and present information about the programs
- Do call reminders to clients about their upcoming appointments
- Send a "We Missed You" note to client who misses an appointment
- Consider an "open house" in your facility
- Conduct focus group interviews with program clients to gain insight about utilization of services
- Consider involvement in or coordination of development of community support groups that reach target audiences, i.e. pregnant women/teenagers, infants
- Consider marketing at facilities where the younger population socialize
- Be creative working on techniques to get clients to come in for appointments and receive checks, i.e. office hour flexibility
- Have time set aside at staff meetings to share marketing ideas or to discuss what could be done for marketing activities

Media

- Provide WIC office schedules to local media
- Promote the sdwic.org website and the South Dakota WIC Facebook page
- PSA of breastfeeding mom who shows support received from WIC
- Article in newspaper/newsletter that reaches ranchers and farmers
- Work with the local newspaper for a feature story about services available in your office
- Ask local radio stations to do PSA's or special interview type programs
- Ask local radio to do spot announcements of the Clinic
- Encourage local news to do stories on "How Working Families Can Apply for WIC" and other services available
- For PSAs created by the Central Office in audio and written form, please see M:\DOH\OFCHS\WIC\Media\PSA's.
  ***When planning to work with the media to promote WIC, contact the Department of Health Public Information Officer at (605) 773-4967.**

Migrants

- Provide WIC information to employers who hire migrant farm workers
- Market to migrant farm workers by placing WIC information in camps, schools, SNAP offices, grocery stores, laundromats or Head Start centers
- Contact farm worker groups to reach migrant participants

Organizations

- Provide WIC information to:
  - Food pantry
  - Local community health council
  - Clubs that include young moms or grandparents
  - Women centers and shelters
  - Day care facilities
  - Clergy
  - Foster parents through foster parent programs
  - Ministerial association
  - Local shelters
  - Rotary club
  - Jaycees
  - Good Will
  - Salvation Army
  - Interagency meetings
  - Senior centers whose clientele can share information with family members
  - Kiwanis organizations

Other Government Agencies

- Promote WIC as an agriculture (USDA) funded program
- Promote WIC at local Farm Service Agencies
- Attend commissioner's meetings to share information about the WIC Program
- Distribute income information to low income housing facilities
- Provide WIC information to Share Programs to be put in food boxes
- Offer WIC marketing materials to the Department of Social Services
- Speak to the National Guard about services available
- Coordinate with Indian Health Services, Extension Services, etc. on the WIC Program services and breastfeeding support
- Place program marketing materials at Job Service
- Offer WIC information to Tribal Head Start
- Place WIC marketing poster in Post Office