Oregon MCH Title V Priority Area: Adolescent Well Visit

Inputs	Strategies	Sample Activities	Outputs (Process Measures)	Short term outcomes	*Intermediate Outcomes*	*Long term outcomes*
Staffing & expertise • Program Assessment, Evaluation, EPI • Managers • Nurses Funding / resources • Title V • Medicaid • Other Partnerships within agency • Healthy Communities • SBHCs • Nurses Community partnerships • Schools • Districts • School Nurses • SBHCs • CCOs • Private Insurance • Local Pediatric Practices	1. Increase outreach to key populations in community. This could include raising awareness of importance of well care and leveraging SBHCs to conduct outreach.	- Work with local youth-serving organizations, CCOs, community providers, SBHCs and schools to disseminate consistent messaging for providers, youth and families. - Promote adolescent well visits with children aged 12-17 coming in to the local/tribal health agency for family planning visits, WIC, etc. - Conduct education and awareness activities within the school (i.e. presentations in health classes, assemblies).	1.1 Number of outreach, social media, or educational activities completed.	- Increased number of clinics with youth friendly, confidential services - Increased number of visits that combine sports physical with adolescent well visit - Increased knowledge among providers, parents, youth, and other stakeholders of barriers to adolescent health - Increased knowledge among providers, parents, youth, and other stakeholders of adolescent well visits in underserved areas and among underserved populations - Increased communication between schools, the health care system, and public health	- National Performance Measure 10: Percent of adolescents, ages 12-17 with a preventive medical visit in the past year. - Increase in youth centered and youth friendly spaces in the health care environment	- Improved adolescent physical health - Improved adolescent mental health - Improved adolescent sexual/reproductive health - Improved social connectedness and resiliency among adolescents - Improved educational outcomes for adolescents including reduction in chronic absenteeism and improved high school completion rates
	2. Promote practice of going beyond sports physicals to wellness exams.	- Partner with schools and CCOs to provide and promote adolescent well care visits in place of sports physical s - Work with partners (including SBHC) to develop policy that aligns providing sports physical and annual adolescent well care visits in same visit.	2.1 Percent of SBHC patients with an adolescent well visit. 2.2 Number of providers trained. 2.3 Number of policies developed or implemented			
	3. Develop and strengthen partnerships with public and private entities invested in adolescent health.	- Convene partners from local youth-serving organizations, CCOs, community providers, SBHCs and schools to identify shared goals and resources.	3.1 Number of new partnerships developed or further established.			
	4. Promote policies and practices to make health care more youth-friendly. Including engaging youth as peer health educators.	- Support and train youth as peer educators. - Partner with CCOs, local providers, SBHCs to deliver patient-modeled youth-led training of providers (i.e. Adolescent Health Care Communication Training). - Help create or support a youth advisory council for local SBHC or other community clinic.	4.1 Number of policies developed or implemented 4.2 Number of youth engaged as peer health educators			

Data • Oregon Healthy Teens Survey • CCO data Evidence base / best practice • AAP	5. Investigate barriers to adolescent well visits.	- Partner with local organizations to hold a listening session to understand youth's experience of care.	5.1 Number of youth, providers or other partners surveyed to identify barriers 5.2 Number of activities completed to address identified barriers	
	6. Strengthen health care privacy and confidentiality policies and practices.	- Align policies and practices to support implementation of HB 2758 and incorporate best practices as recommended by American Academy of Pediatrics.	6.1 Number of policies developed or implemented 6.2 Number of clinical procedures improved.	

Oregon MCH Title V Priority Area: Breastfeeding

Inputs	Strategies	Sample Activities	Outputs (Process Measures)	Short term outcomes
Staffing & expertise • Programs • Assessment, Evaluation, Epi • Managers • Community Health Workers Funding / resources • Title V • WIC • Other Partnerships within agency • Healthy Communities • WIC • Other	1. Increase the number of fathers, non-nursing partner and family members, especially grandmothers, who learn about the importance of breastfeeding	- Educate family support members to understand breastfeeding importance - Provide outreach to families to encourage accompanying mothers who attend breastfeeding classes / support - Provide community awareness activities	1.1 Percent of pregnant & breastfeeding women whose family member participated in classes/support. 1.2 Number of community awareness events	- Increased knowledge about importance of breastfeeding - Improved attitudes about breastfeeding - Increased skill and capacity in support of breastfeeding - Increased community engagement and partnerships for breastfeeding support - Increased or improved policies and programs supportive of breastfeeding
	2. Fill unmet needs for peer support of breastfeeding	- Provide quality breastfeeding support groups led by trained peer facilitators - Support & fund CBOs to promote / support breastfeeding among communities of color - Collaborate with CBOs & hospitals to support creation and/or maintenance of mother-to-mother support groups - Establish referral pathways from hospital to community for all types of lactation care	2.1 Number of mother-to-mother peer support groups established	
	3. Educate pregnant women about breastfeeding	- Provide breastfeeding education that promotes self-efficacy, especially for pregnant teens and underserved women - Ensure that new mothers are educated about the use of breast pumps and have access to resources supporting breastfeeding initiation and duration - Collaborate with hospitals, primary care providers, and CCOs to expand structured prenatal breastfeeding education	3.1 Percent of pregnant & breastfeeding women provided breastfeeding education 3.2 Number of agreements with partners about breastfeeding education	

Intermediate Outcomes
National Performance Measure 4A: Percent of infants who are ever breastfed National Performance Measure 4B: Percent of infants breastfed exclusively through 6 months Improved environments for breastfeeding support Strengthened workforce capacity of breastfeeding providers Empowered families and communities are able to access breastfeeding support

Long term outcomes
- Reduced infant mortality - Decreased risk of SIDS - Reduced risk of infant morbidity - Reduced risk of chronic disease later in life for both infant and mother - Reduced risk of post-partum depression - Strengthen responsive feeding and parenting style supporting parent-child attachment - Healthy brain development

Community partnerships • Health care providers • Hospitals • Local breastfeeding coalitions • Early Learning partners • CCOs • Local business community • County planning • Other Data • State and national performance measures • Community Health Assessments • Community Health Improvement Plans • Census • CDC Breastfeeding Report Card Evidence base / best practice • Surgeon General's Call to Action to Support Breastfeeding • The CDC Guide to Strategies to Support Breastfeeding Mothers and Babies	4. Increase workforce support for breastfeeding through training and access to high quality services	- Provide professional breastfeeding support that is accessible, timely and culturally appropriate for all women served - Train health care staff about breastfeeding - Collaborate with organizations that provide breastfeeding support - Support partnerships to increase the number of racial and ethnic minority IBCLCs - Train staff to ensure minimum competency & skills in lactation care are met - Train public health home visiting nurses to become IBCLCs - Improve access to professional lactation support through work with local CCO	4.1 Percent of staff who meet minimum competency in lactation care. 4.2 Number of community HCP trained 4.3 Number of staff supported to obtain IBCLC 4.4 Number of agreements with partners / CCO to provide professional lactation support	
	5. Increase access to workplace breastfeeding support	- Address barriers to breast pump access and ensure breast pump education - Foster community partnerships in promotion and adoption of lactation accommodation laws - Provide education & TA about benefits of comprehensive, high-quality support for breastfeeding employees - Promote innovative programs that allow mothers to directly breastfeed their babies after they return to work - Develop and implement workplace policy and practice tools for employer breastfeeding support	5.1 Number of breastfeeding workplace support policies adopted / implemented	
	6. Increase the support of breastfeeding at child care settings through policy, training, and workforce development	- Train public health staff to provide consultation or coaching to ECE providers - Provide TA & training to ECE providers to ensure high quality resources & training are available to implement breastfeeding support	5.2 Percent of child care providers who have received training or coaching 5.3 Number of child care providers who have adopted / implemented breastfeeding support policies	

Oregon MCH Title V Priority Area: Culturally and Linguistically Appropriate Services (CLAS)

Inputs	Strategies	Sample Activities	Outputs (Process Measures)	Short term outcomes
Staffing & expertise • Programs • Health Equity Workgroup • Community Health Workers **Funding / resources** • Title V • Other **Partnerships within agency** • Office of Equity and Inclusion • AGRH Health Equity Group • PHD Health Equity Workgroup **Community partnerships** • Regional Health Equity Coalitions • Coalition of Communities of Color	1. Provide effective, equitable, understandable, and culturally responsive services	- Develop and implement community health worker model to provide culturally responsive services to diverse communities - Include traditional cultural practices in community engagement, program development and service provision. - Inform all individuals of availability of language assistance services clearly and in their preferred language	1.1 Number of culturally responsive practices or policies implemented 1.2 Number of clients served by culturally responsive services	- Increased availability of culturally and linguistically responsive services and programs for individuals and communities to access - Increase in traditional cultural practices being included in maternal and child health programs - Increased comprehensive understanding of cultural responsiveness by maternal and child health staff and providers - Increased understanding of community and agency needs related to culturally and linguistically responsive services
	2. Develop and improve organizational policy, practices, and leadership to promote CLAS and health equity and infuse them throughout all planning and operations	- Require mandatory cultural competence trainings (annual) - Adopt recruitment and hiring policies that promote staff diversity - Require/support continuing education and language training for staff - Require diversity training as part of new employee orientation - Continuing education credits for cultural competency training - Diversity training as part of new employee orientation - Continuing education credits for cultural competency training - Hiring staff who represent the diversity of the community. - Designate funds for diverse hiring policies. - Assign a staff member to oversee diverse recruiting - Training staff to develop cultural agility. - Flexibility around cultural holidays or important community events - Offer incentives and advancement opportunities to diverse staff	2.1 Number of culturally responsive practices or policies developed and promoted 2.2 Number of providers or staff trained in cultural responsiveness	

Intermediate Outcomes

- State Performance Measure 3A: Percent of children age 0 - 17 years who have a healthcare provider who is sensitive to their family's values and customs
- State Performance Measure 3B: Percent of new mothers who have ever experienced discrimination while getting any type of health or medical care
- Improved experience of maternal and child health and other health systems by historically underserved/unserved communities

Long term outcomes

- Elimination of maternal and child health disparities
- Improved health of women, children and families in Oregon

Data • State and national performance measures • Organization assessment data **Evidence base / best practice** • Think Cultural Health (HHS) • National CLAS standards		3. Conduct ongoing assessments of the organizations' CLAS related activities and integrate CLAS related measures into CQI activities	- Conduct initial organizational assessment for equity to identify agency strengths and barriers to equity - Recruitment and hiring policies that promote staff diversity - Non-discrimination policies that prohibit discrimination based on race, ethnicity, language spoken and personal characteristics - Create conflict- and grievance-resolution processes that are culturally and linguistically appropriate to identify, prevent and resolve conflicts or complaints.	3.1 Number of assessments conducted to examine CLAS related activities 3.2 Number of policy or practice changes implemented based on assessments of CLAS activities	

Priority Area: Oral Health

Inputs	Strategies	Sample Activities	Outputs (Process Measures)	Short-Term Outcomes	Intermediate Outcomes	Long-Term Outcomes

Staffing & expertise
• Programs
• Managers
• Assessment, Evaluation & Epidemiology
• Home Visiting Nurses
• Community
• Health Workers
• Outreach/Referral Coordinators
 	
Funding / resources
• Title V
• Other
 	
Partnerships within agency
• Nurse Home Visiting Programs
• Oregon MothersCare Program
• WIC Program
• Primary Care Clinic
• Dental Clinic
• SBHC
 	
Community partnerships
• OHA Oral Health Program
• CCOs
• Dental Care Organizations
• FQHCs
• Rural Health Centers
• Tribal Health Centers
• Primary Care Providers
• Dental Providers
• Women's Health & OBGYN Providers
• Pediatricians
• Schools
	1. Provide oral health preventive services (e.g. screenings and fluoride varnish) or education & referral/case management services through Oregon's Home Visiting System	- Provide oral health screenings & preventive services (i.e. fluoride varnish) to clients
		- Provide oral health education & referral/case management services to clients
		- Sponsor a "First Tooth" and/or "Maternity: Teeth for Two" Training for staff
			1.1 Percent of home visiting clients who have received oral health preventive services
			1.2 Percent of home visiting clients who have received oral health referral & education
			1.3 Number of providers or staff who have received oral health related training
				- Improved awareness & understanding of oral health by providers and clients
				- Increased access to preventive oral health services provided by health care providers
				- Increased community engagement & partnerships for oral health
				- Increased oral health services through community clinics, including SBHCs
				- Policies that support optimal oral health such as water fluoridation
					- National Performance Measure 13A: Percent of women who had a dental visit during pregnancy
					- National Performance Measure 13B: Percent of children 0-17 who had a preventive dental visit in the past year
					- Public Health Accountability Metric: Dental visits among children 0-5 years old
					- Increased oral health integration & coordination of care
						- Improved oral health across the lifespan, including:
						  - Women have improved oral health during pregnancy and postpartum
						  - Children have fewer decayed teeth or cavities
						- Improved oral health equity
						- More public water districts are fluoridated

	2. Provide oral health preventive services during well-child visits as recommended in the American Academy of Pediatrics (AAP) Bright Futures Guidelines	- Provide oral health screenings & preventive services during well-child visits - Sponsor a "First Tooth" training for staff and/or providers in the county - Build partnerships to encourage oral health preventive services during well-child visits	2.1 Number of children who have received oral health preventive services such as screening or fluoride varnish 2.2 Number of providers or staff who have received oral health related training			
	3. Collaborate with primary care providers to follow the American Congress of Obstetricians & Gynecologists (ACOG) oral health recommendations for pregnant women	- Implement ACOG oral health recommendations - Sponsor a "Maternity: Teeth for Two" training for staff and/or providers in the county - Build partnerships to encourage implementation of ACOG recommendations	3.1 Number of pregnant women who have received oral health referral & education 3.2 Number of providers or staff who have received oral health related training 3.3 Percent of providers that have implemented ACOG oral health recommendations for pregnant women			
	4. Incorporate oral health preventive services for adolescents into School-based Health Centers (SBHCs) & adolescent well care visits	- Provide oral health screenings & preventive services during the adolescent well care visit - Provide oral health education & referral services to adolescents	4.1 Number of adolescents who have received oral health preventive services such as screening or fluoride varnish 4.2 Number of adolescents who have received oral health referral or education			

Inputs	Strategies	Sample Activities	Outputs (Process Measures)	Short-Term Outcomes	Intermediate Outcomes	Long-Term Outcomes
• SBHCs • Oral Health Coalitions • Oregon Oral Health Coalition (OrOHC) • City Council Data • State & National Performance Measures • Public Health Accountability Metrics • Medicaid Data • Oregon Smile Survey • Community Health Assessments • Community Health Improvement Plans Evidence base / best practice • Guide to Community Preventive Services • American Academy of Pediatrics (AAP) • American Academy of Pediatric Dentistry • American College of Obstetricians & Gynecologists (ACOG) • Association of State & Territorial Dental Directors (ASTDD) • American Dental Association • National Maternal & Child Oral Health Resource Center		- Build community partnerships to incorporate oral health preventive services into SBHCs & adolescent well care visits	4.3 Number of providers or staff who have received oral health related training			
	5. Educate pregnant women, parents/caregivers of children, & children 0-17 about oral health & the importance of dental visits	- Incorporate oral health education & referral services into all programs administered - Develop & distribute culturally appropriate oral health education materials, toolkits, etc. - Register to be an outreach partner & promote the Text4baby program - Develop & facilitate an oral health coalition	5.1 Number of clients who have received oral health preventive services, referral, or education 5.2 Number of oral health educational materials developed or trainings conducted			
	6. Promote community water fluoridation (CWF)	- Build community partnerships to promote CWF through education & policy change - Develop culturally appropriate CWF education materials & messages - Collaborate with the local City Council to fluoridate the city's water supply	6.1 Number of public water systems that are optimally fluoridated 6.2 Percent of residents on public water systems receiving fluoridated water 6.3 Number of fluoridation related policy briefs, educational materials, presentations, or trainings developed & disseminated			

Oregon MCH Title V Priority Area: Food Insecurity

Inputs	Strategies	Sample Activities	Outputs (Process Measures)	Short term outcomes	*Intermediate Outcomes*	*Long term outcomes*
Staffing & expertise • Programs • Assessment, Evaluation, Epi • Managers • Community Health Workers Funding / resources • Title V • WIC • Other Partnerships within agency • Healthy Communities • SBHC • WIC Community partnerships • DHS (Snap & Snap-Ed) • Schools (school meals) • Child care (child and adult care food program) • Early Learning • Local food pantries	1. Screen & Intervene: screen clients for food insecurity & provide referrals for food assistance	- Implement a validated food insecurity screening tool - Address client factors that may increase vulnerability to health impacts of food insecurity - Link clients / families to resources - Provide food prescription/ medically-tailored meal program for vulnerable populations - Conduct food insecurity screening across a targeted population - Support / promote community partners to conduct screening - Promote health care facilities to implement universal food insecurity screening - Provide training to improve referral/intervention - Establish referral pathways to community resources & food assistance programs	1.1 Percent of clients that are screened for food insecurity 1.2 Percent of clients with positive food insecurity screenings that are referred to resources	- Increased knowledge about importance of food security - Improved attitudes about food security - Increased skill in support of food security - Increased community engagement and partnerships for food security - Increased or improved policies and programs supportive of food security	State Performance Measure 2A: Percent of households experiencing food insecurity State Performance Measure 2B: Percent of households with children < 18 years of age experiencing food insecurity - Improved environments for supporting food security - Strengthened workforce capacity to address food insecurity - Empowered families and communities are able to access safe, healthy and culturally acceptable food	- Reduced risk of poor health status, developmental delays, obesity, poor growth, malnutrition - Reduced risk of behavioral and mental health conditions (e.g. depression, anxiety, stress) - Reduced risk of poor educational outcomes
	2. Support or provide food security education	- Sponsor education programs in the community - Reduce barriers to class attendance through enabling services - Sponsor community based education and outreach campaign - Provide training for health care staff about food insecurity & related issues	2.1 Percent / Number of clients /community members who received education 2.2 Number of education &/or outreach campaigns sponsored 2.3 Percent of staff trained			

• Local Extension services • Farmers & Farmers Markets • County Planning • Food Policy Council • Other Data • State and national performance measures • Community Health Assessments • Community Health Improvement Plans • Census • USDA household food insecurity • Feeding America's Map the Meal Gap Evidence base / best practice • Promoting Food Security for All Children, American Academy of Pediatrics Policy Statement • Oregon Title V Strategies: Food Insecurity Toolkit	3. Increase access to healthy, affordable food, (including food assistance safety net programs)	- Develop partnerships to address barriers in accessing food resources - Promote access to fruits & vegetables - Conduct outreach and education - Engage in local needs assessment or planning process - Sponsor volunteers/interns to provide outreach and strengthen partnerships - Engage schools in access to healthy food through school-based policies	3.1 Number of community partnerships strengthened/ developed with focus on improving access to healthy food 3.2 Percent of clients provided with access to affordable healthy food 3.3 Number of needs assessment or policy planning processes engaged in 3.4 Number of outreach or education activities conducted	
	4. Increase economic stability for individuals and families	- Promote savings & asset building programs for individuals & families - Promote & provide outreach about income-support programs	4.1 Number of promotion activities targeting savings & asset building programs for individuals & families 4.2 Number of outreach activities that promote income support programs	

Oregon MCH Priority Area: Physical Activity

Inputs	*Strategies*	*Sample Activities*	*Outputs*	*Short term Outcomes*
Staffing & expertise • Programs • Assessment, Evaluation, Epi • Managers • Community Health Workers Funding / resources • Title V • Other Partnerships within agency • Healthy Communities • SBHC Community partnerships • Schools • Districts • EI/ECSE/SpEd • County planning • County transportation • Police • Safe Kids Coalitions Data • State and national performance measures • Community Health Assessments	1. Support physical activity in child care settings through policy, training and workforce development	- Provide TA and training to ECE providers - Provide coaching for implementation - Provide TA and support for policy development and implementation	1.1 Number of policies or policy briefs developed, promoted, or implemented 1.2 Number of providers trained	- Increased knowledge about importance of physical activity - Improved attitudes about physical activity - Increased community engagement and partnerships for physical activity - Increased and/or improved policies supportive of physical activity - Increased access to physical activity choices - Increased resources for the promotion of physical activity
	2. Support physical activity before, during and after school, for all children, including those with special needs	- Participate in School Wellness committees to strengthen policies - Develop and support SRTS programs - Develop and support joint use agreements - Partner with education partners on training for staff and inclusion of physical activity goals in IEPs and 504 plans	2.1 Number of new partnerships developed with schools/districts 2.2 Number of schools/districts that have adopted physical activity policies 2.3 Number of joint use agreements	
	3. Improve the physical environment for physical activity	- Participate in land use, planning, and transportation meetings - Inventory and map community to identify needed improvements	3.1 Number of completed maps, inventories, or assessments 3.2 Number of new partnerships developed	
	4. Increase safe and active transportation options	- Promote and grow active transportation options for all ages - Participate in land use, planning, and transportation meetings - Be the voice of “health at all tables”	4.1 Number of opportunities to inform strategic direction in community, or to convene and influence decisions 4.2 Number of schools/districts that have increased safe and active transportation options	
	5. Promote policies and programs for healthy worksites, with a focus on physical activity	- Provide TA and support in healthy worksite policy development and implementation	5.1 Number of presentations re: policy change 5.2 Number of sites w/ policy change 5.3 Number of new policies in place	

Intermediate Outcomes
- National Performance Measure 8: Percent of children ages 6-11 who are physically active at least 60 minutes per day - More opportunities for age-appropriate, enjoyable, varied physical activity - More safe and active transportation options

Long term outcomes
- Decreased overweight and obesity among children - Improved emotional health - Healthier bones, muscles, joints - Better brain development - Better grades in school - Better classroom behaviors - Strengthened social skills - Lifelong improved health

• Community Health Improvement Plans • Census Evidence base / best practice • Community Guide • AAP	6. Promote partnerships with clinical care providers to support anticipatory guidance and implementation of AAP guidelines for physical activity for children	- Promote Rx to Play, or similar - Engage medical providers in community campaigns - Engage providers in promoting AAP guidelines for physical activity for children with special health needs	6.1 Number of partnerships developed 6.2 Number of providers engaged in promoting and implementing physical activity guidelines for children	

Oregon MCH Title V Priority Area: Smoking

Inputs	Strategies	Sample Activities	Outputs (Process Measures)	Short term outcomes
Staffing & expertise • Programs • Nurse Supervisors, Managers • Home Visitors Funding / resources • Title V Partnerships within agency • TPEP • Community Partner Enrollment Assisters • Family Planning • WIC • OMC Community partnerships • CCOs, DCOs • Providers • Retail Tobacco • Early Childhood Providers Data • State and National Performance Measures • Community	1. Develop a policy agenda that decreases youth exposure to tobacco products and decreases likelihood for initiation and use.	- Develop a policy agenda decreasing youth exposure to tobacco for the county. - Collaborate with TPEP staff to work in restricting retail environments in dispensing tobacco to adolescents. - Develop a plan to counter retail price reductions at the county level	1.1 Number of policies developed, implemented or promoted. 1.2 Number of partnerships developed or strengthened.	- Increased capacity across health care and public health to decrease youth and pregnant individuals' exposure to tobacco - Increased provider ability to provide cessation best practices for pregnant individuals - Increased percent of pregnant individuals who use tobacco engaged in smoking cessation programs - Improved understanding by pregnant individuals who use tobacco on how to utilize their health care coverage cessation programs
	2. 5As Intervention and Quit Line Referral (or other customized Evidence-Informed Program) within MCH Programs including Home Visiting, Oregon MothersCare, Family Planning, and WIC (if applicable)	- Obtain 5As and MI training. - Conduct the 5As intervention at every visit or encounter with an MCH client. - Develop a workplan for implementing and conducting customized, evidenced-based program. - Ensure use of the Five A's Intervention Record Tracking Form for every MCH client. - Ensure that every woman who smokes has received quit line information. - Participate in continuous quality improvement regarding 5As provision to clients. - Promote provider use of quit line fax and EHR referrals for pregnant women who smoke. - Provide incentives to pregnant women for use of the quit line (additional phone minutes).	2.1 Percent of clients receiving 5A's intervention. 2.2 Percent of clients referred to Quit Line.	
	3. Collaborate w/CCOs, DCOs, medical and early childhood/education providers to build screening and intervention processes into their work practices, including workforce training.	- Attend 5As and MI Training to gain screening and referral expertise. - Engage CCOs, DCOs, ELC's and/or medical and early childhood/education providers as partners and encourage building screening and intervention processes into medical practices. - Organize training activities for CCOs, DCOs, ELCs, and/or medical and early childhood/education providers. - Liaison with providers to encourage them to provide consistent, ongoing screening and intervention to clients.	3.1 Number of partnerships developed or strengthened. 3.2 Number of processes developed or improved. 3.3 Number/percent of providers, partners or staff trained.	

Intermediate Outcomes
- National Performance Measure 14A: Percent of women who smoke during pregnancy - National Performance Measure B: Percent of children who live in households where someone smokes - Public Health Accountability Metric: Percent of adults who smoke cigarettes

Long term outcomes
- Decreased adverse birth outcomes - Decrease in developmental impacts of tobacco on children - Decrease in infant mortality - Decrease in chronic disease and cancer - Improvement in lifelong and multigenerational health - Improved life expectancy

Health Assessments • Community Health Improvement Plans • Oregon Tobacco Facts Evidence base / best practice • Community Guide • ACOG • Oregon HERC • Healthy People 2020		4. Promote health insurance coverage benefits for pregnant and postpartum women and promote their utilization.	- Ensure that MCH population is made aware of tobacco cessation benefits for the Oregon Health Plan - Develop communication messages regarding tobacco cessation benefits for pregnant women. - Provide materials to MCH population who smokes enrolling in OHP regarding cessation insurance benefit coverage.	4.1 Number/percent of women educated about insurance coverage. 4.2 Number of social media, outreach, or educational campaigns regarding insurance benefits	

Oregon MCH Title V Priority Area: Trauma, ACEs and resilience

Inputs	Strategies	Sample Activities	Outputs (Process Measures)	Short term outcomes
Staffing & expertise • MCH Program • Assessment, evaluation, epi • Managers • Community health workers Funding / resources • Title V • Other Partnerships within agency • MIECHV • WIC Community partnerships • Schools • Social services • Mental health • Early education • Businesses • CCOs' • Primary care	1. Promote family friendly policies that decrease toxic stress and adversity, increase economic stability, and promote health.	- Partnerships to develop policy initiatives, support paid family leave, promote earned income tax credit, etc. - Provide data on health impact of family friendly policies. - Develop and implement family friendly internal agency policies to support employees and clients (e.g. flexible scheduling)	1.1 Number of policies developed or promoted 1.2 Number of partnerships developed or strengthened	- Increased knowledge about NEAR science and the health impact of trauma and adversity among caregivers, community, and professionals - Improved knowledge/skills in parent and child development among caregivers, communities, and professionals - Increased availability of trauma informed MCH systems and services - Increased capacity of families and partner agencies to engage in supporting early childhood policies and initiatives - Increase in number of family friendly policies that prevent toxic stress and promote resilience at the agency, community, or state level - Increased parent-child attachment and bonding
	2. Increase understanding of NEAR science (neurobiology, epigenetics, ACEs and resilience), and the impact of childhood adversity on lifelong health.	- Develop public awareness/social marketing campaigns, - Conduct outreach/community education events - Deliver presentations to providers and partners (NEAR science, public health approaches to prevent ACEs and promote resilience)	2.1 Number of events or education campaigns 2.2 Number or percent of providers or staff trained 2.3 Number of people reached through outreach or education	
	3. Engage partners to build capacity for safe, connected, equitable and resilient communities.	- Mobilize community partners (including CCOs and EL Hubs). - Convene coalitions, inter-agency collaborations, and cross-systems initiatives to prevent/address trauma and ACEs and promote resilience. - Implement community level equity initiatives, trauma and violence prevention programs, etc. - Work with partners to create safer public spaces and opportunities for connection to community, spirituality and culture; ensure equitable access to affordable housing, jobs, schools, transportation, healthy food, clean air and water and concrete supports for families in need.	3.1 Number of partnerships developed or strengthened 3.2 Number of projects /coalitions convened or implemented with partners	

Intermediate Outcomes

- State Performance Measure 1A: Percent of new mothers who experienced stressful life events before or during pregnancy
- State Performance Measure 1B: Increased social support for parents of young children
- Reduced family violence and child abuse
- Increase in children protected from ACES
- On track early childhood development
- Increased neighborhood safety and community connection
- Enhanced community capacity to support families
- Improved parental capabilities and economic stability
- Trauma-informed workforce, workplaces and services

Long term outcomes

- Resilient and connected families and communities
- Safe and supportive environments
- Children flourishing
- Improved lifelong physical, social-emotional, and mental health

Data • Community health assessments • Community health improvement plans • State and national surveys • Community partners Evidence base / best practice • Trauma Informed Oregon • CDC • Harvard Center for the Developing Child • ACES connection	4. Conduct assessment, surveillance, and epidemiological research. Use data and NEAR science to drive policy decisions.	- Conduct community needs assessment and/or surveys; - Develop policy briefs using state and local data; present to policy makers to inform policy, funding, and program decisions impacting children, youth and families. - Engage communities to ensure that the data is accessible and useful to them; - Use Oregon Health Authority REAL D protocols for data collection whenever possible; - Conduct community based participatory research	4.1 Number of needs assessments, surveys, or other data gathering activities conducted 4.2 Number of policy briefs, data or educational tools developed 4.3 Number of community members engaged in research activities	
	5. Develop trauma-informed workforce, workplaces, systems, and services.	- Train providers in trauma and trauma-informed care, - Integrate principles of TIC into agency policies and practices; - Make changes in workplaces and service settings to prevent re-traumatization. Integrate TI and culturally-specific approaches into services and systems for children, youth and families. - Identify children, youth and families experiencing adversity and refer them to needed supports and services. - Develop culturally and linguistically competent systems to screen and refer for adversity including food and diaper insecurity, ACEs, homelessness, depression, etc. - Provide screening in home visiting, health and other settings; - Use community health workers, home visitors, etc. to support families to access services.	5.1 Number / percent of providers or staff trained 5.2 Number of trauma informed or culturally responsive approaches integrated 5.3 Number / percent of clients who have received screening, referrals, or education	
	6. Strengthen protective factors for individuals and families.	- Support programs that: build parent capabilities, children's social emotional competence, supportive/nurturing relationships; and/or foster connection to community, culture and spirituality. (e.g. home visiting, parenting education, comprehensive early care and education, community respite programs, and culturally-specific evidence-based social support and mental health practices.	6.1 Number of individuals served by programs that build family or community protective factors 6.2 Number of activities that build family or community protective factors	

Priority: Well Woman Care

Inputs	Strategies	Sample Activities	Outputs (Process Measures)	Short term outcomes
Staffing & expertise • MCH and Reproductive Health Staff Funding / resources • Title V • Other Partnerships within agency • WIC • Clinical Services Community partnerships • Clinicians • Home Visiting Programs Data • State and national performance measures Evidence base / best practice • CDC • ACOG	1. Case-management to improve utilization of well-woman care	Collaborate with MCH home visiting programs to implement a strategy for increasing awareness of the importance of and supporting access to appropriate well-woman and pre/interconception care among clients.	1.1 Number/percent of clients with referral to or facilitation of well woman visit 1.2 Number/percent of clients asked the One Key Question 1.3 Number/percent of clients with completed annual well woman visit.	- Increase in knowledge of importance of well woman care among women and providers - Improved system coordination between public health and the health care system to facilitate well woman care - Reduction or removal of barriers to well woman care - Improved provider skills in delivery of high quality and culturally responsive well woman care - Increase in percent of women with health care coverage
	2. Increase the number of persons covered by health insurance to improve access to well-woman care	Provide outreach for insurance enrollment and referral to services Policy strategies that increase insurance coverage and address churn for pregnant women.	2.1 Number of outreach campaigns 2.2 Number of individuals reached by outreach campaigns	
	3. Use traditional and social marketing to educate the population and promote well woman care	Expand public education and decrease stigma about preconception and well-woman care through traditional and social media.	3.1 Number of traditional or social marketing campaigns 3.2 Number of individuals reached by traditional or social marketing campaigns	
	4. Provide education/training on preconception/ interconception and well woman care for health care providers	Provide education/training to improve comfort, knowledge and skills to provide appropriate culturally and linguistically appropriate pre/interconception and well woman care. Promote pregnancy intention screening as a part of routine well woman care.	4.1 Number/percent of providers or staff trained	
	5. Support access to well-woman care through Family Planning Clinics	Collaborate with Family Planning Clinics to promote and facilitate access to well woman care as a routine part of reproductive health visits.	5.1 Number/percent of clients with referral to or facilitation of well woman care services	

Intermediate Outcomes

National Performance Measure 1: Increase in the percent of women with a past year preventive visit.

Public Health Accountability Metric: Increased effective contraception use among women.

Increase in women receiving recommended clinical preventive services, screening and management of chronic conditions.

Improved preconception health for women.

Increase in intended pregnancies.

Long term outcomes

- Improved health among women including decreased chronic disease and decrease in high risk health behaviors
- Decreased maternal mortality and morbidity
- Increased healthy birth outcomes
- Decreased infant mortality

		6. Use of the postpartum health care visit to increase utilization of well-woman visits.		Collaborate with primary care, prenatal care providers and CCOs to develop and implement a plan to improve postpartum visit content and attendance. Collaborate with MCH home visiting programs to implement a strategy for supporting access to postpartum care among clients.		6.1 Number/percent of clients with referral to or facilitation of postpartum checkup 6.2 Number/percent of clients with completed postpartum checkup		