<table>
<thead>
<tr>
<th>Inputs</th>
<th>Strategies</th>
<th>Sample Activities</th>
<th>Outputs (Process Measures)</th>
<th>Short term outcomes</th>
<th>Intermediate Outcomes</th>
<th>Long term outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staffing &amp; expertise • Program Assessment, Evaluation, EPI • Managers • Nurses</td>
<td>1. Increase outreach to key populations in community. This could include raising awareness of importance of well care and leveraging SBHCs to conduct outreach.</td>
<td>- 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).</td>
<td>1.1 Number of outreach, social media, or educational activities completed.</td>
<td>- 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</td>
<td>- 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</td>
<td></td>
</tr>
<tr>
<td>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</td>
<td>2. Promote practice of going beyond sports physicals to wellness exams.</td>
<td>- Partner with schools and CCOs to provide and promote adolescent well care visits in place of sports physicals. - Work with partners (including SBHC) to develop policy that aligns providing sports physical and annual adolescent well care visits in same visit.</td>
<td>2.1 Percent of SBHC patients with an adolescent well visit.</td>
<td>2.2 Number of providers trained. 2.3 Number of policies developed or implemented</td>
<td>- 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</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Develop and strengthen partnerships with public and private entities invested in adolescent health.</td>
<td>- Convene partners from local youth-serving organizations, CCOs, community providers, SBHCs and schools to identify shared goals and resources.</td>
<td>3.1 Number of new partnerships developed or further established.</td>
<td>4.1 Number of policies developed or implemented 4.2 Number of youth engaged as peer health educators</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4. Promote policies and practices to make health care more youth-friendly. Including engaging youth as peer health educators.</td>
<td>- 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.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

February 2018
<table>
<thead>
<tr>
<th>Data</th>
<th>5. Investigate barriers to adolescent well visits.</th>
<th>6. Strengthen health care privacy and confidentiality policies and practices.</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Oregon Healthy Teens Survey</td>
<td>- Partner with local organizations to hold a listening session to understand youth's experience of care.</td>
<td>- Align policies and practices to support implementation of HB 2758 and incorporate best practices as recommended by American Academy of Pediatrics.</td>
</tr>
<tr>
<td>• CCO data</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evidence base / best practice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• AAP</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>5.1 Number of youth, providers or other partners surveyed to identify barriers</td>
<td>6.1 Number of policies developed or implemented</td>
</tr>
<tr>
<td></td>
<td>5.2 Number of activities completed to address identified barriers</td>
<td>6.2 Number of clinical procedures improved.</td>
</tr>
</tbody>
</table>
## Oregon MCH Title V Priority Area: Breastfeeding

### Inputs

- Staffing & expertise
  - Programs
  - Assessment, Evaluation, Epidemiology
  - Managers
  - Community Health Workers
- Funding / resources
  - Title V
  - WIC
  - Other
- Partnerships within agency
  - Healthy Communities
  - WIC
  - Other

### Strategies

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

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

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

### Sample Activities

- 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
- 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
- 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

### Outputs (Process Measures)

1.1 Percent of pregnant & breastfeeding women whose family member participated in classes/support
1.2 Number of community awareness events
2.1 Number of mother-to-mother peer support groups established
3.1 Percent of pregnant & breastfeeding women provided breastfeeding education
3.2 Number of agreements with partners about breastfeeding education

### Short term outcomes

- 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

### 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

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

February 2018
<table>
<thead>
<tr>
<th>Inputs</th>
<th>Strategies</th>
<th>Sample Activities</th>
<th>Outputs (Process Measures)</th>
<th>Short term outcomes</th>
<th>Intermediate Outcomes</th>
<th>Long term outcomes</th>
</tr>
</thead>
</table>
| Staffing & expertise  
- Programs  
- Health Equity Workgroup  
- Community Health Workers | 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 | - Increased availability of culturally and linguistically responsive services and programs for individuals and communities to access | - 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 | - Elimination of maternal and child health disparities  
- Improved health of women, children and families in Oregon |
| Funding / resources  
- Title V  
- Other | | | 1.2 Number of clients served by culturally responsive services | | |
| Partnerships within agency  
- Office of Equity and Inclusion  
- AGRH Health Equity Group  
- PHD Health Equity Workgroup | | | 2.1 Number of culturally responsive practices or policies developed and promoted | | |
| Community partnerships  
- Regional Health Equity Coalitions  
- Coalition of Communities of Color | 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 | 2.2 Number of providers or staff trained in cultural responsiveness | | |

**February 2018**
<table>
<thead>
<tr>
<th>Data</th>
<th>Evidence base / best practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>• State and national performance measures</td>
<td>• Think Cultural Health (HHS)</td>
</tr>
<tr>
<td>• Organization assessment data</td>
<td>• National CLAS standards</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Conduct ongoing assessments of the organizations’ CLAS related activities and integrate CLAS related measures into CQI activities</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>- Conduct initial organizational assessment for equity to identify agency strengths and barriers to equity</td>
<td>3.1 Number of assessments conducted to examine CLAS related activities</td>
</tr>
<tr>
<td>- Recruitment and hiring policies that promote staff diversity</td>
<td>3.2 Number of policy or practice changes implemented based on assessments of CLAS activities</td>
</tr>
<tr>
<td>- Non-discrimination policies that prohibit discrimination based on race, ethnicity, language spoken and personal characteristics</td>
<td></td>
</tr>
<tr>
<td>- Create conflict- and grievance-resolution processes that are culturally and linguistically appropriate to identify, prevent and resolve conflicts or complaints.</td>
<td></td>
</tr>
</tbody>
</table>
## Priority Area: Oral Health

### Inputs
- 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

### Strategies

1. Provide oral health preventive services (e.g. screenings and fluoride varnish) or education & referral/case management services through Oregon's Home Visiting System

2. Provide oral health preventive services during well-child visits as recommended in the American Academy of Pediatrics (AAP) Bright Futures Guidelines

3. Collaborate with primary care providers to follow the American Congress of Obstetricians & Gynecologists (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

### Sample Activities

- 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
- 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
- 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
- Provide oral health screenings & preventive services during the adolescent well care visit
- Provide oral health education & referral services to adolescents

### Outputs (Process Measures)

1. Number of home visiting clients who have received oral health preventive services
2. Number of home visiting clients who have received oral health referral & education
3. Number of providers or staff who have received oral health related training
4. Number of children who have received oral health preventive services such as screening or fluoride varnish
5. Number of providers or staff who have received oral health related training
6. Number of pregnant women who have received oral health referral & education
7. Number of providers or staff who have received oral health related training
8. Percent of home visiting clients who have received oral health preventive services
9. Percent of home visiting clients who have received oral health referral & education
10. Number of providers or staff who have received oral health related training

### Short-Term Outcomes
- Improved awareness & understanding of oral health by providers and clients
- Improved 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

### Intermediate Outcomes
- 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

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

February 2018
## Oregon MCH Title V Priority Area: Food Insecurity

<table>
<thead>
<tr>
<th>Inputs</th>
<th>Strategies</th>
<th>Sample Activities</th>
<th>Outputs (Process Measures)</th>
<th>Short term outcomes</th>
<th>Intermediate Outcomes</th>
<th>Long term outcomes</th>
</tr>
</thead>
</table>
| Staffing & expertise • Programs • Assessment, Evaluation, Epi • Managers • Community Health Workers | 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 meal program  
- 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 | - 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 |
| Funding / resources • Title V • WIC • Other | 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 | 2. Support or provide food security education | 2.1 Percent / Number of clients /community members who received education  
2.2 Number of education & outreach campaigns sponsored | | |
| Partnerships within agency • Healthy Communities • SBHC • WIC | 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 & outreach campaigns sponsored  
2.3 Percent of staff trained | | | |
| 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 |
|---|---|
| 4. Increase economic stability for individuals and families | - Promote savings & asset building programs for individuals & families  
- Promote & provide outreach about income-support programs |
| 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 |  |
| 4.1 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
- **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

### Strategies
- **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

- **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

- **3. Improve the physical environment for physical activity**
  - Participate in land use, planning, and transportation meetings
  - Inventory and map community to identify needed improvements

- **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”

- **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

### Sample Activities
- Provide TA and training to ECE providers
- Provide coaching for implementation
- Provide TA and support for policy development and implementation

### Outputs
- **1.1 Number of policies or policy briefs developed, promoted, or implemented**
- **1.2 Number of providers trained**
- **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**
- **3.1 Number of completed maps, inventories, or assessments**
- **3.2 Number of new partnerships developed**
- **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**
- **5.1 Number of presentations re: policy change**
- **5.2 Number of sites w/ policy change**
- **5.3 Number of new policies in place**

### Short term Outcomes
- 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

### 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

---

February 2018
<table>
<thead>
<tr>
<th>6. Promote partnerships with clinical care providers to support anticipatory guidance and implementation of AAP guidelines for physical activity for children</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Promote Rx to Play, or similar</td>
</tr>
<tr>
<td>- Engage medical providers in community campaigns</td>
</tr>
<tr>
<td>- Engage providers in promoting AAP guidelines for physical activity for children with special health needs</td>
</tr>
</tbody>
</table>

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
- Staffing & expertise
  - Programs
  - Nurse Supervisors, Managers
  - Home Visitors
- Funding / resources
  - Title V
- Partnerships within agency
  - TPEP
  - Community Partner Enrollment Assistors
  - Family Planning
  - WIC
  - OMC
- Community partnerships
  - CCOs, DCOs
  - Providers
  - Retail Tobacco
  - Early Childhood Providers
- Data
  - State and National Performance Measures
  - Community

### Strategies
1. Develop a policy agenda that decreases youth exposure to tobacco products and decreases likelihood for initiation and use.

### Sample Activities
- 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.

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)

### Outputs (Process Measures)
1. Number of policies developed, implemented or promoted.
2. Number of partnerships developed or strengthened.

### Short term outcomes
- 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.
- Improved life expectancy.

### Intermediate Outcomes
- 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.

### Data
- State and National Performance Measures
- Community
<table>
<thead>
<tr>
<th>Health Assessments</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Community Health Improvement Plans</td>
</tr>
<tr>
<td>• Oregon Tobacco Facts</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Evidence base / best practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Community Guide</td>
</tr>
<tr>
<td>• ACOG</td>
</tr>
<tr>
<td>• Oregon HERC</td>
</tr>
<tr>
<td>• Healthy People 2020</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Inputs</th>
<th>Strategies</th>
<th>Sample Activities</th>
<th>Outputs (Process Measures)</th>
<th>Short term outcomes</th>
<th>Intermediate Outcomes</th>
<th>Long term outcomes</th>
</tr>
</thead>
</table>
| 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) | - 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) | 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 | - Enhanced community capacity to support families  
- Improved parental capabilities and economic stability  
- Trauma-informed workforce, workplaces and services | - Resilient and connected families and communities  
- Safe and supportive environments  
- Children flourishing  
- Improved lifelong physical, social-emotional, and mental health |
|  | 2. Increase understanding of NEAR science (neurobiology, epigenetics, ACEs and resilience), and the impact of childhood adversity on lifelong health.  
- 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. | - 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 | 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 | - 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 | - Resilient and connected families and communities  
- Safe and supportive environments  
- Children flourishing  
- Improved lifelong physical, social-emotional, and mental health |
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

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.

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.)

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

5.1 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

6.1 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
<table>
<thead>
<tr>
<th>Priority: Well Woman Care</th>
</tr>
</thead>
</table>

### Inputs
- 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

### Strategies
1. **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.

2. **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.

3. **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.

4. **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.

5. **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.

### Sample Activities

### Outputs (Process Measures)
1. **1.1 Number/percent of clients with referral to or facilitation of well woman visit**
2. **1.2 Number/percent of clients asked the One Key Question**
3. **1.3 Number/percent of clients with completed annual well woman visit.**

### Short term outcomes
- 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

### 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
<table>
<thead>
<tr>
<th>6. Use of the postpartum health care visit to increase utilization of well-woman visits.</th>
<th>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.</th>
<th>6.1 Number/percent of clients with referral to or facilitation of postpartum checkup 6.2 Number/percent of clients with completed postpartum checkup</th>
</tr>
</thead>
</table>