Oregon's 2021-2025 MACH Title V Priorities, strategies, local activities, measures, and resources

Women's and Infant Health

Priority: Well Woman Care

Performance measure: Percent of women with a past year preventive visit

State lead: Anna Stiefvater

Well Woman Care – Strategy #1: Strengthen early identification of and supports for women's behavioral health needs.

Foundational area: Policy and Systems

State lead: Anna Stiefvater

Related Foundational Priorities:

☐SDOH-E ☒ Toxic stress/trauma/ACEs ☐CLAS

Local Level Activities	Local measures	Resources
1. Conduct and/or fund culturally specific behavioral health outreach and education efforts among perinatal populations.	a. Number of culturally specific outreach or education efforts/activities/campaigns b. Number of individuals engaged by outreach or education efforts/activities/campaigns	NAMI Black/African American resources: https://www.nami.org/Your-Journey/Identity-and-Cultural-Dimensions/Black-African-American Sista Afya: https://www.sistaafya.com/resources-information NAMI Latinx/Hispanic resources: https://www.nami.org/Your-Journey/Identity-and-Cultural-Dimensions/Latinx-Hispanic Familias en Acción MH resources: https://www.familiasenaccion.org/mental-health-latinx-community-resources/ Orgs working to promote BIPOC MH: https://www.self.com/story/bipoc-mental-health-coronavirus National Maternal Mental Health Hotline: https://mchb.hrsa.gov/national-maternal-mental-health-hotline/faq
2. Develop, implement and/or fund behaviorist models in primary care, hospital and perinatal care settings.	a. Number of behaviorist models implemented b. Number of clients served by behaviorist model c. Number of health care partners engaged	Yamhill County maternal medical home (Healthy Futures program): https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/HEALTHSYSTEMTRANSFORMATION/Documents/success-stories/case-study-yamhill.pdf
3. Implement screening and referrals for	a. Number of clients screened b. Number of clients referred	ACOG Implementing Perinatal Mental Health Screening https://www.acog.org/programs/perinatal-mental-health/implementing-perinatal-mental-health-screening PSI screening resources: https://www.postpartum.net/professionals/screening/

perinatal mood disorders in clinical and community settings.		
4. Partner with and/or fund community-led efforts to provide trauma-informed, culturally specific and/or peer-delivered behavioral health services for perinatal populations.	a. Number of community partners engaged b. Number of perinatal clients served by community-led behavioral health services	Well Mama (Lane County): https://www.wellmama.help/ Baby Blues Connection (Statewide): http://www.babybluesconnection.org/ Postpartum Support International: https://www.postpartum.net/locations/oregon/ OHSU Avel Gordly Center for Healing (Portland): https://www.ohsu.edu/brain-institute/ohsu-avel-gordly-center-healing-portland

Well Woman Care – Strategy #2: Support advanced training, coaching and quality improvement activities for home visitors related to well woman care.

Foundational area: Workforce capacity & effectiveness

State lead: Anna Stiefvater

Related Foundational Priorities:

☒SDOH-E ☒ Toxic stress/trauma/ACEs ☒CLAS

Local Level Activities	Local measures	Resources
1. Provide or arrange for Home Visiting staff to attend training and participate in quality improvement activities that work	a. Number of home visiting staff trained b. Number of improvements implemented	Resources: Healthy Start Benchmark, Well Woman Care: http://www.healthystartepic.org/wp-content/uploads/2018/03/Well_Woman_visit508.pdf Examples: • Establish a process in your program or workflow to screen participants annually on whether they have had a well woman visit in the past year. • Establish referral systems with local health care providers to coordinate well woman visits for Healthy Start participants.

towards increasing the number of home visiting clients that receive an annual preventive visit.		
2. Provide or arrange for Home Visiting staff to attend training and participate in quality improvement activities that work towards increasing the number of home visiting clients that receive a post-partum care visit	a. Number of home visiting staff trained b. Number of improvements implemented	Resources: Healthy Start Benchmark, Postpartum Care: http://www.healthystartepic.org/wp-content/uploads/2018/03/Postpartum_visit508.pdf Examples (Healthy Start): • Establish a scheduling practice to refer or coordinate a postpartum visit for clients as they near delivery. • Implement an outreach process to remind clients of an upcoming postpartum visit with a health care provider (e.g., reminder calls/ postcards/ texts).

Well Woman Care – Strategy # 3: Ensure access to culturally responsive preventive clinical care for low income and undocumented women.

Foundational area: Community, individual & family capacity

State lead: Anna Stiefvater

Related Foundational Priorities:

☐SDOH-E ☐ Toxic stress/trauma/ACEs ☒CLAS

Local Level Activities	Local measures	Resources
1. Partner with organizations and shelters that serve unhoused people to ensure access for preventive reproductive care	a. Number of organizations and shelters partnered with b. Number of houseless individuals referred to preventive care	Evidence: Health Care for the Homeless, American Journal of Public Health: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3969140/ Health Care for Homeless Women: https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2013/10/health-care-for-homeless-women
2. Support patient reminder/recall systems, provider education, and implementation of a designated clinic/extended hours at Reproductive Health Clinics.	a. Number of patient reminder/invitation systems implemented b. Number of clients receiving reminder c. Number of providers trained d. Number of designated clinics/clinics with extended hours	Evidence: MCH Evidence, Well Woman Care: https://www.mchevidence.org/tools/npm/1-well-woman-visit.php
3. Provide outreach and education to support access to health coverage and health care.	a. Number of outreach efforts implemented b. Number of individuals reached	Resources: Oregon Community Partner Outreach Program: https://oregoncpop.org/ Oregon Health Care: https://healthcare.oregon.gov/Pages/index.aspx 12 month postpartum coverage by Oregon Health Plan: https://content.govdelivery.com/accounts/ORDHS/bulletins/3199f94 Reproductive Health Client Services: https://www.oregon.gov/oha/PH/HEALTHYPEOPLEFAMILIES/REPRODUCTIVESEXUALHEALTH/OREGONCONTRACEPTIVECARE/Pages/index.aspx

4. Provide community education on well-woman visits and woman's health.	a. Number of individuals receiving education b. Number of educational activities/events/campaigns	Evidence: MCH Evidence, Well Woman Care: https://www.mchevidence.org/tools/npm/1-well-woman-visit.php Resources: Show Your Love Campaign: https://showyourlovetoday.com/ Preconception Infant Mortality CoIIN: Preconception Infant Mortality CoIIN Black Maternal Health Week social media toolkit: https://blackmamasmatter.org/2023-black-maternal-health-week/ Advancing Reproductive Health, Rights and Justice with Local Resolution toolkit: https://www.nirhealth.org/wp-content/uploads/2018/03/NIRH_NCJW_LocalResolutions_Toolkit_2017.pdf Women's Preventive Services Institute: https://www.womenspreventivehealth.org/ Examples (Healthy Start): http://www.healthystartepic.org/wp-content/uploads/2018/03/Well_Woman_visit508.pdf • Organize a group model for 6-7 mother/baby dyads that come together for 8-9 sessions to focus on well-woman and well-baby care. • Provide outreach and education to promote awareness on the role of preventive well woman visits among community partners and in the community. • Distribute preconception/interconception health materials at community events such as Farmer's Markets, community baby shower, beauty and nail salons, and school open houses.

Well Woman Care – Strategy #4: Establish community based perinatal, women's and infant health advisory groups to share best practices, strategize and impact policy change. Engage affected communities including people of color in leadership.

Foundational area: Community, individual & family capacity

State lead: Anna Stiefvater

Related Foundational Priorities:

☒SDOH-E ☒ Toxic stress/trauma/ACEs ☒CLAS

Local Level Activities	Local measures	Resources
1. Convene or participate in a local community based perinatal, women's and infant health advisory group	a. Number of partners convened b. Number of advisory group meetings attended	Example: Southern Oregon Perinatal Task Force: https://hccso.org/perinatal-task-force/ Note: Recommend doing activity 2 with activity 1.
2. Engage and pay community members to participate in and lead community based advisory groups.	a. Percent of advisory group consisting of community members b. Number of community members financially supported to participate in advisory groups c. Number of community members supported through training or tools to participate in advisory groups	Resources: Family Engagement and Leadership, AMCHP: http://www.amchp.org/programsandtopics/family-engagement/Pages/default.aspx Family Voices: https://familyvoices.org/