

Oregon’s 2021-2025 MACH Title V Priorities, strategies, local activities, measures, and resources (rev 1/14/22)

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 |
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| 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 |
| 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 perinatal mood disorders in clinical and community settings. | a. Number of clients screened b. Number of clients referred | OPC Family Well Being Assessment: https://oregonperinatalcollaborative.org/initiative/fwba/ ACOG perinatal depression screening guidance: https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/11/screening-for-perinatal-depression |

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| | | PSI screening resources: https://www.postpartum.net/professionals/screening/ Perinatal Depression Screening and Referral Project, AMCHP Innovation Station: http://www.amchp.org/programsandtopics/BestPractices/InnovationStation/ISDocs/Perinatal-Depression-Screening-Referral_2015.pdf |
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| 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.wellmamaoregon.com/ 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 Culturally Specific BH resources (Portland and Statewide): https://multco.us/novel-coronavirus-covid-19/culturally-specific-behavioral-health-resources Northwest Portland Area Indian Health Board: http://www.npaihb.org/maternal-child-health/#dQXpnSDm |
| <p>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</p> | | |
| <div style="border: 1px solid black; padding: 5px; background-color: #f9f9f9;"> <p>Related Foundational Priorities:</p> <p><input checked="" type="checkbox"/> SDOH-E <input checked="" type="checkbox"/> Toxic stress/trauma/ACEs <input checked="" type="checkbox"/> CLAS</p> </div> | | |
| 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 towards increasing the number of home visiting clients that receive an annual preventive visit. | a. Number of home visiting staff trained b. Number of improvements implemented | Healthy Start Benchmark, Well Woman Care: http://www.healthystartepic.org/wp-content/uploads/2018/03/Well_Woman_visit508.pdf Examples: <ul style="list-style-type: none"> • 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. |
| 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 | a. Number of home visiting staff trained b. Number of improvements implemented | Healthy Start Benchmark, Postpartum Care: http://www.healthystartepic.org/wp-content/uploads/2018/03/Postpartum_visit508.pdf Examples (Healthy Start): <ul style="list-style-type: none"> • Establish a scheduling practice to refer or coordinate a postpartum visit for clients as they near delivery. |

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| visiting clients that receive a post-partum care visit | | <ul style="list-style-type: none"> Implement an outreach process to remind clients of an upcoming postpartum visit with a health care provider (e.g., reminder calls/ postcards/ texts). |
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| <p>Well Woman Care – Strategy # 3: Support efforts to improve diversity in the workforce Foundational area: Workforce capacity & effectiveness State lead: Anna Stiefvater</p> <div style="border: 1px solid black; padding: 5px; margin: 10px auto; width: fit-content;"> <p>Related Foundational Priorities:</p> <p><input type="checkbox"/> SDOH-E <input type="checkbox"/> Toxic stress/trauma/ACEs <input checked="" type="checkbox"/> CLAS</p> </div> | | |
| Local Level Activities | Local measures | Resources |
| 1. Support CHWs and doulas working with the MCH population in becoming an OHA certified Traditional Health Worker. | <p>a. Number of community health workers participating in trainings leading to certification as a traditional health worker</p> <p>b. Number of community health workers certified as traditional health workers</p> | <p>OEI Traditional Health Worker certification website: https://www.oregon.gov/oha/OEI/Pages/THW-Become-Certified.aspx</p> <p>Oregon Community Health Work Association: https://www.orchwa.org/</p> |
| <p>Well Woman Care – Strategy # 4: Ensure access to culturally responsive preventive clinical care for low income and undocumented women Foundational area: Community, individual & family capacity State lead: Anna Stiefvater</p> <div style="border: 1px solid black; padding: 5px; margin: 10px auto; width: fit-content;"> <p>Related Foundational Priorities:</p> <p><input type="checkbox"/> SDOH-E <input type="checkbox"/> Toxic stress/trauma/ACEs <input checked="" type="checkbox"/> CLAS</p> </div> | | |
| Local Level Activities | Local measures | Resources |
| 1. Partner with organizations and shelters that serve unhoused people to ensure access for preventive reproductive care | <p>a. Number of organizations and shelters partnered with</p> <p>b. Number of houseless individuals referred to preventive care</p> | <p>Evidence: Health Care for the Homeless, American Journal of Public Health: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3969140/</p> |

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| <p>2. Implement a patient reminder/invitation system at Reproductive Health Clinics to improve access to Well Woman Care.</p> | <p>a. Number of patient reminder/invitation systems implemented b. Number of clients receiving reminder</p> | <p>Evidence: MCH Evidence, Well Woman Care: https://www.mchevidence.org/tools/npm/1-well-woman-visit.php</p> |
| <p>3. Partner with Coordinated Care Organization to promote, incentivize and support attendance at postpartum visits.</p> | <p>a. Number of CCOs partnered with b. Number of efforts/campaigns implemented in partnership with CCOs c. Percent of CCO clients attending postpartum visit</p> | <p>Timeliness of Postpartum Care Technical Assistance, OHA Transformation Center: https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Timeliness-Postpartum-Care.aspx</p> |
| <p>4. Provide community education on well-woman visits and woman’s health.</p> | <p>a. Number of individuals receiving education b. Number of educational activities/events/campaigns</p> | <p>Evidence: MCH Evidence, Well Woman Care</p> <p>Resources: Show Your Love Campaign: https://showyourlovetoday.com/ Preconception Infant Mortality CoIIN: Preconception Infant Mortality CoIIN National Women’s Law Center Toolkit: https://nwlc.org/sites/default/files/v1_nwlc_providerwellwomantoolkit_0.pdf Black Maternal Health Week social media toolkit: https://blackmamasmatter.org/bmhw/toolkit/ 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</p> <p>Examples (Healthy Start): http://www.healthystartepic.org/wp-content/uploads/2018/03/Well_Woman_visit508.pdf</p> <ul style="list-style-type: none"> • 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. |

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Well Woman Care – Strategy #5: 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/ |