February 9, 2016, 9:00-4:00

Maternal and Child Health Title V Block Grant Grantee Meeting

Wilsonville Training Center, room 108B, Clackamas Community College
29353 Town Center Loop East, Wilsonville, OR 97070

GOALS

- Discuss changes in Oregon's Title V program
- Provide guidance for planning, implementing, measuring and reporting Title V funded activities
- Identify and address local Title V grantee needs related to the new priorities, strategies and measures

AGENDA

▶ **Welcome, introductions and agenda overview**
Cate Wilcox, Oregon Health Authority, Public Health Division, & Diana Bianco, Artemis Consulting

▶ **MCH Title V Block Grant 3.0: Where we are and how we got here**
Cate Wilcox, Marilyn Hartzell, Office for Children and Youth with Special Health Needs (OCCYSHN) & Nurit Fischler, Oregon Health Authority, Public Health Division

▶ **MCH Title V local grantee implementation guidelines**
Lindsey Manfrin, Co-chair, CLHO Healthy Families & Cate Wilcox

▶ **Overview of national MCH priorities and strategies for Oregon***
- » Well woman care - Anna Stiefvater
- » Breastfeeding – Robin Stanton
- » Physical activity for children – Heather Morrow-Almeida
- » Adolescent well-visit – Liz Thorne
- » Oral health – Amy Umphlett
- » Smoking – Lesa Dixon-Gray
- » Q & A

**Note: Title V work on the two priorities for Children and Youth with Special Healthcare Needs - medical home and transition to adulthood - is funded and managed through OCCYSHN and will not be substantively addressed at this meeting.*

Break

▶ **National priorities learning opportunity – Rotating topic groups**
- » Visit four tables, spending 20 minutes at each to learn about the priorities and strategies

Networking lunch (12:30-1:30)

▶ **State-specific priorities learning opportunity – Rotating topic groups**
Overview
- » Toxic stress, trauma and adverse childhood experiences – Nurit Fischler
- » Food insecurity and nutrition – Robin Stanton
- » Culturally and linguistically responsive services – Wendy Morgan

▶ **Planning tools and technical assistance needs**
Nurit Fischler & Maria Ness, Oregon Health Authority, Public Health Division

▶ **Team work**
- » Work with your county or neighboring counties/tribes to discuss next steps

▶ **Summary and next steps**
Diana Bianco & Cate Wilcox

Oregon Health Authority

Maternal and Child Health Title V Grantee Meeting
Participant List

2/9/2016

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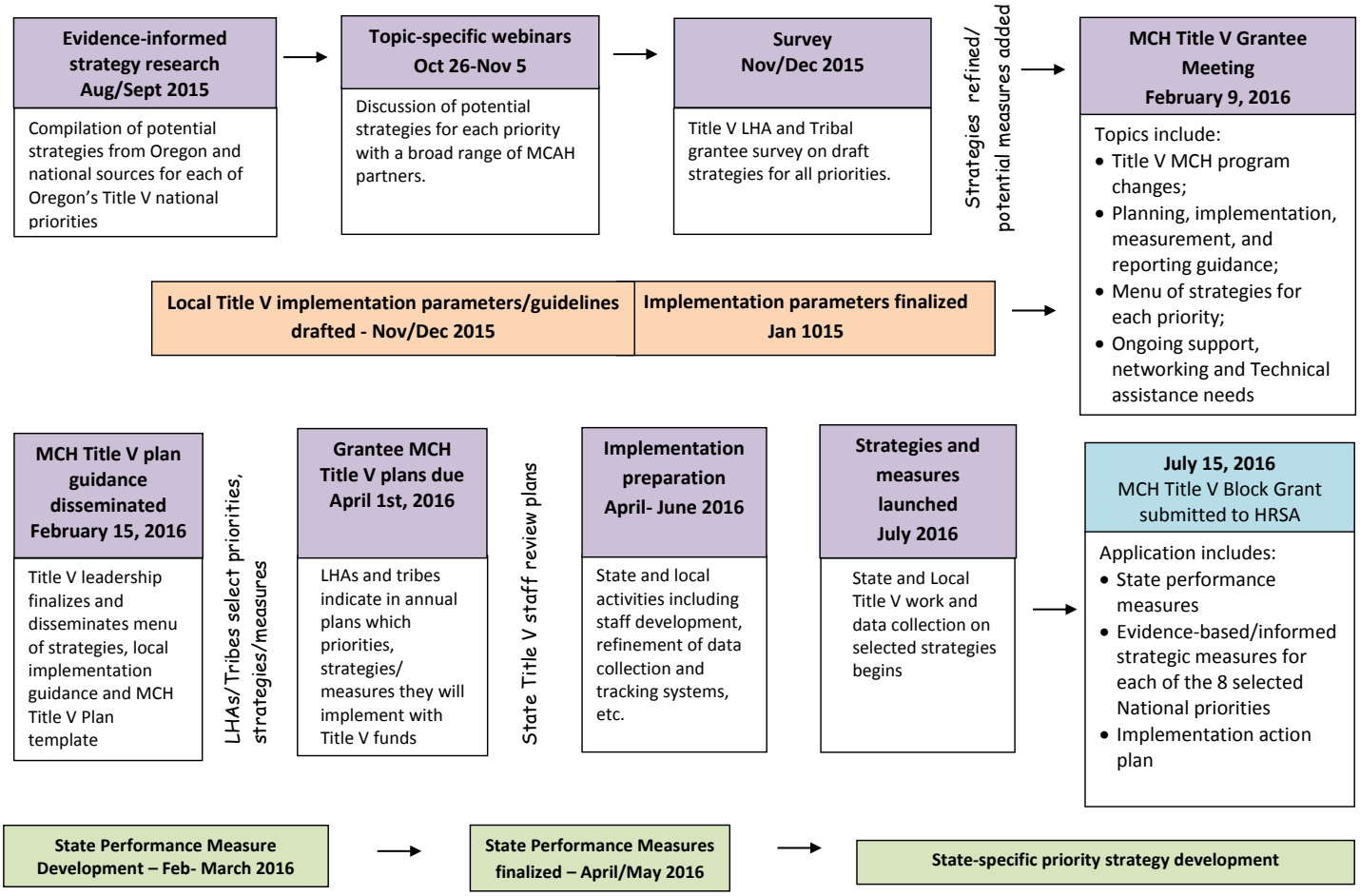
Development and Launch of Strategies and Measures for Oregon's 2016- 2020 MCH Title V Priorities



Rev 12/15/15

Maternal and Child Health Title V Block Grant

Oregon Maternal and Child Health Title V Grantee meeting
February 9, 2016

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Purpose of the MCH Title V Block Grant

The Federal Title V Maternal and Child Health program provides a foundation for ensuring the health of the Nation's mothers, women, children and youth, including children and youth with special health care needs, and their families.

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Federal Legislation

- Enacted in **1935** as a part of the Social Security Act, the Title V Maternal and Child Health Program is the Nation's oldest Federal-State partnership.
- Converted to a Block Grant Program in **1981**
- The Omnibus Budget Reconciliation Act of **1989** redefined the mission and function of Children and Youth with Special Healthcare Needs (CYSHN) programs:
  - To provide and to promote family-centered, community-based coordinated care (including care coordination services…) for children with special health care needs… 42 U.S.C. § 701 (a)(1)(D)
- **Currently** administered by the Dept. of Health and Human Services (DHHS), Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB)

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Title V MCH Block Grant Outcomes

- Assure **access to quality care**, especially for those with low-incomes or limited availability of care;
- Reduce **infant mortality**;
- Provide and ensure access to comprehensive **prenatal and postnatal care to women** (especially low-income and at risk pregnant women);
- Increase the number of **children receiving health assessments and follow-up diagnostic and treatment** services;
- Provide and ensure access to **preventive and child care services as well as rehabilitative services** for certain children;
- Implement family-centered, community-based, systems of **coordinated care for children with special healthcare needs**;
- Provide **toll-free hotlines and assistance in applying for services** to pregnant women with infants and children who are eligible for Title XIX (Medicaid).

Funding

- It is a federal appropriation
- Current national annual appropriation: $636 million (partial reinstatement of sequestered funding)
- State funding formula is based on number of children in poverty
- Oregon's current funding: approximately $6 million annually.
- At least 30 percent of Federal Title V funds are earmarked for preventive and primary care services for children and at least 30 percent are earmarked for services for children with special health care needs.
- States and jurisdictions must match every $4 of Federal Title V money that they receive with at least $3 of State and/or local money.

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MCH Title V Block Grant 3.0

MCHB is transforming Title V's work to align with Federal health care transformation.

- Goals of the transformation: reduce burden, increase accountability, and maintain flexibility

States are required to:

- Conduct a 5-year needs assessment
- Choose 8 of 15 national priority areas/performance measures, plus 3 state-specific priorities
- Develop strategies and measures to "move the needle" on the national priorities
- Align use of funds with these priorities and strategies

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MCH Title V Needs Assessment and Prioritization

Title V Needs Assessment:

- engaged 2,000 stakeholders around the state to assess Oregon's current and emerging MCH needs (through surveys, listening sessions, webinars, online discussion forum, etc.)

Prioritization process:

- brought together a cross-section of key stakeholders for two meetings last winter to discuss needs assessment results and determine Oregon's MCH Title V priorities for 2016 – 2020.

Maternal, Child, and Adolescent Health Domains

- Maternal and Women's Health
- Perinatal and Infant Health
- Child Health
- Adolescent Health
- Children and Youth with Special Healthcare Needs
- Cross-cutting/Lifecourse

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National Priority Areas

1. Well woman care
2. Low risk cesarean deliveries
3. Perinatal Regionalization
4. Safe Sleep
5. Developmental Screening
6. Child safety/injury
7. Adolescent Well-Visit
8. Bullying
9. Adequate Insurance Coverage
10. Breastfeeding
11. Physical Activity
12. Oral Health
13. Medical Home
14. Transition into Adult Health Care
15. Household Smoking

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Oregon's 2016-2020 Title V Priorities

Oregon's selected national priority areas

- –Well woman care
- –Breastfeeding
- –Children's Physical activity
- –Adolescent well visit
- –Medical home
- –Transition into Adult Health Care
- –Oral health
- –Smoking

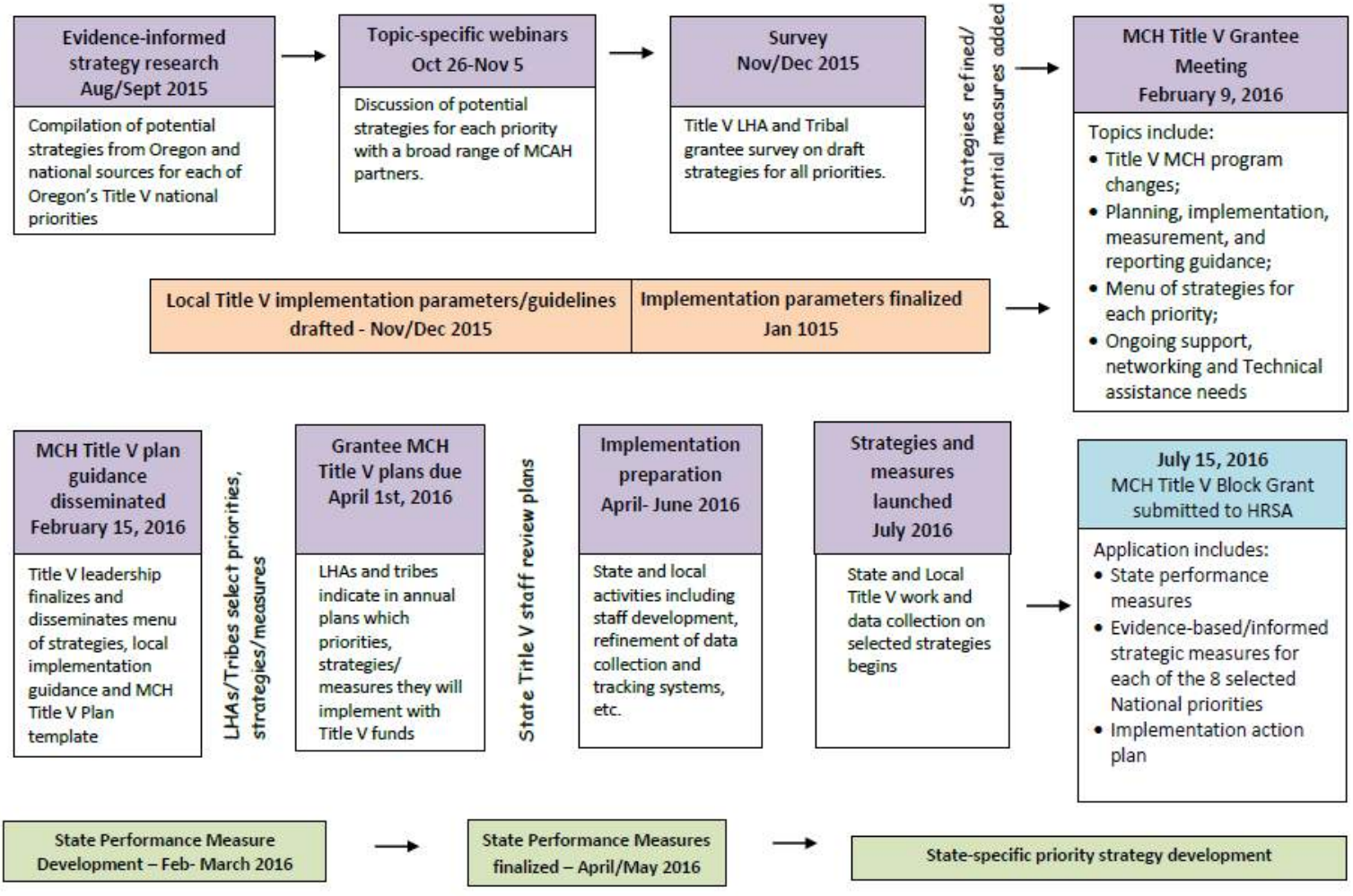
State-specific priority areas:

- –Toxic stress, trauma and ACEs
- –Food insecurity
- –Culturally and linguistically responsive MCH services

Implementation of the 2016-2020 priorities

- Develop evidence-informed strategies and measures for each of the selected national priority areas;
- Develop state performance measures for each of the state-specific priority areas;
- Modify Oregon's Title V program structure (state and local) to align with the new Block Grant requirements.
- Develop action plans and launch state and local work on the new priorities

Development and Launch of Strategies and Measures for Oregon's 2016- 2020 MCH Title V Priorities



Children and Youth with Special Health Needs Strategy Development

November 2014 through June 2015 - Title V CYSHCN Needs Assessment and Input Process

- Family, Provider, Care Coordinators, & Youth Surveys
- CaCoon Nurse Regional Meetings – Input into priorities and strategies
- OCCYSHN Key Stakeholders Meeting – Input into state priorities
- Listening Sessions on the Standards for Systems Serving CYSHCN to identify strategies to impact services for CYSHCN
  - Community Providers (PCP, Care Coordinators)
  - Parent Partners

September 2015 through Early January 2016 – Review strategies to impact priority areas of Medical Home for CYSHCN and Transition to Adult Health Care

- Identify activities to implement within strategy; to impact population of CYSHCN
- State and Local level activities

February through March 2016 – Finalize state plan and share identified strategies with local partners

Questions?

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Additional questions and comments?

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Oregon MCH Title V Block Grant 2016-2020

Local Grantee Implementation Guidelines

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Implementation Guidelines- Priority Selection

Title V Funding level	Minimum # of priorities
Less than $25,000 per year	1
$25,000 - $99,999 per year	2
$100,000 or more per year	3

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Implementation Guidelines- Priority Selection

National Priorities	State Priorities
Well women care	Toxic Stress, trauma ACES
Breastfeeding	Culturally and linguistically responsive services
Physical activity for children	Food insecurity
Adolescent well visit	
Oral health	
Smoking	

Implementation Guidelines

- Strategy Selection
  - Encouraged to use a variety of strategies from menu of options to address priorities
  - Grantees working on more than one priority and/or strategy must select at least one strategy at the community, institutional, or societal level

Level of influence	Examples (spectrum of prevention)
Individual/relationship level	Strengthening individual knowledge and skills
Community level	**Promoting community education; fostering coalitions or networks**
Institutional level	**Changing organizational practices, educating providers**
Societal level	**Influencing policy and legislation**

Implementation Guidelines

- Use of Title V Funds
  - At least 30% must be used for child or adolescent health
  - No more than 10% for indirect costs
  - Up to 20% of Title V funds can be used for locally-identified MCH work that falls outside of Oregon's Title V priorities and/or strategy menu if approved by OHA
  - Can be used to contract with other programs or agencies

Implementation Guidelines

Annual Plan

- Annual Plan with selected priorities, strategies, activities and measures due April 1, 2016.
- Strategy/activity implementation and measure collection begin July 1, 2016.

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Implementation Guidelines

Data tracking and reporting

- Grantees must report on at least one measure for each strategy they choose to implement. Measures can be locally-defined.
- Beginning March 2017, an annual progress report will accompany the annual plan.

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Overview of national MCH priorities and strategies for Oregon

Oregon Maternal and Child Health Title V Grantee meeting
February 9, 2016

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Priority: Well-woman Care

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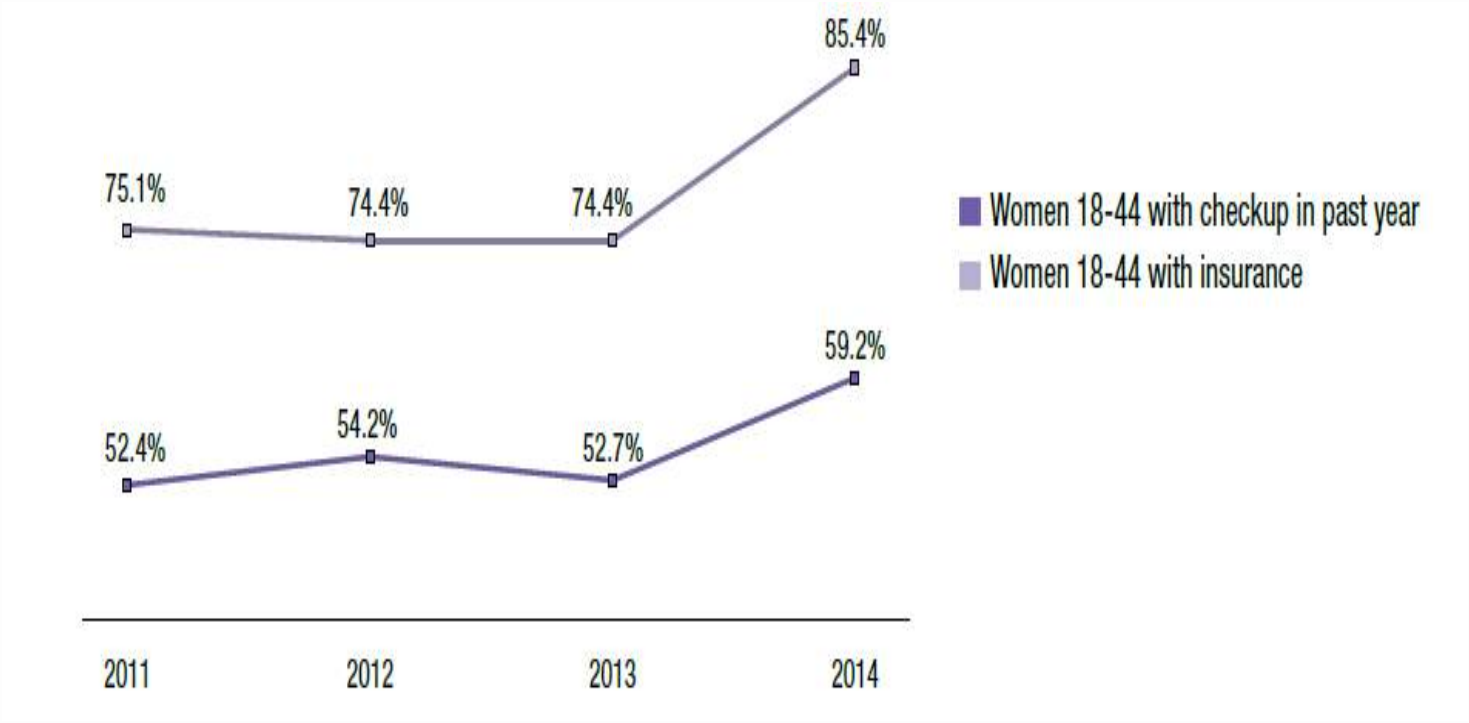
Access to high-quality well-woman care:

- Is a key driver for optimizing the health of women before, between and beyond potential pregnancies.
- Provides a critical opportunity to receive recommended clinical preventive services, screening and management of chronic conditions, counseling to achieve a healthy weight and smoking cessation, and immunizations.
- Increases the likelihood that any future pregnancies are by choice rather than chance.
- Decreases the likelihood of complications for future pregnancies.

Performance Measure: Oregon women age 18-44 with checkup in the past year



Source: Behavioral Risk Factor Surveillance System

Strategies: Well-woman Care

Level of Influence: Individual/relationship

#1 Case-management to improve utilization of well-woman care

#2 Provide outreach for insurance enrollment and referral to services

#5 Provide access to well-woman care through Family Planning Clinics

Strategies: Well-woman Care

Level of Influence: Community & Institutional

#3 Use traditional and social marketing to educate the population and promote well woman care

#4 Provide education/training on preconception/interconception health for providers

#6 Use of the postpartum health care visit to increase utilization of well-woman visits

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Breastfeeding

Robin Stanton, MA, RDN, LD
Nutrition Consultant
MCH & WIC Programs

- *20+ years at PHD, actively involved in state breastfeeding work*
- *10+ years providing leadership at national level*
- *4+ years as breastfeeding mom*

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Breastfeeding:

A) percent of infants ever breastfed

B) percent of infants breastfed exclusively through 6 months

- >60% women are unable to meet their own breastfeeding goals: Oregon challenges—*Exclusivity & Duration*
- Barriers to support: in communities, health care, workplace & child care
- First Food deserts more prevalent in low-resource areas

Strategies: Breastfeeding – Community

1. Increase the number of fathers, non-nursing partners and family members, especially grandmothers, who learn about the importance of breastfeeding

2. Fill unmet needs for peer support of breastfeeding

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Strategies: Breastfeeding – Health Care

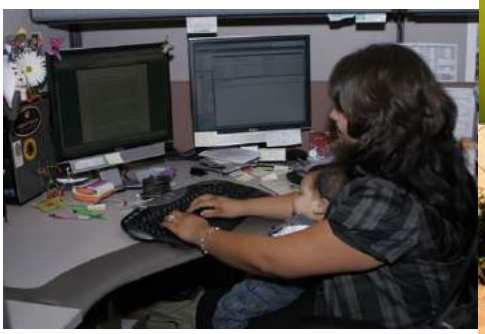
3. Education / training of health care providers about breastfeeding

4. Education of pregnant women about breastfeeding

5. Increase the availability of breastfeeding support from professionals

Strategies: Breastfeeding – Workplace & Child Care

6. Increase access to workplace breastfeeding support



7. Increase the support of breastfeeding at child care settings through policy, training & workforce development

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Physical Activity for Children

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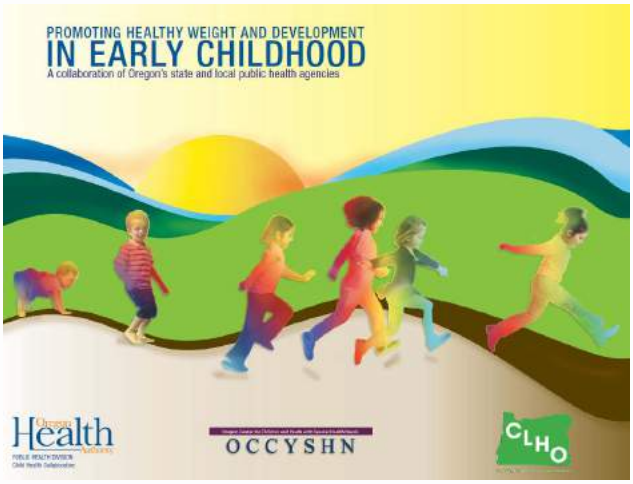

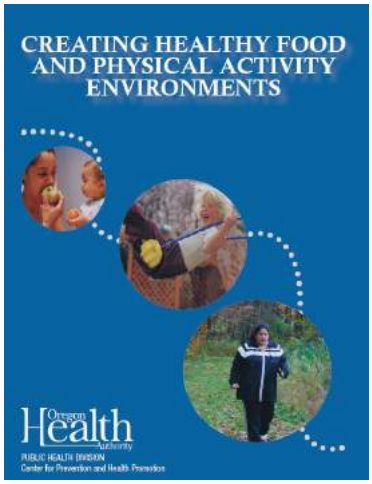

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Child Physical Activity: Percent of children ages 6-11 years who are physically active at least 60 minutes/day

- *Brain development and ability to learn*
- *Emotional health, promotes self-esteem and feelings of happiness*
- *Social skills – problem solving, sharing, communicating, decision making*
- *Promotes lifelong healthy habits*

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Strategies: Child Physical Activity

1. *Support physical activity in child care settings through policy, training and workforce development.*

2. *Support physical activity before, during and after school; support the implementation of the Oregon physical education in schools law (HB 3141).*

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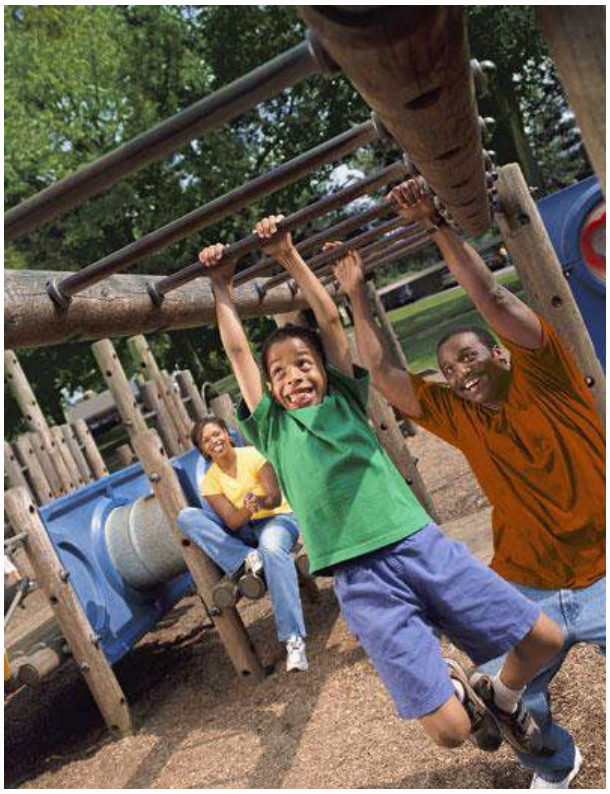
Strategies: Child Physical Activity

3. *Promote community-wide campaigns for physical activity.*

4. *Improve the physical environment for physical activity.*

5. *Increase safe and active transportation options.*

Strategies: Child Physical Activity



6. Promote policies and programs for healthy worksites, with a focus on physical activity.

7. Promote partnerships with clinical care providers to provide anticipatory guidance about the importance of physical activity, as recommended in the American Academy of Pediatrics Bright Futures Guidelines.

Adolescent Well Care (AWC)

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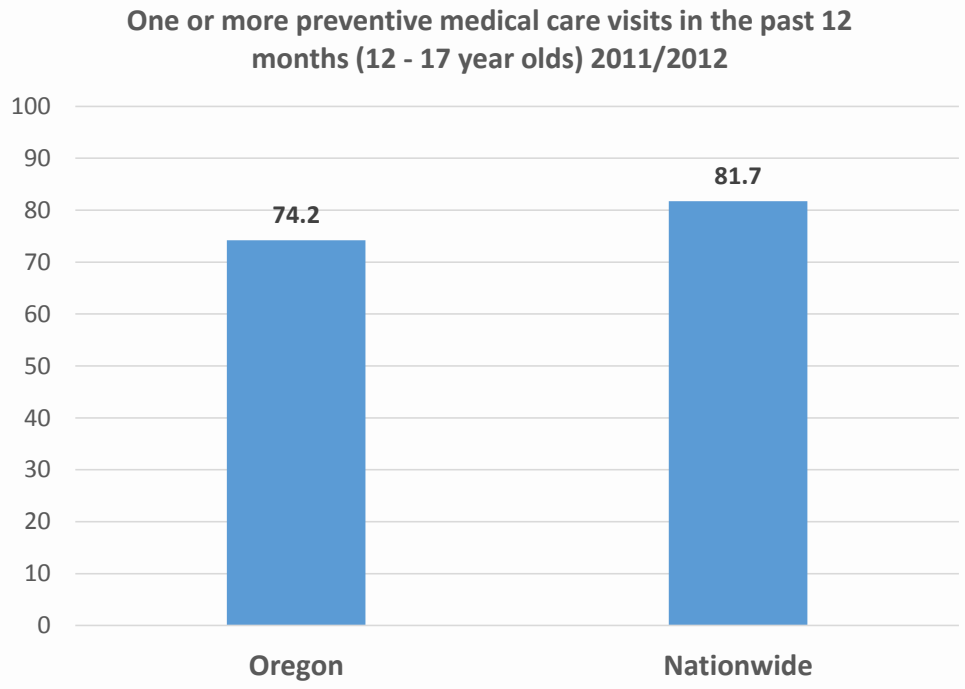
Adolescent Well Care: National Performance Measure

% of children 12-17 with one or more preventive medical visit in past 12 months

National Survey of Children's Health



Significance of AWC for Oregon

Oregon Health Authority

Adolescent well care: Strategies

Strategy	Level of Influence	State/Local
Increase outreach to key populations	Individual, Community	Local
Promote practice of going beyond sports physicals	Community, Institutions, Societal	Local/State
Develop and strengthen partnerships with entities invested in adolescent health.	Community	Local/State
Raise awareness of the importance of adolescent well care.	Community, Institutions	Local/State
Leverage SBHC to conduct broader outreach with school/community.	Community	Local

Adolescent well care: Strategies

Strategy	Level of Influence	State/Local
Engage adolescents as community health workers.	Community	Local/State
Promote policies and practices to make health care more youth-friendly	Community, Institutional, Societal	Local/State
Investigate barriers to adolescent well visits.	Community	Local/State
Strengthen health care privacy and confidentiality policies and practices.	Community, Institutional, Societal	Local/State

Oral Health

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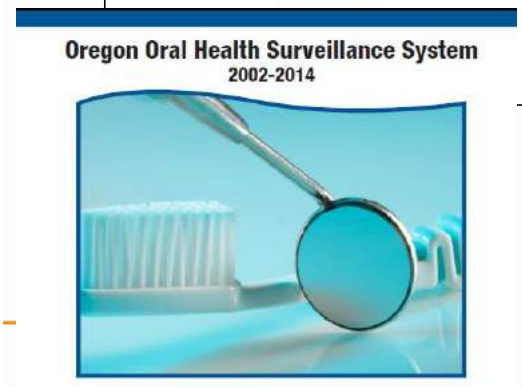
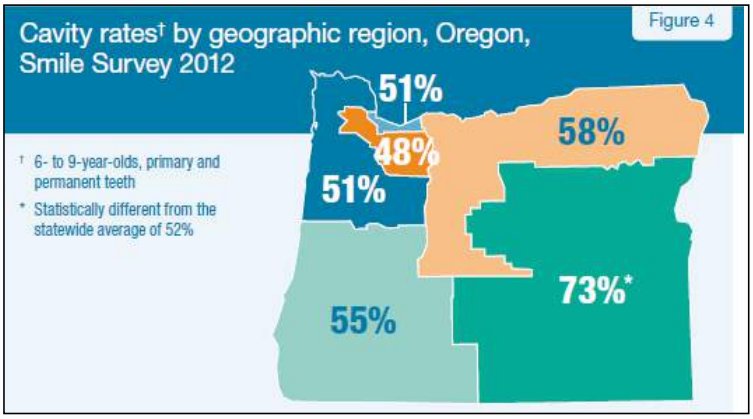


Importance of Oral Health



- 48% of first graders have had a cavity, jumping to 58% by third grade (Oregon Smile Survey, 2012 Report).
- 15,000 emergency department visits for non-traumatic dental problems (Oregon hospital database, 2013).
- Oregon ranks 48th nationally for optimally-fluoridated public water systems (22.6%) (CDC Water Fluoridation Statistics, 2010).

Oral Health: Performance Measures

Percent of women who had a dental visit during pregnancy.

- Data source: Centers for Disease Control and Prevention (CDC), Pregnancy Risk Assessment Monitoring System (PRAMS)
- Baseline: 56.1% (2012)

Percent of children, ages 1 to 17 years, who had a preventive dental visit in the last year.

- Data source: National Survey of Children's Health (NSCH)
- Baselines: 75.7% (2007)
  77.0% (2011-2012)

Strategies: Oral Health

1. Provide oral health services, education and referral/case management services for dental care through Oregon's Home Visiting System

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

3. Collaborate with primary care providers to follow the American Congress of Obstetricians and Gynecologists (ACOG) oral health recommendations for pregnant women

Strategies: Oral Health

4. Collaborate with Early Childhood Care and Education to plan and implement methods to increase preventive dental services for children
5. Incorporate oral health services for adolescents into School-based Health Centers (SBHCs) and adolescent well-child visits
6. Promote the provision of dental sealants and oral health education in schools
7. Educate pregnant women, parents/caregivers of children, and children 0-17 about oral health
8. Promote community water fluoridation

SMOKING

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Oregon Smoke-Free Mothers & Babies

Lesa began working in the Maternal and Child Health Section in 2002. She had previous experience in alcohol and drug addiction, and was hired to coordinate the Smoke-Free Mothers and Babies Program, a training and quality improvement project that focused on MCM nurses using cessation best practices. Currently, she coordinates Oregon MothersCare and works with TPEP on the Public Health Division State Health Improvement Plan for tobacco cessation.

Oregon Health Authority

Smoking:

A. Percentage of women who smoke during pregnancy

B. Percentage of children who live in households where someone smokes

- *Tobacco use during pregnancy effects both the mother and her unborn baby; prenatal smoke exposure provides a 5.5 times increased risk of becoming a smoker in adolescence.*
- *Pregnant women who smoke are more likely to experience a fetal death or deliver a low birth weight baby.*
- *Women have more difficulty quitting than men, but pregnancy is a strong motivator. Unfortunately, smoking rates tend to increase post-partum.*
- *Children with special health care needs are more likely to live in a household where someone smokes, and to be exposed to secondhand smoke.*

Oregon Health Authority

Strategies: Smoking

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

2. *5As Intervention within MCH Programs including Home Visiting, Oregon MothersCare, Family Planning, and WIC (if applicable).*

3. *Develop customized programs for specific at-risk populations of women who are smokers and of reproductive age.*

Strategies: Smoking

4. *Collaborate w/CCOs, DCOs, and medical and early childhood/education providers to build screening and intervention processes into their work practices, including workforce training.*

5. *Implement a media campaign that targets women during childbearing years.*

Oregon Health Authority

Strategies: Smoking

6. Collaborate with the Oregon Quit Line Program to improve outreach and quit rates for pregnant and postpartum women.

7. Promote health insurance coverage benefits for pregnant and postpartum women and promote their utilization.

Oregon Health Authority

National Priority Area: Adolescent well-care visit

National performance measure: Percentage of adolescents with a preventive services visit in the last year.

Title V MCH Block Grant in Oregon

The Title V Maternal and Child Health (MCH) Block Grant is a federal program that provides funding to states to improve the health of all women, children, adolescents, and families, including children with special health care needs (CYSHCN). Oregon's Title V MCH priorities for 2016-2020 include: well-woman care, breastfeeding, physical activity for children, adolescent well-care visits, oral health, smoking, toxic stress and trauma, nutrition and food insecurity, culturally and linguistically responsive services, and medical homes and services for the transition to adulthood for children and youth with special health care needs.

More information about each of the above priorities is available at: http://Healthoregon.org/titlev.

Significance of the issue

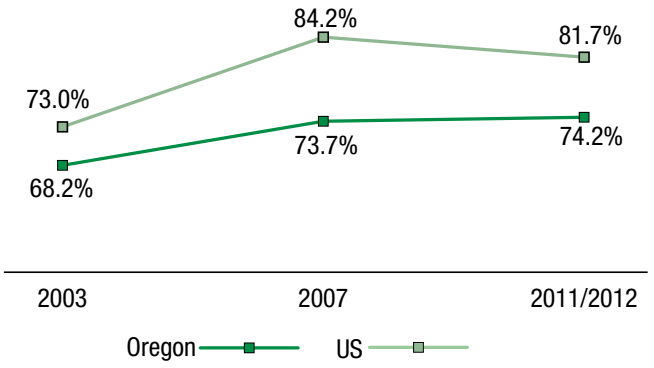
While generally characterized by good health, adolescence is a key transition period in the life course that requires a unique set of health care services. Adolescents are establishing health behaviors that lay the foundation for their health in adulthood, which carry implications for lifelong health outcomes, health care spending and economic stability. Furthermore, adolescence is a critical time to empower, educate and engage youth as they begin to transition to independent consumers of health care services. The Bright Futures guidelines recommend that adolescents (11-24) have annual well-visits. The visit should cover a comprehensive set of preventive services, such as a physical examination and discussion of health-related behaviors including: healthy eating, physical activity, substance use, sexual behavior, violence, and motor vehicle safety.

Nationally, only about half (46%) of adolescents on Medicaid aged 12–21 years received a well-visit in the past year, the lowest utilization of primary care compared to any other age group. The adolescent well-visit rate for the Oregon Health Plan is significantly lower, with 32% of Medicaid enrollees aged 12–21 years having a well-care visit in the past 12 months in 2014.[1]

Health Status Data

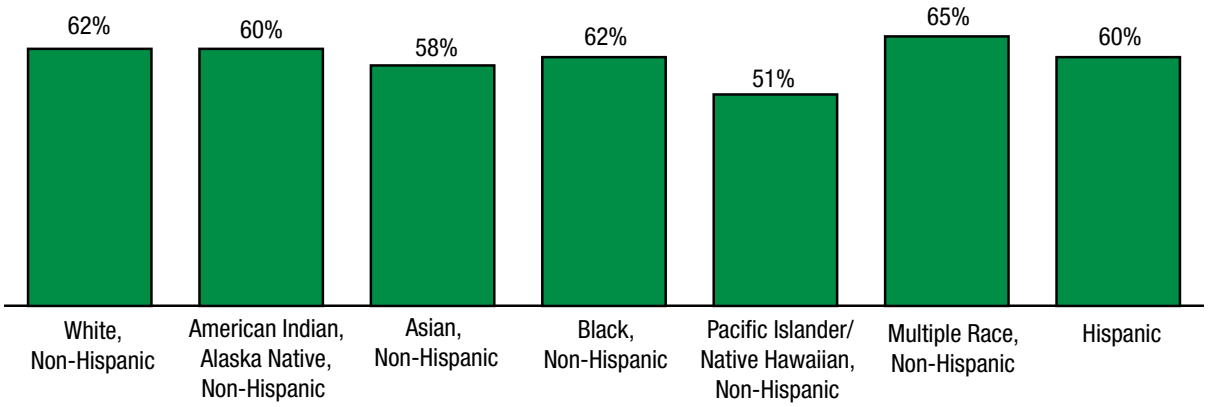
Percent of adolescents age 12-17 years with one or more preventative medical visits in the last year, 2003-2011/12

Source: National Survey of Children's Health



1 *CCO administrative (billing) data. http://www.oregon.gov/oha/Metrics/Pages/measure-adolescent.aspx*

11th grade- Saw doctor or nurse in the past 12 months, not for sickness or injury, Oregon 2015
Source: Oregon Healthy Teens



Many Oregon youth could benefit from increased access to screening and anticipatory guidance. According to 11th graders in 2015:

- 29% felt depressed in the past 12 months
- 16% seriously considered suicide in the past 12 months
- 41% have ever had sex
- Among those who have ever had sex 38% did not use a condom at last intercourse
- 29% drank alcohol in the past month
- 20% used marijuana in the past month

Context for the Issue in Oregon

The Patient Protection and Affordable Care Act (ACA) elevated the importance of preventive care for children and youth by ensuring access to the gold standard preventing care – screenings and services recommended by the American Academy of Pediatrics Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents—without cost sharing. Bright Futures recommends annual well-care visits for adolescents from ages 11-21. Increasing the number of youth receiving a preventive visit in the past year has been a Title V state-selected priority since 2010. The adolescent well-visit was selected as an incentive measure for Coordinated Care Organizations (CCOs), which greatly elevated the focus on the adolescent population. The well-visit has been included as a key performance measure for certified school-based health centers (SBHCs) since 2008. During the 2013–14 school year, 32% of youth aged 12–21 years seen in an SBHC received a well-visit.

Though it is a clinical measure, the adolescent well-visit shines a light on the unique needs of adolescents in accessing health services, such as physical access points (i.e. SBHCs), confidentiality in the provision of care to adolescents, and the availability of culturally relevant, and developmentally appropriate care. There is a general lack of awareness that youth should see doctor for a preventive visit every year, and many youth do not view a well visit as a priority. There is growing acknowledgment that young people must be actively engaged as partners in the delivery of health care to increase the proportion that access preventive services. There is increased interest in using public health tools and strategies to shift the culture and raise awareness of the importance of adolescent well-care.

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National Priority Area: Breastfeeding

National performance measure: A) Percentage of infants who are ever breastfed, and B) percentage of infants breastfed exclusively through 6 months.

Title V MCH Block Grant in Oregon

The Title V Maternal and Child Health (MCH) Block Grant is a federal program that provides funding to states to improve the health of all women, children, adolescents, and families, including children with special health care needs (CYSHCN). Oregon's Title V MCH priorities for 2016-2020 include: well-woman care, breastfeeding, physical activity for children, adolescent well-care visits, oral health, smoking, toxic stress and trauma, nutrition and food insecurity, culturally and linguistically responsive services, and medical homes and services for the transition to adulthood for children and youth with special health care needs.

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Significance of the issue

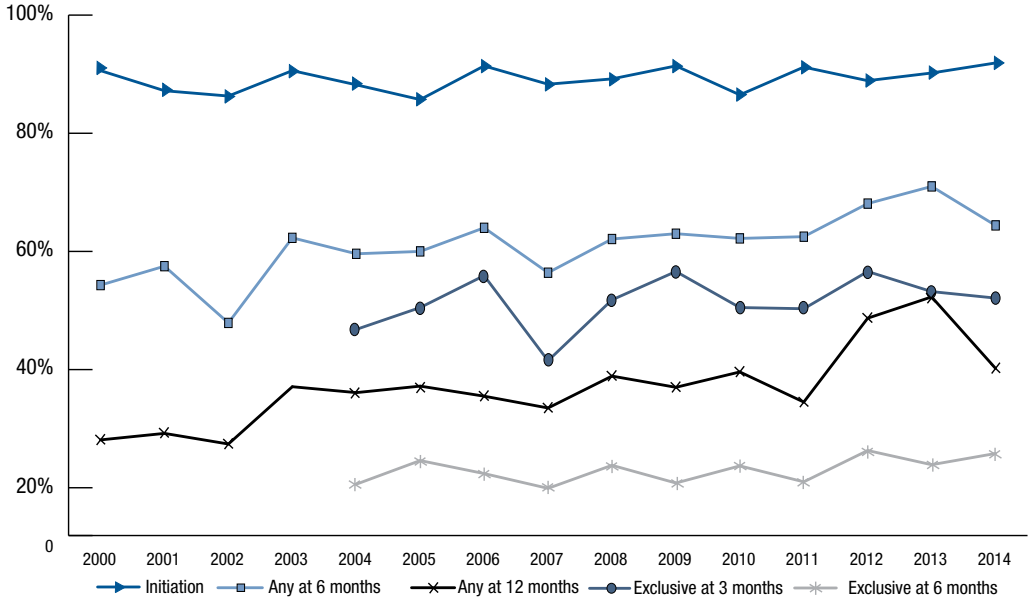
The American Academy of Pediatrics recommends all infants (including premature and sick newborns) exclusively breastfeed for six months and to continue breastfeeding, with the addition of complementary foods, for at least 12 months of age as human milk supports optimal growth and development. Children who are not breastfed or fed human milk have an increased risk for a number of health conditions including infections, allergies, asthma, diabetes, sudden infant death syndrome (SIDS), childhood cancers and childhood obesity. Mothers who do not breastfeed have higher rates of breast, uterine and ovarian cancer, diabetes, heart disease and osteoporosis. Breastfeeding also supports attachment by promoting close bonding with their infant and reduces the risk of postpartum depression.

Despite positive breastfeeding trends, significant racial disparities persist. Although Oregon race/ethnicity data is limited, national data indicate lower breastfeeding rates among African American, Native American and Asian women, and rates are lower among Hispanic women who have become more acculturated.

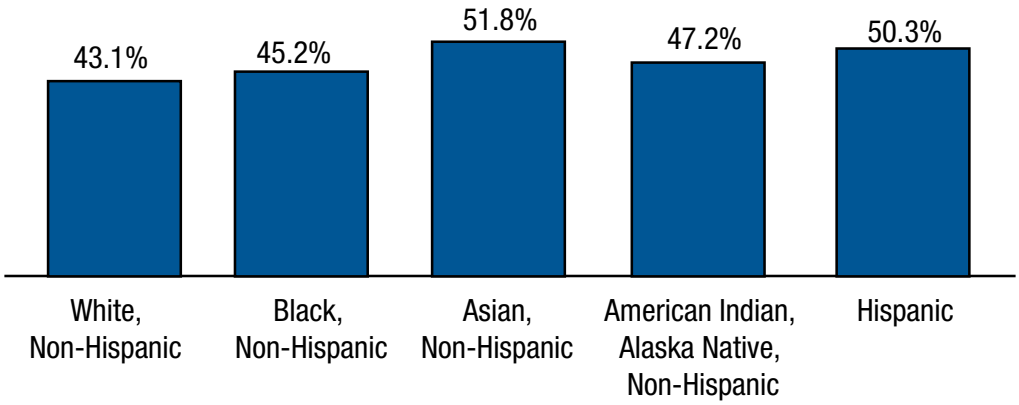
Health Status Data

Oregon Breastfeeding Rates. 2000-2014

Source: National Immunization Survey



Percentage of infants exclusively breastfed at 6 months, by race/ethnicity, Oregon, 2009 births
Source: Pregnancy Risk Assessment Monitoring System



Context for the Issue in Oregon

Oregon has one of the highest breastfeeding rates in the US; most Oregon mothers initiate breastfeeding. Since data has been collected by CDC NIS (2000), Oregon has met all HP 2010 / 2020 breastfeeding objectives with the exception of 6 months exclusive breastfeeding (2011 and 2013), and 6 months any breastfeeding (2002). Trends for any breastfeeding at all time periods appear to be slowly increasing; trends for exclusive breastfeeding, especially at 6 months, appear stagnant over time, indicating that there are many barriers that prevent women from continuing to exclusively breastfeed.

Low income women in Oregon (WIC data) initiate and sustain breastfeeding at a rate comparable to more affluent Oregon women, whereas in most states there is a wide gap between these two groups.

Work in progress

Oregon has many supports in place to encourage women to initiate and continue breastfeeding, as described below, however sustaining breastfeeding remains the primary challenge in Oregon.

- Community Support: Oregon has a law that supports breastfeeding in public, a network of geographic and culturally specific breastfeeding coalitions and peer support programs in some counties.
- Health Care: The majority of hospitals are making progress in maternity care practices that support breastfeeding and the number of Baby Friendly Hospitals has increased from 5 in 2007 to 10 in 2015.
- Workplace: State and Federal laws that support breastfeeding accommodation in the workplace provide legal protection to the vast majority of Oregon women
- Child Care: Programs that are enrolled in the Child and Adult Care Food Program are able to be reimbursed for breast milk feeding of infants.

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National Priority Area: Physical Activity for Children

National performance measure: Percentage of children ages 6 through 11 years who are physically active at least 60 minutes per day.

Title V MCH Block Grant in Oregon

The Title V Maternal and Child Health (MCH) Block Grant is a federal program that provides funding to states to improve the health of all women, children, adolescents, and families, including children with special health care needs (CYSHCN). Oregon's Title V MCH priorities for 2016-2020 include: well-woman care, breastfeeding, physical activity for children, adolescent well-care visits, oral health, smoking, toxic stress and trauma, nutrition and food insecurity, culturally and linguistically responsive services, and medical homes and services for the transition to adulthood for children and youth with special health care needs.

More information about each of the above priorities is available at: http://Healthoregon.org/titlev.

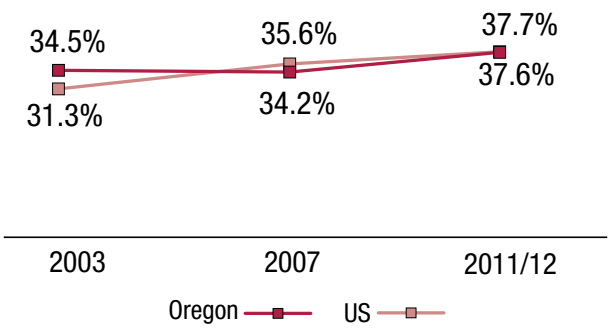
Significance of the issue

Physical activity contributes to achieving and maintaining a healthy weight, promotes emotional health and self-esteem, reduces anxiety and stress, supports the development of social skills, promotes good sleep, promotes the ability to learn, and builds and maintains strong bones muscles and joints. Regular physical activity can improve the health and quality of life of Americans of all ages, regardless of the presence of a chronic disease or disability. It also reduces the risk for cardiovascular disease, hypertension, Type II diabetes, and osteoporosis. In addition to aerobic and muscle-strengthening activities, bone- strengthening activities are especially important for children in order to build peak bone mass.

Health Status Data

Percent of children ages 6-11 years who are physically active at least 20 minutes per day, 2003-2011/12

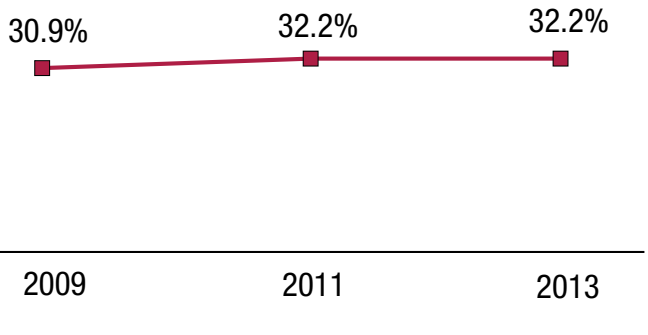
Source: National Survey of Children's Health



Note: NSCH reports 20 minutes of physical activity, and racial/ethnic stratification not available

Percent of 8th graders who report exercising for at least 60 minutes everyday, 2009-2013

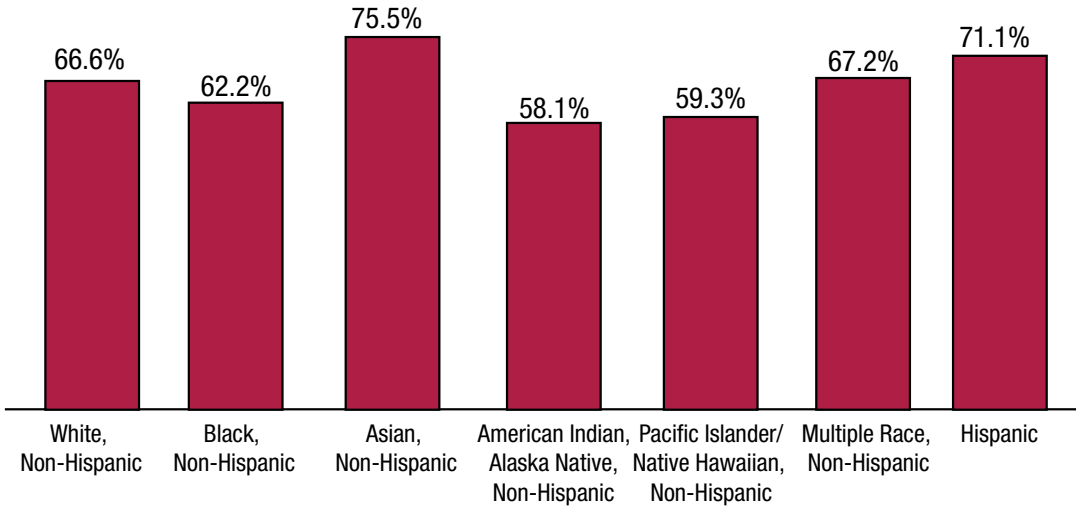
Source: Oregon Healthy Teens



Note: US data not available for 8th graders

Percentage of 8th graders who report exercising for at least 60 minutes a day, by race/ethnicity, Oregon, 2013

Source: Oregon Healthy Teens



Context for the Issue in Oregon

Children spend a significant portion of their day in school, making schools a critical setting for increasing physical activity. In 2007, the Oregon Legislature passed physical education standards for public schools, specifying that all K-5 students receive 150 minutes per week of physical education and that students in grades 6-8 receive 225 minutes per week by 2017. According to the February 2015 Physical Education Legislative Report, few schools offered the required amount of instruction to all students all year long, and the average minutes per week of physical education instruction for all grades remains significantly below the levels outlined in HB3141.

There are many initiatives and partners around the state promoting comprehensive approaches to increase physical activity throughout the day, including implementation of the Comprehensive School Physical Activity Program (CSPAP). CSPAP includes activity before and after school (e.g. Walk and Bike to School), during school (recess) and physical education. Finally, physical activity habits learned early in life influence lifelong health and success in learning. Child care settings offer critical opportunities to support the promotion of healthy behaviors like physical activity.

Work in progress

- Increasing opportunities for physical activity is a key strategy to slow the increase of obesity in Oregon's State Health Improvement Plan as well as the Public Health Division's Strategic Plan.
- Diabetes measures, which are directly related to physical activity, are both incentive and performance measures for Oregon CCOs.
- Physical activity priority areas are identified in CCO Community Health Improvement Plans (CHIPs).
- Physical activity is a primary focus of a current CDC grant held by the Center for Prevention and Health Promotion in the Public Health Division.
- Promoting and increasing physical activity are among the health and safety standards promoted in Oregon's Quality Rating Improvement System (QRIS) for child care facilities.

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National Priority Area: Oral Health

National performance measure: A) Percentage of women who had a dental visit during pregnancy and B) percentage of infants and children, ages 1 through 17 years, who had a preventive dental visit in the last year.

Title V MCH Block Grant in Oregon

The Title V Maternal and Child Health (MCH) Block Grant is a federal program that provides funding to states to improve the health of all women, children, adolescents, and families, including children with special health care needs (CYSHCN). Oregon's Title V MCH priorities for 2016-2020 include: well-woman care, breastfeeding, physical activity for children, adolescent well-care visits, oral health, smoking, toxic stress and trauma, nutrition and food insecurity, culturally and linguistically responsive services, and medical homes and services for the transition to adulthood for children and youth with special health care needs.

More information about each of the above priorities is available at: http://Healthoregon.org/titlev.

Significance of the issue

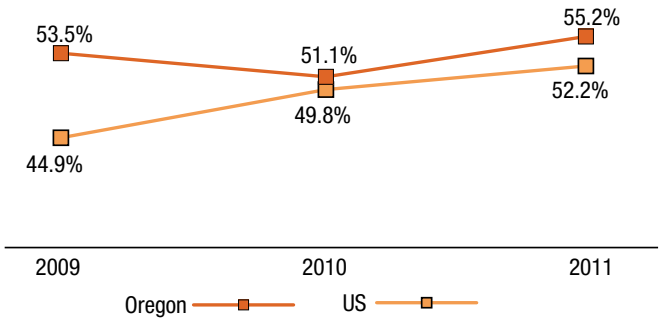
Oral health is a vital component of overall health and well-being across the lifespan. Access to dental care, good oral hygiene, and adequate nutrition are essential components of oral health to help ensure that children, adolescents, and adults achieve and maintain a healthy mouth. People with limited access to preventive oral health services are at greater risk for oral diseases. Among pregnant women, oral infections can increase the risks for premature delivery and low birth weight babies.

Oral health care remains the greatest unmet health need for children. Insufficient access to oral health care and effective preventive services affects children's health, speech, nutrition, growth, social development, and the ability to learn. Early dental visits teach children that oral health is important. Children who receive oral health care early in life are more likely to have a good attitude about oral health professionals and dental visits. Pregnant women who receive oral health care are more likely to take their children to get oral health care.

Health Status Data

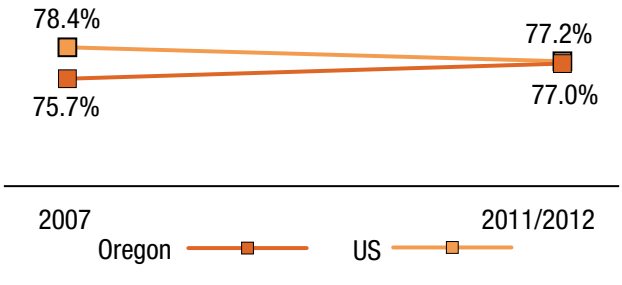
Percent of women who had a dental visit during pregnancy, 2009-2011

Source: Pregnancy Risk Assessment Monitoring System



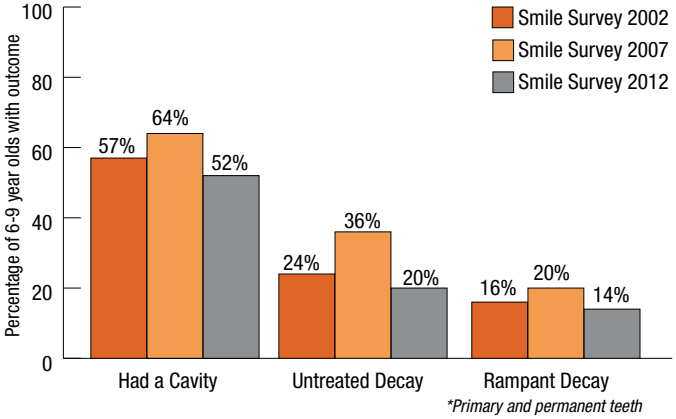
Percent of children age 1-17 with a preventative dental visit in the last year, 2007-2011/12

Source: National Survey of Children's Health



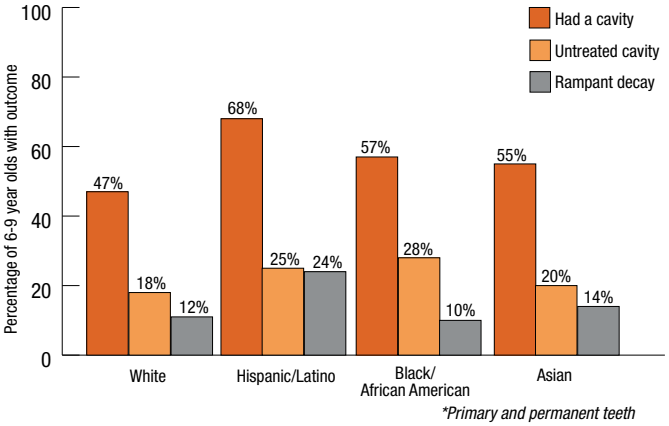
Oral health status* among children 6-9 years old, Oregon

Source: Smile Survey 2002-2012



Oral health status* among children 6-9 years old by race/ethnicty, Oregon, 2012

Source: Smile Survey 2012



- 48% of first graders have had a cavity. This rate jumps to 58% by third grade, to 70% in 8th grade and 74% in 11th grade. Cavities are almost entirely preventable.
- Hispanic/Latino children experienced particularly high rates of cavities, untreated decay and rampant decay compared to White children.
- Black/African American children had substantially higher rates of untreated decay compared to White children.

Context for the Issue in Oregon

State Title V Maternal and Child Health programs have long recognized the importance of improving the availability and quality of services to improve oral health for children and pregnant women. Strategies for promoting oral health include providing preventive interventions, such as dental sealants and use of fluoride; providing oral health services during well-child visits; following the American Congress of Obstetricians and Gynecologists (ACOG) oral health recommendations for pregnant women; incorporating oral health in chronic disease prevention and management models; and increasing the number of community and school-based health centers with an oral health component.

Oregon has a comprehensive state-based oral health surveillance system, a nationally recognized best practice school-based dental sealant program, a robust statewide oral health coalition, a successful early childhood cavities prevention program (First Tooth), and integration of dental services in the Coordinated Care Model. Despite these:

- Non-traumatic dental needs are one of the most common reasons for emergency department visits.
- The statewide fluoridation rate remains around 22.6%.
- Children residing in rural and frontier areas have less access to care and higher rates of decay.

Work in Progress

- Oral health is one of the six priority areas in the State Health Improvement Plan for 2015-2019.
- Oregon released the Strategic Plan for Oral Health in Oregon: 2014-2020 that comprehensively outlines the priorities for improving oral health across the lifespan.
- Oregon Coordinated Care Organizations (CCOs) have a dental sealant performance metric.
- As part of Senate Bill 738, dental pilot projects are now being accepted to test various types of new and expanded workforce models to improve access and outcomes for the most vulnerable populations.

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National Priority Area: Smoking

National performance measure: A) Percentage of women who smoke during pregnancy and B) the percentage of children who live in households where someone smokes.

Title V MCH Block Grant in Oregon

The Title V Maternal and Child Health (MCH) Block Grant is a federal program that provides funding to states to improve the health of all women, children, adolescents, and families, including children with special health care needs (CYSHCN). Oregon's Title V MCH priorities for 2016-2020 include: well-woman care, breastfeeding, physical activity for children, adolescent well-care visits, oral health, smoking, toxic stress and trauma, nutrition and food insecurity, culturally and linguistically responsive services, and medical homes and services for the transition to adulthood for children and youth with special health care needs.

More information about each of the above priorities is available at: http://Healthoregon.org/titlev.

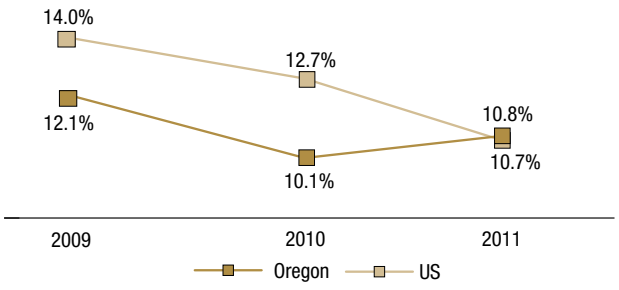
Significance of the issue

Tobacco use during pregnancy is a special concern because of the effects of smoking on both the mother and the developing fetus. Those exposed in-utero have a 5.5 times greater risk of becoming smokers in adolescence.[1] Prenatal cigarette smoke exposure is also related to lifetime tobacco dependence.[2] Women who smoke during pregnancy are more likely to experience a fetal death or deliver a low birth weight baby. Secondhand smoke is a mixture of mainstream smoke (exhaled by smoker) and the more toxic side stream smoke (from lit end of nicotine product) and is classified as a known human carcinogen by the US Environmental Protection Agency. Adverse effects of parental smoking on children have been a clinical and public health concern for decades and were documented in the 1986 U.S. Surgeon General Report.

Health Status Data

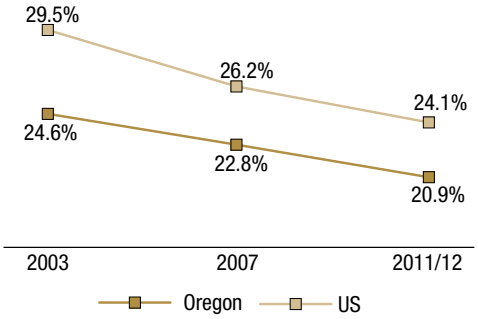
Percent of women who smoked during the last 3 months of their pregnancy, 2009-2011

Source: Pregnancy Risk Assessment Monitoring System



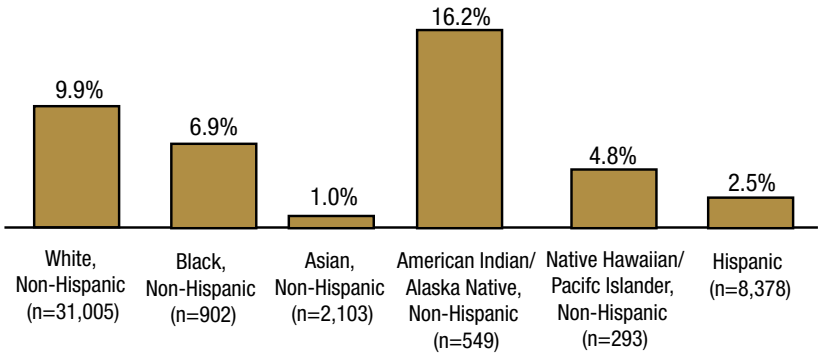
Percent of children who live in a household with someone who smokes, 2003-2007

Source: National Survey of Children's Health



- Oregon's rate of smoking during pregnancy has always been above the national average. An estimated 10,381 women smoked at the time of pregnancy in 2011.[3]
- Pregnant women who are younger, have a low level of education, are non-Hispanic White or Native American, and are unmarried are more likely to smoke during pregnancy.[4]
- Most pregnant women make quit attempts during pregnancy; according to Oregon PRAMS (2011), 71% of women attempted to quit. And smoking rates decrease during pregnancy from 23.2 to 10.8% in the last trimester.

Percent of women who smoked during the last 3 months of their pregnancy, by race/ethnicity. Oregon, 2011 Births
Source: Pregnancy Risk Assessment Monitoring System



- Smoking rates increase after a baby is born to 13.8% (PRAMS, 2011). Smoking rates by pregnant women are not consistent across race and ethnicity, with the highest rates among American Indian/Alaska Native and White mothers.
- Children with Special Health Care Needs are more likely to live in a household where someone smokes and to be exposed to second-hand smoke inside the home than children who don't have special health care needs.[5]

Context for the Issue in Oregon

Community programs: Public Health Nurses are routinely trained in the evidenced-based 5As intervention (Ask, Advise, Assess, Assist, and Arrange). Maternity Case Management home visiting programs throughout Oregon are required to conduct the 5As on women who smoke each and every time a woman is seen. This intervention is also conducted in other home visiting and maternal and child health programs.

Local Tobacco Prevention and Education Programs (TPEP) convene a workgroup on the topic of tobacco use and pregnant women. They share successful strategies and learn from guest speakers regarding pregnant women and tobacco use using policy and systems change approaches. MCH Programs focusing on tobacco as a Title V priority will also participate in a corresponding workgroup, joining forces when shared issues arise.

Cessation: The Oregon Tobacco Quit Line offers enhanced services to smokers who are pregnant. The program offers pregnant smokers increased support with women receiving ten consultation calls, up to six months post-partum, from the Quit Line. (www.quitnow.net/oregon) This pregnancy program is grounded in existing scientific evidence, and provides pregnant smokers the resources they need to be successful in quitting tobacco use.

Work in progress

- Maternal and child programs have tobacco cessation as a priority for pregnant women and children affected by second-hand smoke.
- Addressing tobacco use for the entire population is a primary priority of Oregon's State Health Improvement Plan.
- Tobacco use is an incentivized performance measure for Oregon's CCO's.
- A variety of strategies are used by the PHD, which works to protect all Oregonians from secondhand smoke in their homes, workplaces and communities, and also help smokers, including those who are pregnant, to quit.

1. *Cornelius, M.D., Leech, S.L., Goldschmidt, L., & Day, N. (2000). Prenatal tobacco exposure: Is it a risk factor for early tobacco experimentation? Nicotine & Tobacco Research, 2, 45-52, doi:10.1010/14622200050011295*
2. *Buka, S., Shenassa, E., & Niaura, R. (2003). Elevated risk of tobacco dependence among offspring of mothers who smoked during pregnancy: A 30-year prospective study. American Journal of Psychiatry, 160, 1978-1984. Doi:10.1176/appi.ajp.160.11.1978*
3. *Oregon Pregnancy Risk Assessment Monitoring System (PRAMS), 2011.*
4. *Child Trands Data Bank. http://www.childtrends.org/?indicators=mothers-who-smoke-while-pregnant*
5. *Children with Special Health Care Needs in Context: A portrait of States and the Nation 2007. http://mchb.hrsa.gov/nsch/07cshcn/national/2chf/1hdr/pages/01sh.html*

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National Priority Area: Well-woman care

National performance measure: Percentage of women with a preventive visit in the past year.

Title V MCH Block Grant in Oregon

The Title V Maternal and Child Health (MCH) Block Grant is a federal program that provides funding to states to improve the health of all women, children, adolescents, and families, including children with special health care needs (CYSHCN). Oregon's Title V MCH priorities for 2016-2020 include: well-woman care, breastfeeding, physical activity for children, adolescent well-care visits, oral health, smoking, toxic stress and trauma, nutrition and food insecurity, culturally and linguistically responsive services, and medical homes and services for the transition to adulthood for children and youth with special health care needs.

More information about each of the above priorities is available at: http://Healthoregon.org/titlev.

Significance of the issue

Access to high-quality well-woman care is a key driver for optimizing the health of women before, between and beyond potential pregnancies. By taking action on health issues throughout the lifespan, future problems for the mother and baby can be prevented. Access to high-quality well-woman care:

- Provides a critical opportunity to receive recommended clinical preventive services, screening and management of chronic conditions such as diabetes, counseling to achieve a healthy weight and smoking cessation, and immunizations.
- Increases the likelihood that any future pregnancies are by choice rather than chance.
- Decreases the likelihood of complications for future pregnancies.

High-quality well-woman care includes pre/interconception health care education that is tailored to each woman.

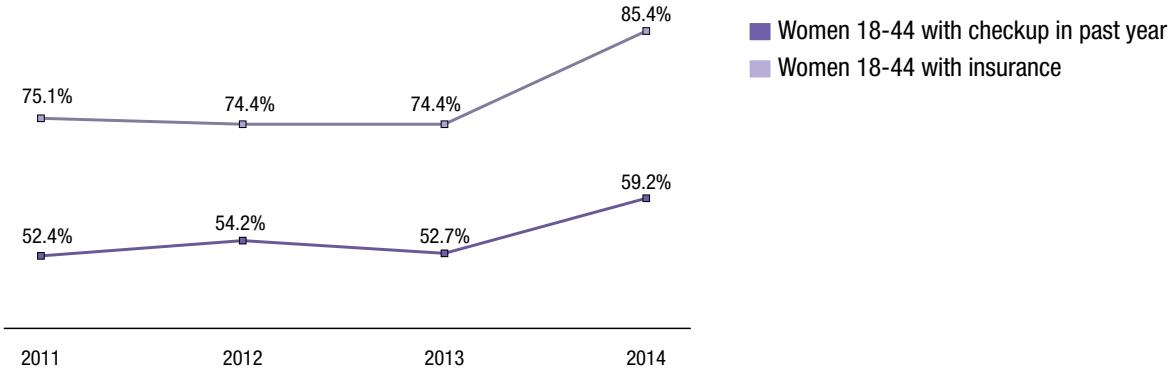
- Pregnancy Intention Screening allows for individualized care to best meet overall and reproductive health needs.
- Preconception care is focused on reducing maternal and fetal morbidity and mortality, increasing the chances of conception when pregnancy is desired, and providing contraceptive counseling to help prevent unintended pregnancies.
- Interconception care refers specifically to care provided between pregnancies. Details and risk factors associated with previous pregnancies are integral to interconception care.
- Postpartum care provides important opportunities to assess the physical and psychosocial well-being of the mother, counsel her on infant care and family planning, and detect and give appropriate referrals for preexisting or developing chronic conditions such as diabetes, hypertension, or obesity. In 2014 in Oregon, only 57.7 percent of women who had a baby during the measurement period also had a postpartum care visit.

Health Status Data

National Performance Measure: is defined as the percent of women aged 18-44 with a past-year preventive medical visit. The measure is based on self-report to the following survey question: "About how long has it been since you last visited a doctor for a routine checkup? A routine checkup is a general physical exam, not an exam for a specific injury, illness, or condition."

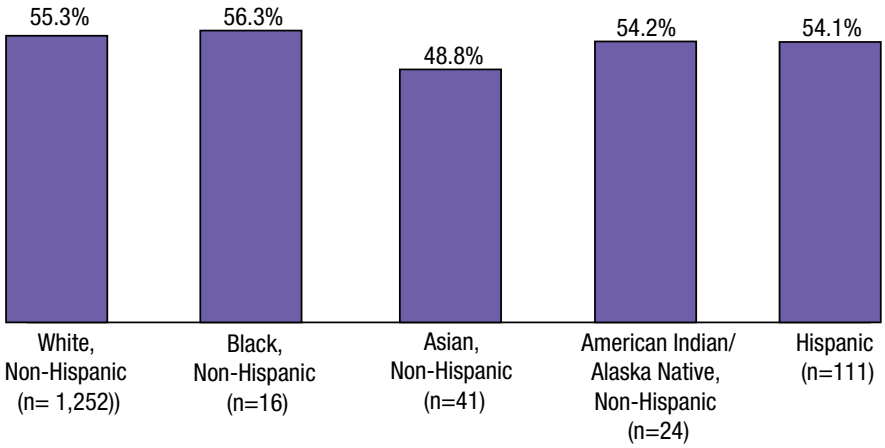
Oregon women 18-44 with insurance, with checkup in the past year

Source: Behavioral Risk Factor Surveillance System



Percent of women ages 18-44 who had a routine checkup within the past year, by race and ethnicity, Oregon, 2011

Source: Pregnancy Risk Assessment Monitoring System



Context for the Issue in Oregon

In 2014, approximately 59% of women in Oregon aged 18-44 years had a routine check-up within the past year. This percentage has increased slightly since 2011. In 2011, 55.3% of non-Hispanic white women, 56.3% of non-Hispanic black women, and 54.1% of Hispanic women had a routine checkup in the past year. The 2014 Behavioral Risk Factor Surveillance System (BRFSS) in Oregon found that 41% of the women aged 18-44 without insurance coverage had a routine checkup in the past year, while 62% of women in that age group with insurance had a checkup in the past year.

According to the Pregnancy Risk Assessment Monitoring System (PRAMS), 24.9% of 2012 Oregon births were unintended. 21.1% of all Oregon women who had a live born infant during 2012 were obese at the beginning of their pregnancy, 54.4% of women did not take the recommended folic acid supplements, and 8.4% smoked during the last three months of their pregnancy.

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Topic Area: Toxic stress and trauma

- ☐ National Priority Area
- ☐ Current State Priority Area
- ☑ Emerging State Topic

Significance of the issue

National surveillance from 1994–2011 has shown an increasing prevalence of mental health disorders among children. The brain develops in response to experiences in all domains (physical, social, emotional, linguistic, and cognitive) beginning prenatally and continuing over the lifecourse. The experiences of the first three years of life lay down the neurological pathways and connections which create procedural memories and responses, including positive or negative lifelong expectations, physiological stress responses, emotional regulation, the development of attachment and bonding, and style of relating to others.

Behavioral health problems, whether originating in childhood or adulthood, are often the first visible consequences of stress and trauma. Toxic stress results from intense adverse childhood experiences that may be sustained over a long period of time.[1] Without identification and treatment, children who are exposed to toxic stress and trauma are at increased risk for mental and addictive disorders as well as learning deficits, which in turn can contribute to academic failure, compromised occupational achievement, lower socioeconomic status, and health problems. Adults who experience violence and trauma are also at increased risk for a variety of poor health and social outcomes. Without effective support and intervention, the risk increases for inter-generational exposure to toxic stress and trauma, creating a "vicious circle" of self-reinforcing mechanisms that undermine population health and well-being.[2]

A public health approach to reducing toxic stress includes strategies for preventing or reducing extreme stress and trauma, building resilience, and providing effective care and treatment for people who have been exposed to trauma.[3]

Adverse childhood experiences (ACEs) is a term used to describe neglect, abuse, violence, and/or distressed family environments that children under the age of 18 may experience. The cumulative effect of ACEs can be traumatic, especially if experienced repeatedly at a young age.[4] ACEs are associated with negative health outcomes in adults including depression, obesity, diabetes, cardiovascular disease, asthma and others.

Context for Oregon

- Oregon has invested $2,380,000 this biennium to expand mental health-related evidence based practices to children under 8 yrs. old, increase the expertise of service providers in the area of early childhood mental health, and increase the number of mental health service providers to underserved areas of the state.
- Adults in Oregon were surveyed about their childhood exposure to ACEs in 2011 and 2013 through the Behavioral Risk Factor Surveillance System Survey (BRFSS). The results below demonstrate the relationship between the number of ACEs Oregonians experienced and their adult health outcomes.

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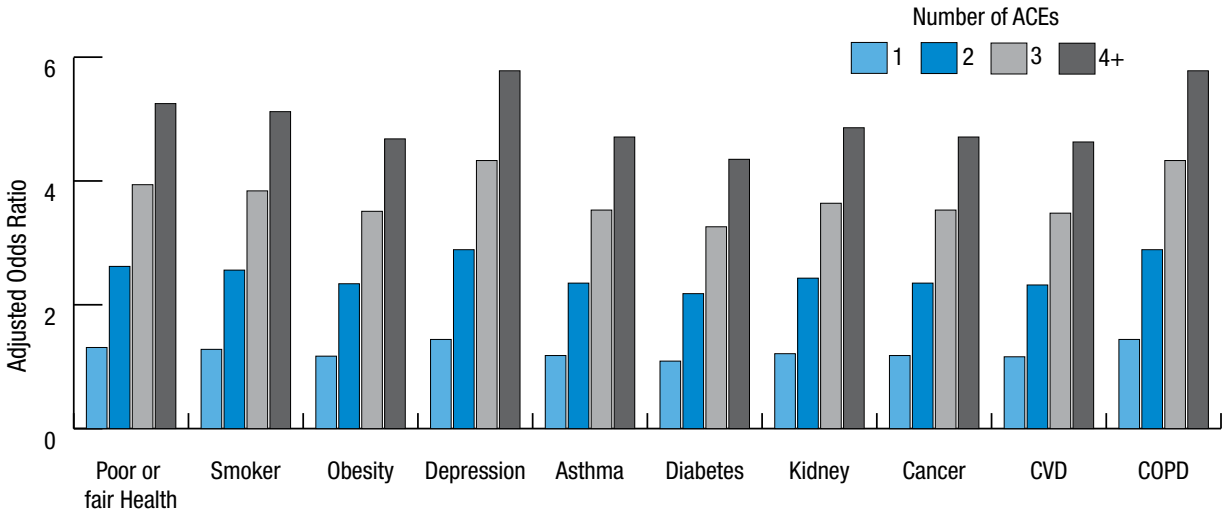
[1] *Middlebrooks, Jennifer S. and Audage, Natalie C. "The Effects of Childhood Stress on Health Across the Lifespan" available at http://www.cdc.gov/ncipc/pub-res/pdf/Childhood_Stress.pdf*

[2] *Blanch, Shern, and Steverman. "Toxic Stress, Behavioral Health, and the Next Major Era in Public Health". Mental Health America. 2014.*

3 Blanch, Shern, and Steverman. "Toxic Stress, Behavioral Health, and the Next Major Era in Public Health". Mental Health America. 2014.

[4] *Schonkoff, Jack, Th eFoundations of Lifelong Health are Vuilt in Early Childhood, Center for the Developing Child, Harvard University http://developingchild.harvard.edu/resources/reports_and_working_papers/foundations-of-lifelong-health/*

The association between ACEs and adult health outcomes, Oregon, 2013



Note: Odds ratios adjusted for age, sex, education, poverty, race and ethnicity and smoking for COPD and CVD

Stakeholder input

- In a review of 53 community health assessments conducted in Oregon over the past 3 years: mental health, depression and suicide was the 2nd most mentioned unmet maternal and child health need.
- Among 29 priority areas included in the MCH needs assessment's provider and partner survey, respondents ranked toxic stress/ACEs 1st in terms of its impact on health (4.59 on a scale of 1 to 5 with 5 being the highest degree of need), 2nd in terms of its importance to addressing equity (4.68), last in terms of the amount of time and effort currently applied (2.16), and 3rd in terms of its potential for leveraging state resources (4.30).
- Mental health was the most frequently referenced non-system emerging topic in the MCH Needs Assessment listening sessions conducted with Regional Health Equity Coalitions, the Oregon Parenting Education Collaborative, and Oregon's tribal MCH partners.

Alignment with partners

- The Addictions and Mental Health Division of the Oregon Health Authority included a goal in their Behavioral Health Strategic Plan for 2015-2018 to develop and enhance programs that emphasize prevention, early identification, and intervention for at-risk children and families.
- The Oregon Youth Authority, OHA Addictions and Mental and Public Health Division, Children First for Oregon, Oregon Health Sciences University, Portland State University, and the Oregon Pediatric Society are partnering through the Trauma Informed Leadership team to develop a framework and action plan for Trauma informed care.
- Oregon's Maternal, Infant, and Early Childhood Home Visiting program and the OHA Transformation Center have convened an Infant Mental Health Work Group to establish an Infant Mental Health Endorsement for Oregon.
- Oregon's community of early childhood professionals is working to integrate the emerging science of toxic stress and ACEs with practice and systems of care. Development of strategies to address ACEs and support parents is a focus of:
  - the Child Health Policy Team (a subcommittee of: the Joint Policy Steering Committee (JPSC) of OHA/DHS);
  - Trauma Informed Oregon;
  - Multnomah County Project Launch; and
  - Maternal, Infant, and Early Childhood Home Visiting (MIECHV).

Topic Area: Culturally and linguistically responsive services

- ☐ National Priority Area
- ☐ Current State Priority Area
- ☑ Emerging State Topic

Significance of the issue

The field of maternal and child health is grounded in a lifecourse framework which recognizes the need to eliminate health inequities in order to improve the health of all women, children, and families. Health inequities are systemic, avoidable, unfair and unjust differences in health status and mortality rates that are sustained over generations and beyond the control of individuals. Institutional changes, including the development of culturally and linguistically responsive maternal and child health (MCH) services and systems are needed to address health inequities.

The principal national standard for culturally and linguistically appropriate services (CLAS) is: Provide effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.

Context for Oregon

- As Oregon's population has becomes increasingly diverse, the need for culturally and linguistically responsive MCH services has become more urgent than ever.
- Oregon's geography, with large rural and frontier areas as well as concentrations of new immigrants in various communities, poses unique challenges for the delivery of culturally and linguistically responsive MCH services

Stakeholder input

- In a review of 53 community needs assessments, the need for culturally and linguistically accessible services was the 11th most commonly referenced unmet maternal and child health need.
- In the MCH needs assessment's provider and partner survey, respondents were asked to rate the level of need for Oregon's MCH system to build capacity for linguistically competent approaches to MCH service delivery rated the need as 3.9 out of 5 (with 5 being the highest degree of need).
- Challenges to delivery of coordinated MCH services and recommendations for improving culturally competent approaches to MCH services were discussed in an online discussion forum and listening sessions held with health equity coalitions, parent educators, tribal MCH leads, and local health departments. The need for culturally relevant services and services for non-English speakers were among the top concerns raised across all of these forums.

Oregon Center for Children & Youth with Special Health Needs

- Key stakeholder panel members underscored the importance of families being able to communicate with their child's health providers in their primary language. Panelists also stated that culturally responsive services includes education and socioeconomic status in addition to race and ethnicity as norms and expectations can also differ by these social characteristics.
- Public health nurses attending the CaCoon regional meeting in Bend identified a need for culturally responsive services in areas of the state that employ seasonal migrant workers

Alignment with partners

- Health equity and cultural responsiveness is one of the foundational capabilities in the modernization of Public Health Framework currently being proposed in the current Oregon Legislative Session.
- The delivery of culturally and linguistically responsive services is a core value for both the health and early learning systems transformation efforts in Oregon.
- Ensuring culturally and linguistically responsive MCH services is a key component of the newly revised Title V MCH Block Grant.
- Oregon's Tribal MCH grantees focus on delivery of culturally relevant MCH services in 5 of Oregon's 9 federally recognized tribes.
- CaCoon is a statewide public health nurse home visiting program for children and youth with special health care needs that includes the provision of care coordination. Promotoras work with CaCoon programs in 4 counties with high concentrations of Spanish-speaking families.

Topic Area: Nutrition and food insecurity

- ☐ National Priority Area
- ☐ Current State Priority Area
- ☑ Emerging State Topic

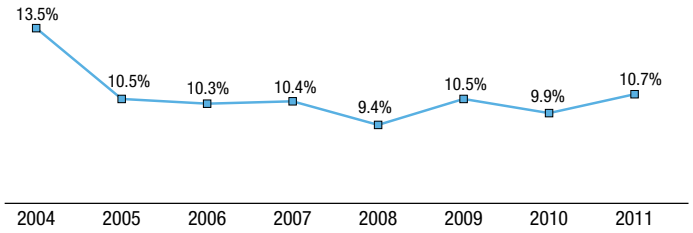
Significance of the issue

Food insecurity is defined as limited or uncertain availability of nutritionally adequate and safe foods, or limited or uncertain ability to acquire acceptable foods in socially acceptable ways.

Food insecurity influences health status in several ways. Level of access to adequate and nutritious food is related to overweight and obesity, hypertension, high cholesterol and diabetes. In addition, food insecurity affects child development and readiness to learn, and has long-lasting impacts during pregnancy. Compared to children living in food-secure households, those with inadequate access to food have higher rates of iron deficiency anemia, which may cause slow cognitive and social development, higher hospitalization rates, and increased psychosocial and academic problems. Screening for food insecurity is rarely done. Parents, caregivers and others are reluctant to admit that they are unable to provide adequate food for their families and themselves, but when asked directly will reveal that they often run out of food or cannot provide a meal that day.

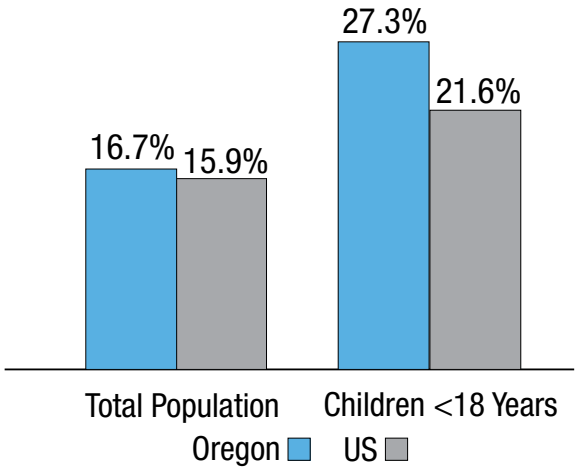
Rural communities are hit hard by food insecurity; and some populations experience hunger at higher rates. African-Americans, Latinos, and female-headed single parent families experience food insecurity at higher rates than the national average.

Percent of mothers who reported food insecurity in the 12 months before giving birth, Oregon, 2004-2011



Source: Pregnancy Risk Assessment Monitoring System

Food insecurity among total population and children <18 years, Oregon and U.S., 2012



Source: Oregon State Health Profile

Context for Oregon

- In 2012 over 16% of Oregon households were food insecure. [1] This is slightly higher than the overall US rate. Children in Oregon have much higher rates of food insecurity than the total population, and rates in Oregon are higher than in the US. Oregon rates remain higher than before the recession.
- Since 2000, Oregon has made a number of changes to reduce hunger and poverty, such as expanding the earned income tax credit, getting more people enrolled up for SNAP benefits, and opening new food pantries.
- The Nutrition and Health Screening (WIC) Program cultivates a strong regional food system in Oregon through expansion of Farm Direct Voucher program for seniors and WIC participants and strengthening healthy food choices in grocery stores across the state.

[1] *http://www.ers.usda.gov/media/1565415/err173.pdf ; http://www.feedingamerica.org/hunger-in-america/our-research/map-the-meal-gap/*

Stakeholder input

- In a review of 53 Oregon community needs assessments, nutrition/food insecurity ranked 7th out of 33 unmet maternal and child health needs.
- In the MCH needs assessment's partner and provider survey, nutrition/food insecurity was the 4th most frequent response to an open-ended question about topics that should be added to Oregon's maternal, child and adolescent health priorities (after mental health, reproductive care and education, and substance abuse).
- Nutrition/ food insecurity was the second most frequently referenced of five emerging topics in listening sessions with the Regional Health Equity Coalitions, the Oregon Parenting Education Collaborative and a webinar with tribal maternal and child health partners.

Alignment with partners

- Partners with a focus on addressing nutrition and food insecurity include:
  - Oregon Hunger Task Force, Partners for a Hunger-Free Oregon, the Nutrition and Health Screening (WIC) Program, the Supplemental Nutrition Assistance Program (SNAP), Oregon State University Extension (SNAP_ Ed), the Oregon Department of Education Child and Adult Care Food Program, and the Oregon Food Bank.
- Oregon's Nutrition and Health Screening (WIC) Program's work to address food insecurity will include:
  - Strengthening coordination and collaboration with partners to improve access to and use/preparation of healthy foods by WIC participants;
  - Support for local agency outreach to increase access to WIC services for the highest risk, most vulnerable populations and families of color; and
  - Expansion of screening for hunger and food insecurity in select WIC agencies.
- Partners for a Hunger-Free Oregon have a strategic plan for addressing food insecurity in Oregon, Ending Hunger Before It Begins, Oregon's Call to Action 2010-2015 (https://oregonhunger.org/oregon-hunger-plan)
- The Public Health Division's draft 2015-2019 Strategic Plan identified food insecurity as a long term indicator. The Division has a goal of decreasing the rate of food insecurity from 15.9% (in 2012) to 13.2% by 2019 (USDA ERS, Household Food Security) with identified strategies and actions to achieve this goal.

Plan/Report: Oregon Title V Maternal and Child Health Block Grant

Local health agency:

Name of staff completing form:

Phone number:

Email address:

Date completed:

Questions? Please contact:
Nurit Fischler
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(971) 673 - 0344
or
Maria Ness
maria.n.ness@state.or.us
(971) 673 - 0383

INSTRUCTIONS FOR COMPLETING YOUR MCH TITLE V PLAN - DUE APRIL 1, 2016

STEP 1. Complete the MCH funding overview table below

STEP 2. Use the TABS at the bottom of the screen to navigate to the appropriate sheet for each priority that your agency is working on

Note: Grantees funded at less than $25,000 per year are required to work on a minimum of 1 priority areas; $25,000-$99,000 per year a minimum of 2 priority areas; $100,000 or more per year a minimum of 3 priority areas. If you are unsure of your Title V funding level, please contact nurit.r.fischler@state.or.us

1. MCH Funding overview table instructions:

- In the funding overview table below, check off each priority area you plan to implement at your agency.
- For each checked priority area, indicate a minimum of one strategy you have chosen to implement. (For national priority areas choose strategies from the drop down lists; for state priority areas and other priorities type in your strategies.)
- If you would like to indicate more than three strategies for a particular priority area, please contact Nurit Fischler (nurit.r.fischler@state.or.us) for an expanded version of this plan/report template.
- Enter the percentage of your Title V funds that you have allocated to each strategy. The percentages you enter will automatically be summed into a total. This total should equal 100% once you have entered all your strategies.
- In addition to entering percentage of Title V funds, you can also enter the dollar amount of any other state MCH funds you intend to allocate to the strategy. The amounts you enter will also be automatically summed into a total.

2. Priority area tab instructions

Once you have completed funding overview table on this page, use the TABS below to complete your plan for each priority area your agency is working on.

Note: If you are using Title V funds to work on more than one priority, you will fill in information on more than one tab. Tabs are labelled with the priority name.

- Click on the tab for the first priority area that you are planning to work on using Title V funds (At least one national priority area is required)
- The strategies you have selected in the funding overview table will automatically appear in the priority area tabs.
- Complete the requested information on planned activities, measures, etc. for each strategy you have selected.
- Navigate to additional priority tabs and complete as needed.
- If you cannot see the tab you need, use arrows at bottom left corner of window to scroll through all tabs.

MCH Funding Overview Table

Priority Area	Strategy	Percent of Title V funds budgeted (%)	Additional funds allocated from State MCH funds - flexible perinatal and child ($)
National priority areas: select at least one.	Select at least one strategy from the drop down lists below for each national priority area you plan to work on.		
☐ Well Woman Care			
☐ Breastfeeding			
☐ Child Physical Activity			
☐ Adolescent Well Visit			
☐ Oral Health			
☐ Smoking			
State priority areas: may be selected once at least one national priority area is selected.	Type in at least one strategy below for each state priority area that you plan to work on.		
☐ Toxic Stress/Trauma/ACEs			
☐ Nutrition/Food Insecurity			
☐ Culturally/Linguistically Responsive Services			
Other locally identified priority areas or strategies funded by Title V: may be selected once at least one national priority area and strategy are selected (max 20% of Title V grant funding).	Type in each locally identified strategy below that you plan to work on.		
☐ Specify priority:	Specify strategy:		
☐ Specify priority:	Specify strategy:		
☐ Specify priority:	Specify strategy:		
☐ Title V indirect funds (max 10%)	Strategy not applicable		
	Total	0.0%	$0.00

Oregon MCH Title V Block Grant 2016-2020

Local Grantee Implementation Guidelines

Background/introduction

This document provides guidance for implementing the contractual obligations for LHAs and Tribes who receive Title V MCH Block Grant funds under PE 42 and 45 related to:

- Submission of a work plan for use of Title V funds demonstrating how Title V funds support activities that are directly related to Oregon's Title V priorities and action plan (PE 42, sec 3.b.i.);
- Provide MCAH services and activities funded by Title V which align with the Title V action plan, state and national Title V priorities and performance measures, and state-selected evidence-informed strategies and measures (PE 42, sec 3.b.ii); and
- Report on MCAH services and activities funded by Title V in an annual progress report submitted in conjunction with the LPHA Annual progress report due each year by March 1. (PE 42, sec 4).

Overview of Oregon's Title V Block Grant 3.0 Transformation

The Maternal and Child Health Bureau (MCHB) is transforming Title V's work to align with Federal health care transformation and the evolving role of maternal and child health. Under the new Federal guidance, Oregon is required to:

- ▶ Conduct a 5-year needs assessment
- ▶ Choose 8 of 15 national priority areas/performance measures, plus 3 state-specific priorities
- ▶ Develop strategies and strategic measures to "move the needle" on the national priorities
- ▶ Align use of funds with these priorities and strategies

Oregon's Title V MCH program recently completed its 5-year needs assessment and stakeholder engagement to select 8 National MCH priorities and 3 state specific MCH priorities for our Title V MCH work over the next five years. Two priorities specific to children and youth with special health needs (CYSHN) are funded separately through the Oregon Center for Children and Youth with Special Health Needs and are not addressed in this guideline. Each national priority has associated performance measures which are federally determined.

(See attached list of priorities and performance measures)

Required Title V-funded activities: priorities and strategies

Each Title V Grantees is required to work on a minimum of 1-3 Title V priorities as follows:

Title V Funding level	Minimum # of priorities
Less than $25,000 per year	1
$25,000 - $99,999 per year	2
$100,000 or more per year	3

Required Title V-funded activities: priorities and strategies (continued)

Grantees may request an exemption to work on fewer than the required number of priorities in writing from OHA

- All grantees must choose at least one of the 6 national priority areas to work on.
- Grantees that work on 2 or more priorities have the option to work on state-specific priority areas once they have satisfied the requirement to select at least one national priority area. FY 2017 plans for state-specific priority area work will include locally identified strategies and measures; local grantees are encouraged to participate in the development of state strategic plan for their priority area.
- For each priority selected, grantees will select one or more evidence-informed strategies to implement from the Title V strategy menu provided for that priority.
- Grantees will report to OHA which strategies they plan to implement and collect data needed to report on each strategy annually.
- Activities for carrying out each strategy and measures for the strategies/activities will be locally identified and tailored to community and target population-specific needs.
- All grantees are encouraged to use a variety of strategies which reflect the foundations of public health and diverse levels of influence: individual/family, community, institutional, or societal.
- Grantees working on more than one priority and/or strategy must select at least one strategy at the community, institutional, or societal level. (These will be indicated in the menu of strategies for each priority.)

Level of influence	Examples (spectrum of prevention)
Individual/relationship level	Strengthening individual knowledge and skills
Community level	Promoting community education; fostering coalitions or networks
Institutional level	Changing organizational practices, educating providers
Societal level	Influencing policy and legislation

Use of Title V funds

- Title V funds must be used in alignment with Federal Title V parameters: at least 30% for child or adolescent health and no more than 10% for indirect costs.
- Up to 20% of Title V funds can be used for locally-identified MCH work that falls outside of Oregon's Title V priorities and/or strategy menu. Any Title V funded work on locally identified priorities outside of state Title V parameters must be described in the grantee's annual Title V MCH plan and approved by OHA.
- Title V funds may be used to contract with other programs or agencies, or to support cross-county or regional collaborations, so long as the work conducted aligns with identified Title V priorities and strategies. In such cases, accountability for data collection and reporting, as well as communication with OHA, will rest with the Title V grantee (not the sub-recipient).
- Local Agencies and Tribes that are recipients of Title V funds are encouraged to find ways to leverage work and resources and collaborate on strategies.
- As long as funds are used for identified Title V priorities and strategies, with appropriate tracking and reporting there are no further constraints regarding new work or use of Title V funds to support ongoing work previously funded by another source.

Planning and selection of Title V priorities and strategies

- Each local agency will select which priorities and strategies from the Title V menu to implement with their Title V funds, based on examination of local data and self-determined local need.
- An annual plan/report reflecting selected priorities, strategies, activities and measures in alignment with Oregon's Title V Block grant is required of all Title V grantees. OHA will provide a template for the MCH Title V plan. The plan will be due annually in conjunction with the March 1st county public health plan, and will reflect activities for the upcoming state fiscal year (July 1 – June 30).
- **Note: For State Fiscal Year 2017 only (July 1, 2016 – June 30 2017)**
  - The MCH Title V Plan will be due April 1, 2016 rather than March 1st to accommodate the need for more planning time. Plans due April 1 must include selected priorities, strategies and initial plans for activities measures.
  - April – June 2016 can be used as additional time to prepare for implementation of Title V program activities and refinement of measures and data collection plans.
  - Implementation of planned Title V strategies/activities and measures collection will begin July 1, 2016.
- For tribes, the annual MCH Title V plan will replace the triennial Title V plan.
- A brief description of the justification for priority/strategy selection will be included in the annual MCH Title V plan (see template).
- Local agencies will decide on an individual basis whether to continue work on a priority/strategy over multiple years or replace them with new priority/strategy work.
- Local grantees will be required to include information regarding the percent of Title V funds used in support of different priorities and strategies in their annual MCH Title V plan (see Title V plan template).

Data tracking and reporting

- Grantees must track and report on at least the one measure for each of the strategies that they choose to implement. Measures can be locally-defined to reflect the activities each grantee chooses to implement within the strategy, and will be reviewed and approved by OHA as part of the MCH plan.
- An MCH Title V progress report will be due in conjunction with the upcoming year's MCH Title V plan on March 1st. The progress report period will cover Title V activities and measures from January 1st – December 31st of the prior year (e.g. calendar year 2016 for the March 2017 report). (see template)

Questions?

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Oregon's 2016-2020 MCH Title V Priorities and strategies

Priority/State Lead	Performance Measure	Strategies
Maternal and Women's Health		
Well woman care (Anna Stiefvater)	Percent of women with a past year preventive visit	1. Case-management to improve utilization of well-woman care 2. Provide outreach for insurance enrollment and referral to services 3. Use traditional and social marketing to educate the population and promote well woman care 4. Provide education/training on preconception/ interconception health for providers (all types) 5. Provide access to well-woman care through Family Planning Clinics 6. Use of the postpartum health care visit to increase utilization of well-woman visits
Perinatal and Infant Health		
Breastfeeding (Robin Stanton)	A) Percent of infants who are ever breastfed; B) Percent of infants breastfed exclusively through 6 months	1. Increase the number of fathers, non-nursing partner and family members, especially grandmothers, who learn about the importance of breastfeeding 2. Fill unmet needs for peer support of breastfeeding 3. Education/training of health care providers about breastfeeding 4. Education of pregnant women about breastfeeding 5. Increase the availability of breastfeeding support from professionals 6. Increase access to workplace breastfeeding support 7. Increase the support of breastfeeding at child care settings through policy, training, and workforce development 8. Advocate for program policies that support breastfeeding

(Rev 3/9/16)

Oregon's 2016-2020 MCH Title V Priorities and strategies

Priority/State Lead	Performance Measure	Strategies
Child Health		
Physical Activity for children (Heather Morrow Almeida)	Percent of children ages 6 through 11 years who are physically active at least 60 minutes per day	1. Support physical activity in child care settings through policy, training and workforce development 2. Support physical activity before, during and after school; support the implementation of HB3141 (school physical education law) 3. Promote community-wide campaigns for physical activity 4. Improve the physical environment for physical activity 5. Increase safe and active transportation options 6. Promote policies and programs for healthy worksites, with a focus on physical activity 7. Promote partnerships with clinical care providers to provide anticipatory guidance about the importance of physical activity, as recommended in the American Academy of Pediatrics Bright Futures Guideline
Adolescent Health		
Adolescent well care visit (Liz Thorne)	Percent of adolescents with a preventive services visit in the last year	1. Increase outreach to key populations in community 2. Promote practice of going beyond sports physicals to wellness exams 3. Develop and strengthen partnerships with public and private entities invested in adolescent health 4. Raise awareness of the importance of adolescent well care 5. Leverage SBHC to conduct outreach within school and community 6. Engage adolescents as community health workers or peer health educators 7. Promote policies and practices to make health care more youth-friendly 8. Investigate barriers to adolescent well visits 9. Strengthen health care privacy and confidentiality policies and practices

(Rev 3/9/16)

Oregon's 2016-2020 MCH Title V Priorities and strategies

Priority/State Lead	Performance Measure	Strategies
Children and Youth with Special Health Needs		
Medical home	Percent of children with and without special health care needs having a medical home	TBD
Transition	Percent of children with and without special health care needs who received services necessary to make transitions to adult health care	TBD
Cross-cutting or Life course		
Oral health (Amy Umphlett)	A) Percent of women who had a dental visit during pregnancy B) Percent of children ages 1 to 17 years who had a preventive dental visit in the last year	1. Provide oral health services, education and referral/case management services through Oregon's Home Visiting System 2. Provide oral health services during well-child visits as recommended in the American Academy of Pediatrics Bright Futures Guidelines 3. Collaborate with primary care providers to follow the American Congress of Obstetricians and Gynecologists (ACOG) oral health recommendations for pregnant women 4. Collaborate with Early Childhood Care and Education to plan and implement methods to increase preventive dental services for children 5. Incorporate oral health services for adolescents into School-based Health Centers (SBHCs) and adolescent well-child visits 6. Promote the provision of dental sealants and oral health education in schools 7. Educate pregnant women, parents/caregivers of children, and children 0-17 about oral health 8. Promote community water fluoridation

(Rev 3/9/16)

Oregon's 2016-2020 MCH Title V Priorities and strategies

Priority/State Lead	Performance Measure	Strategies
Smoking (Lesa Dixon-Gray)	A) Percent of women who smoke during pregnancy B) Percent of children who live in households where someone smokes	1. Develop a policy agenda that decreases youth exposure to tobacco products and decreases likelihood for initiation and use. 2. 5As Intervention within MCH Programs including Home Visiting, Oregon MothersCare, Family Planning, and WIC (if applicable) 3. Develop customized programs for specific at-risk populations of women who are smokers and of reproductive age. 4. Collaborate w/CCOs, DCOs, and medical and early childhood/education providers to build screening and intervention processes into their work practices, including workforce training. 5. Implement a media campaign that targets women during childbearing years. 6. Collaborate with the Oregon Quit Line Program to improve outreach and quit rates for pregnant and postpartum women 7. Promote expansion and utilization of health insurance coverage benefits for pregnant and postpartum women.
State-Specific Priorities		
Toxic stress, trauma, and adverse childhood experiences (Nurit Fischler)	TBD	TBD
Food insecurity and nutrition (Robin Stanton)	TBD	TBD
Culturally and linguistically responsive services (Wendy Morgan)	TBD	TBD

(Rev 3/9/16)

MCH Strategy Table: Well Woman Care

Local/State Level Strategies

Strategy Number	Strategy name/brief description	Level(s) of influence *	Sample local level activities	Sample state level activities
1	Case-management to improve utilization of well-woman care	Individual/ relationship	Educate home visiting and/or other MCH clients on the importance of well woman and pre/interconception care and provide referrals as needed.	Support local efforts and facilitate collaboration at the state level.
2	Provide outreach for insurance enrollment and referral to services	Individual/ relationship Community	a. Provide educational and enrollment opportunities, and utilize outreach workers to enroll patients in insurance plans. These services could be provided by LHDs or through collaboration with other health and human services agencies. b. Identify subgroups of women who are uninsured or underinsured and refer them to alternative services. Example: Oregon ScreenWise program http://public.health.oregon.gov/HEALTHYPEOPLEFAMILIES/WOMEN/HEALTHSCREENING/Pages/index.aspx c. Collaborate with community organizations and other groups (colleges, childcare providers, WIC, etc.) to use a community outreach model of care, i.e., women who receive services from any of many different types of health and human services organizations are screened and referred as appropriate.	Support local efforts and facilitate collaboration at the state level.
3	Use traditional and social marketing to educate the population and promote well woman care	Community	Expand public education and decrease stigma about preconception and well-woman care through traditional and social media. Examples: • CDC "Show Your Love" preconception health campaign, http://www.cdc.gov/preconception/showyourlove/index.html • "Amor Y Salud" preconception health campaign http://public.health.oregon.gov/HealthyPeopleFamilies/Women/PreconceptionHealth/amorysalud/Pages/index.aspx • Collaborate with National Text4baby program to include messages around pre/interconception health and well women care and then promote Text4baby to improve reach of the service.	Support local efforts, utilize state communication platforms and resources.

MCH Strategy Table: Well Woman Care

Strategy Number	Strategy name/brief description	Level(s) of influence *	Sample local level activities	Sample state level activities
			• 4) CDC "PACT for prevention of birth defects campaign, http://www.cdc.gov/ncbddd/birthdefects/prevention-month.html 5) Health Care Coalition of Southern Oregon preconception health media campaign	
4	Provide education/training on preconception/ interconception health for providers (providers could include primary care providers, MCH home visitors, WIC staff, family planning providers, community health workers)	Institutional	Provide education/training to improve comfort, knowledge and skills to provide appropriate pre and interconception care. Encourage pregnancy intention screening for well woman care. Resources: • National Preconception / Interconception Care Clinical Toolkit http://beforeandbeyond.org/toolkit/ • Guidelines developed by the Oregon Preconception and Reproductive Health Advisory Committee (OPRHAC) (currently in draft stage) • One Key Question Initiative http://www.onekeyquestion.org/ Have staff in LHDs dedicated to improving collaboration with primary care providers and other practitioners (community health workers, case workers, social workers, etc.)	Support local efforts, provide education and training.
5	Provide access to well-woman care through Family Planning Clinics	Individual/relationship	Integrate well woman care, including reproductive life planning, in reproductive health visits.	Support local efforts and facilitate collaboration at the state level.
6	Use of the postpartum health care visit to increase utilization of well-woman visits	Institutional	Collaborate with primary care, prenatal care providers and CCOs to develop and implement a plan to improve postpartum visit content and attendance, including communicating the value and importance of postpartum visits to women. Postpartum care should support the transition to appropriate well-woman care.	Support local efforts and facilitate collaboration at the state level.

*Examples of work at the different levels of influence

Level of influence	Examples (spectrum of prevention)
Individual/relationship	Strengthening individual knowledge and skills

MCH Strategy Table: Well Woman Care

Community	Promoting community education; fostering coalitions or networks
Institutional	Changing organizational practices, educating providers
Societal	Influencing policy and legislation

State Level only Strategies

Strategy name/brief description	Level(s) of influence	Sample state level activities
Research/assessment to identify barriers to having a usual primary care provider or PCPCH and receiving well-woman care.	Institutional	Assessment of characteristics of women who receive and do not receive well-woman care
OHP policies for provider billing for well-woman care	Societal	Collaborate with Medicaid and CCOs and advocate for payment for dyadic care for mom and baby at well-child care visits. Support development and implementation of alternative payment methodologies for perinatal and well-woman care.
Increase the number of persons covered by health insurance to improve access to well-woman care	Societal	Establish policy within OHA to fund services for subgroups of women would not quality for current coverage, example undocumented immigrants.
Improve continuity of care among insurance plans	Societal	Through policy strategies, address churn for pregnant women in order to provide continuity of care for women that may "churn" between Medicaid and the Exchange plans.

MCH Strategy Table: Breastfeeding

Strategy Number	Strategy name/brief description	Level(s) of influence*	Sample local level activities	Sample state level activities
1	Increase the number of fathers, non-nursing partner and family members, especially grandmothers, who learn about the importance of breastfeeding	Individual	Educate fathers, families, and support members to help them understand the importance of breastfeeding	Develop standardized breastfeeding messages for use by everyone who works with pregnant women and their families
		Community	Provide outreach to families to encourage accompanying mothers who attend breastfeeding classes / support Provide community awareness activities	Provide resources and outreach materials for fathers and family members
2	Fill unmet needs for peer support of breastfeeding	Individual	Provide quality breastfeeding support groups—both prenatally and postpartum—led by trained peer facilitators	Provide support for quality, trained facilitator-led breastfeeding support groups, both prenatally and postpartum Provide training for breastfeeding group peer facilitators
		Community	Support and fund community-based organizations to promote and support breastfeeding among communities of color Collaborate with local community–based organizations and hospitals to support creation and/or maintenance of mother-to-mother support groups	Support and fund community-based organizations to promote and support breastfeeding among communities of color
		Institutional	Establish referral pathways from the hospital to community support for all types of lactation care	Collaborate with other organizations to learn the level of unmet need for peer support of breastfeeding in the community or state, as well as to develop and implement a sustainable

MCH Strategy Table: Breastfeeding

Strategy Number	Strategy name/brief description	Level(s) of influence*	Sample local level activities	Sample state level activities
				plan(s) for Title V support of these programs Conduct a needs assessment to learn about pockets of need and provide resources
3	Education/training of health care providers about breastfeeding	Community	Develop a lactation community of practice where IBCLCs partner and mentor "Breastfeeding Champions" who work in primary care clinics	
		Institutional	Ensure local staff meets minimum competency and skills in lactation care and support through training and continuing education (e.g. home visiting nurse competent to function as breastfeeding consultant)	Provide training and continuing education to ensure maintenance of minimum competencies and skills Establish and incorporate minimum requirements for competency in lactation care into health programs serving pregnant and postpartum women (e.g. MCM, home visit, etc.) Develop state-wide training materials for health care providers and hospital staff
4	Education of pregnant women about breastfeeding	Individual	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	Develop standardized breastfeeding messages for use by everyone who works with pregnant women and their families Ensure that new mothers are educated about the use of breast pumps and have access to

MCH Strategy Table: Breastfeeding

Strategy Number	Strategy name/brief description	Level(s) of influence*	Sample local level activities	Sample state level activities
				resources supporting breastfeeding initiation and duration
		Community Institutional	Collaborate with hospitals, primary care providers, and CCOs to expand structured prenatal breastfeeding education classes/workshops and/or other means for pregnant women	Collaborate with hospitals, primary care providers, and CCOs to expand structured prenatal breastfeeding education classes/workshops
5	Increase the availability of breastfeeding support from professionals	Individual	Provide professional breastfeeding support that is accessible, timely and culturally appropriate for all women served	
		Community	Collaborate with organizations that provide breastfeeding support from professionals (including nurses, lactation consultants, dietitians) during the postpartum period to increase the reach of their programs to support more new mothers. Evidence-based support can be provided in a variety of settings (e.g. WIC, home, by telephone) Foster and support partnerships to increase the number of racial and ethnic minority IBCLCs to provide breastfeeding counseling	Collaborate with organizations that provide breastfeeding support from professionals (including nurses, lactation consultants, dietitians) during the postpartum period to increase the reach of their programs to support more new mothers. Foster and support partnerships to increase the number of racial and ethnic minority IBCLCs to provide breastfeeding counseling; remove barriers to IBCLC certification
		Institutional	Train public health home visiting nurses to become IBCLCs so that they are able to provide breastfeeding support while they are already in the home	Support training of public health home visiting nurses to become IBCLCs so that they are able to provide breastfeeding support while they are already in the home

MCH Strategy Table: Breastfeeding

Strategy Number	Strategy name/brief description	Level(s) of influence*	Sample local level activities	Sample state level activities
				Provide training and support for IBCLCs to be mentors and preceptors so they feel more comfortable in that role
		Societal	Improve access to professional lactation support through work with local CCO; provide education about rights for lactation services and breast pumps under the Affordable Care Act	Improve access to professional lactation support through work with CCOs and DMAP; work to support IBCLC home visits covered by insurance / OHP
6	Increase access to workplace breastfeeding support	Individual	Address individual level barriers to breast pump access and ensure that new mothers are educated on the use of breast pumps	
		Community	Foster community partnerships in promotion and adoption of lactation accommodation laws	Collaborate with the Health Promotion and Chronic Disease Prevention section and Healthy Communities to increase access to workplace breastfeeding support as part of worksite wellness efforts Promote comprehensive, high-quality lactation support programs in worksites and as part of employee benefits package via partnership development
		Institutional	Provide education and technical assistance about the benefits of comprehensive, high-quality support for breastfeeding employees	Conduct assessment and surveillance about compliance with lactation accommodation laws and workplace policies

MCH Strategy Table: Breastfeeding

Strategy Number	Strategy name/brief description	Level(s) of influence*	Sample local level activities	Sample state level activities
			Promote innovative programs that allow mothers to directly breastfeed their babies after they return to work	
		Societal	Develop and implement workplace policy and practice tools for employers to accommodate breastfeeding mothers	Decrease barriers to breast pump access: work with CCOs to improve access to breast pump coverage; streamline process to obtain breast pump from insurance without long wait periods; ensure that new mothers are fully educated on the use of breast pumps
7	Increase the support of breastfeeding at child care settings through policy, training, and workforce development	Institutional	Provide public health consultation for Early Care and Education (ECE) providers to support breastfeeding. • E.g. Develop a written breastfeeding policy Promote available trainings on breastfeeding for ECE providers. Provide resources, information, and tools to ECE providers.	Develop local public health consultation role for Early Care and Education providers Develop training resources for child care providers via Oregon Public Health Division breastfeeding web pages, update breastfeeding information in the Oregon Kids Health & Safety manual for early childhood care and education and partnership with the Oregon Center for Career Development in Childhood Care & Education
		Societal		Collaborate with the Oregon Office of Child Care, the Childhood Care and Education Coordinating Council, Child Care Resource and Referral organizations, community organizations, and/or child care providers to improve support for breastfeeding at child care sites

MCH Strategy Table: Breastfeeding

Strategy Number	Strategy name/brief description	Level(s) of influence*	Sample local level activities	Sample state level activities
				through licensing requirements, provider education and in the Quality Rating and Improvement System (QRIS) standards

*Examples of work at the different levels of influence

Level of influence	**Examples** (spectrum of prevention)
Individual/relationship	Strengthening individual knowledge and skills
Community	Promoting community education; fostering coalitions or networks
Institutional	Changing organizational practices, educating providers
Societal	Influencing policy and legislation

State-level only strategies

Strategy Name/brief description	Level of influence	Sample state level activities
Advocate for program policies that support breastfeeding	Societal	Collaborate with the Oregon Health Plan / Medical Assistance Programs, the Quality and Health Outcomes Committee (QHOC) and CCOs for implementation of policy coverage for lactation services and breast pumps Partner with the Oregon Child and Adult Care Food Program (CACFP) which will be implementing new food guidelines that benefit breastfeeding families, to advocate for guidelines that support breastfeeding Support statewide networks for home- or clinic-based follow-up care provided to all newborns in Oregon Support Temporary Aid for Needy Families (TANF) policy for breastfeeding women in JOBS program

MCH Strategy Table: Physical Activity for Children

Strategy Number	Strategy name/brief description	Level(s) of influence*	Sample local level activities	Sample state level activities
1	**Support physical activity in child care settings through policy, training and workforce development**	Societal Institutional	Provide public health consultation for Early Care and Education (ECE) providers to support physical activity. • E.g. Develop a written physical activity policy Promote and/or deliver trainings on physical activity for ECE providers. Provide resources, information, and tools to ECE providers.	Develop local public health consultation role to support ECE providers. Develop/identify/promote training resources for ECE providers. 1. Add new resources to the Oregon Public Health Division web pages 2. Update physical activity information within the Oregon Kids Healthy and Safe (OKHS) training curriculum Collaborate and promote revisions to child care regulations and QRIS standards to align with best practices and model standards.
2	**Support physical activity before, during and after school; support the implementation of HB3141 (school physical education law)**	Community Institutional	Collaborate with Healthy Communities coordinators, local school boards, PTAs, and other community organizations to: • adopt a comprehensive school physical activity program or policy that increases physical activity minutes before, during and after school (e.g recess in school wellness policies, activity breaks in class, active transportation to and from school) • promote the Oregon Healthy Schools Partnership to activate a comprehensive approach to health in school district wellness policies Educate the community about the benefits of physical activity for academic achievement and lifelong health and wellness.	Collaborate with the Health Promotion and Chronic Disease Prevention Section, the Department of Education, parents and community partners to: • support physical activity embedded throughout the day • strengthen USDA required district wellness policies and promote school wellness councils • develop, strengthen and expand state and community partnerships to support wellness in schools. Support local agencies with capacity, technical assistance and resources. Advocate for adequate resources and trained personnel.

MCH Strategy Table: Physical Activity for Children

Strategy Number	Strategy name/brief description	Level(s) of influence*	Sample local level activities	Sample state level activities
			Promote policies that support enjoyable, lifelong physical activity for children regardless of ability and gender. Collaborate with partners to establish formal agreements to promote physical activity through shared use of public properties or facilities (joint use agreements).	Collaborate with the Health Promotion and Chronic Disease Prevention Section, the Department of Education, and other partners to identify and support use of policy tools for local implementation of joint use agreements for community use of school facilities for physical activity.
3	**Promote community-wide campaigns for physical activity**	Community	Convene community partners, collaborate and foster support for community-wide campaigns that promote equity and inclusion, and the importance of physical activity for lifelong health and wellness. Collaborate with Healthy Communities coordinators, local school boards, PTAs, and other community organizations to promote and adopt point of use (stairwell) campaigns.	Support local agencies with the capacity, technical assistance and resources to take a lead role in their communities.
4	**Improve the physical environment for physical activity**	Community Societal	Collaborate with Healthy Communities coordinators, local county and city planners, architects, engineers, and other partners to identify and promote changes to the physical environment that support safe and accessible physical activity opportunities. Provide education and technical assistance about the benefits of physical activity for academic achievement and lifelong health and wellness.	Collaborate with the Health Promotion and Chronic Disease Prevention Section, ODOT, architects, engineers, and other partners to support changes to the physical environment that support safe and accessible physical activity opportunities Identify policy tools for state and local use. Provide technical assistance to support health impact assessments. Support public policies that promote equity and access for families and children.

MCH Strategy Table: Physical Activity for Children

Strategy Number	Strategy name/brief description	Level(s) of influence*	Sample local level activities	Sample state level activities
			Use Health Impact Assessments to illustrate the importance of a health lens in local land use, design and planning decisions. Promote a Health in all Policies approach.	Promote a Health in all Policies approach.
5	**Increase safe and active transportation options**	Community Societal	Collaborate with Healthy Communities coordinators, local county and city planners, architects, engineers, PTAs and other partners to support safe and active transportation options for children and families, including biking, walking, trails, public transit, Safe Routes to School, Walking School Bus, Safety Towns, etc. Provide education and technical assistance to promote safe and active transportation as a means to achieve physical activity goals and lifelong health and wellness. Use Health Impact Assessments to illustrate the importance of a health lens in local land use and transportation decisions. Partner with school districts and local and state SR2S Programs to promote and encourage pedestrian road safety audits to identify and address pedestrian safety issues for "vulnerable" users, such as low-income neighborhoods, schools, etc. and to obtain resources for education and infrastructure.	Collaborate with the Health Promotion and Chronic Disease Prevention Section, ODOT, architects, engineers, and other partners to support policy, infrastructure and funding to support safe and active transportation options. Identify policy tools for state and local use. Provide technical assistance to support health impact assessments. Promote a Health in all Policies approach.
6	**Promote policies and programs for healthy**	Community	Collaborate with Healthy Communities coordinators and other staff to conduct	Provide technical assistance to local agencies with efforts to implement policies

MCH Strategy Table: Physical Activity for Children

Strategy Number	Strategy name/brief description	Level(s) of influence*	Sample local level activities	Sample state level activities
	worksites, with a focus on physical activity	Institutional	assessment of policies, provide resources, information, training and support, and support implementation of policies for staff and client wellness. Collaborate with community businesses, organizations and schools to implement point-of-decision prompts for physical activity. Provide resources, information and tools to support healthy worksites.	and programs to support wellness and physical activity. Collaborate with and support the Cross Agency Health Improvement Project (CAHIP) Employee Wellness Program Policy efforts.
7	**Promote partnerships with clinical care providers to provide anticipatory guidance about the importance of physical activity, as recommended in the American Academy of Pediatrics Bright Futures Guidelines**	Institutional Individual / relationship	Collaborate with local primary care providers to promote physical activity guidance, evidence-based wellness programs and prevention programs and education for children. Implement enhanced support for physical activity for children and families in MCH home visiting programs.	Collaborate with primary care provider organizations and CCOs to promote use of physical activity counseling and guidance during well-child visits. Identify resources and supports for parent referrals to programs that promote healthy weight for children.

*Examples of work at the different levels of influence

Level of influence	**Examples** (spectrum of prevention)
Individual/relationship	Strengthening individual knowledge and skills
Community	Promoting community education; fostering coalitions or networks
Institutional	Changing organizational practices, educating providers
Societal	Influencing policy and legislation

MCH Strategy Table: Adolescent Well Care Visits

Strategy Number	Strategy name/brief description	Level(s) of influence *	Sample local level activities	Sample state level activities
1	Increase outreach to key populations in community.	Individual, community	Promote adolescent well visits with children aged 12-17 coming in to the local/tribal health agency for family planning visits, WIC, etc.	N/A
2	Promote practice of going beyond sports physicals to wellness exams.	Community, Institutions, Societal	Partner with schools and CCOs to provide and promote adolescent well care visits in place of sports physicals.	Work with partners to align sports physical policy with providing annual adolescent well care visits.
3	Develop and strengthen partnerships with public and private entities invested in adolescent health.	Community	Convene partners from local youth-serving organizations, CCOs, community providers, SBHCs and schools to identify shared goals and resources.	Convene partners from OHA, youth-serving state agencies and private partners to identify opportunities for policy alignment and disseminate best practices.
4	Raise awareness of the importance of adolescent well care.	Community, Institutions	Work with local youth-serving organizations, CCOs, community providers, SBHCs and schools to disseminate consistent messaging for providers, youth and families.	Pilot a media campaign directed to youth to increase awareness of importance of annual preventive care.
5	Leverage SBHC to conduct broader outreach within school and community.	Community	Conduct education and awareness activities within the school (i.e. presentations in health classes, assemblies).	N/A
6	Engage adolescents as community health workers or peer health educators.	Community	Support and train youth as peer educators.	Partner with OHA-Office of Equity and Inclusion to identify training and best practices and policies that support youth in these roles.
7	Promote policies and practices to make health care more youth-friendly.	Community, Institutional, Societal	Partner with CCOs, local providers, SBHCs to deliver patient-modeled youth-led training of providers (i.e. Adolescent Health Care Communication Training).	Partner with CCOs and OHA-Health Systems to pilot test comprehensive training and quality improvement activities for clinics.
8	Investigate barriers to adolescent well visits.	Community	Partner with local organizations to hold a listening session to understand youth's experience of care.	Fund youth participatory action research projects to illuminate youth experience of health care and promising practices.

MCH Strategy Table: Adolescent Well Care Visits

9	Strengthen health care privacy and confidentiality policies and practices.	Community, Institutional, Societal	Align policies and practices to support implementation of HB 2758 and incorporate best practices as recommended by American Academy of Pediatrics.	Education and awareness to support implementation of HB 2758. Work with OHA to identify policy opportunities for OHP members.

* Examples of work at the different levels of influence

Level of influence	**Examples** (spectrum of prevention)
Individual/relationship	Strengthening individual knowledge and skills
Community	Promoting community education; fostering coalitions or networks
Institutional	Changing organizational practices, educating providers
Societal	Influencing policy and legislation

MCH Strategy Table: Oral Health

Strategy Number	Strategy name/brief description	Level(s) of influence*	Sample local level activities	Sample state level activities
1	Provide oral health services, education and referral/case management services through Oregon's Home Visiting System	Individual/Relationship Institutional	Provide oral health screenings and fluoride varnish applications (if trained), oral health education (including the reduction of risk factors in the home), and referral/case management services for dental care through integration into Oregon's Home Visiting System: • MIECHV • Maternity Case Management • Nurse Family Partnership • Babies First! • CaCoon	Develop/identify resources that can be utilized by local programs. Support First Tooth trainings for nurses.
2	Provide oral health services during well-child visits as recommended in the American Academy of Pediatrics Bright Futures Guidelines	Community Institutional Individual/relationship Institutional	Collaborate with CCOs, FQHCs, rural health centers, tribal health centers, school-based health centers, and primary care providers to provide oral health services during well-child visits. • e.g. by implementing First Tooth Program*. Supply a First Tooth trainer for health care providers in the county. ** The Oregon Oral Health Coalition (OrOHC) administers the First Tooth Program, which is a train-the-trainer program that teaches medical and dental providers to deliver early childhood caries prevention services (oral health screenings, fluoride varnish, anticipatory guidance, and referral/case management services) for children 0 to 5 years old.*	Collaborate with CCOs, local health departments, FQHCs, rural health centers, tribal health centers, school-based health centers, and primary care providers to provide oral health services during well-child visits. Collaborate with OrOHC to promote the First Tooth Program.
3	Collaborate with primary care providers	Community	Develop partnerships and communicate with CCOs, FQHCs, rural health centers, tribal	Communicate with CCOs, local health departments, FQHCs, rural health

MCH Strategy Table: Oral Health

Strategy Number	Strategy name/brief description	Level(s) of influence*	Sample local level activities	Sample state level activities
	to follow the American Congress of Obstetricians and Gynecologists (ACOG) oral health recommendations for pregnant women	Community Institutional	health centers, school-based health centers, and primary care providers to encourage use of ACOG oral health recommendations* for pregnant women. Develop/identify tools that can be utilized. Implement the *Maternity: Teeth for Two* program** when available. ** ACOG recommendations include talking to the patient about the importance of oral health and educating her about the safety of dental health procedures during pregnancy.* *** The Oregon Oral Health Coalition (OrOHC) is developing a curriculum, Maternity: Teeth for Two, to educate pregnant women and the medical workforce on the importance of oral health care during pregnancy.*	centers, tribal health centers, school-based health centers, and primary care providers to encourage use of ACOG oral health recommendations for pregnant women. Develop/identify tools that can be utilized. Continue to assist OrOHC in developing the *Maternity: Teeth for Two* curriculum.
4	Collaborate with Early Childhood Care and Education to plan and implement methods to increase preventive dental services for children	Individual/Relationship Institutional Community Institutional	Coordinate with Early Childhood Care and Education providers to implement a daily oral hygiene program for children (e.g. brushing after each meal, fluoride rinse/tablets). Provide resources, information and tools for Early Childhood Care and Education providers targeted at parents and children that: • Promote good oral hygiene practices • Encourage preventive dental visits at recommended times/frequencies	Provide resources, information and tools for Early Childhood Care and Education providers targeted at parents and children that: • Promote good oral hygiene practices • Encourage preventive dental visits at recommended times/frequencies

MCH Strategy Table: Oral Health

Strategy Number	Strategy name/brief description	Level(s) of influence*	Sample local level activities	Sample state level activities
5	Incorporate oral health services for adolescents into School-based Health Centers (SBHCs) and adolescent well-child visits	Community Institutional	Build partnerships and collaborate with the state School-based Health Center (SBHC) Program, CCOs, FQHCs, rural health centers, tribal health centers, and primary care providers to incorporate oral health services into SBHCs and adolescent well-child visits. • Follow Bright Futures guidelines. • Topics would include oral hygiene and the usage of mouth guards during contact sports.	Collaborate with the state School-based Health Center (SBHC) Program, CCOs, local health departments, FQHCs, rural health centers, tribal health centers, and primary care providers to incorporate oral health services into SBHCs and adolescent well-child visits.
6	Promote the provision of dental sealants and oral health education in schools	Community	Partner with school dental sealant programs to provide oral health education for students in K-12 grades. **** The Mercy Foundation Healthy Kids Outreach Program is an example.*	Continue to operate the statewide School-based Dental Sealant Program. Administer the mandatory certification program for local school dental sealant programs.
7	Educate pregnant women, parents/caregivers of children, and children 0-17 about oral health	Community Community	Develop and distribute culturally appropriate oral health education materials, public service announcements, and social media messages geared towards specific target audiences: • Pregnant women • Parents and caregivers of young children • Young children 0-5 • School-age children 6-12 • Adolescents 13-17 • Schools Register to be an outreach partner and promote the Text4baby program*.	Develop and distribute culturally appropriate oral health education materials, public service announcements, and social media messages geared towards specific target audiences: • Pregnant women • Parents and caregivers of young children • Young children 0-5 • School-age children 6-12 • Adolescents 13-17 • Schools

MCH Strategy Table: Oral Health

Strategy Number	Strategy name/brief description	Level(s) of influence*	Sample local level activities	Sample state level activities
		Individual/Relationship	Provide oral health education and/or referral/case management services through: • Oregon MothersCare program • WIC program • Other appropriate venues (e.g. immunizations, tobacco prevention diabetes prevention)	
		Individual/Relationship	Utilize Outreach Coordinators to provide oral health toolkits, oral health education, and/or referral/case management services to pregnant women and children. ** Text4baby is a free health text messaging service for pregnant women and moms with babies under one year. Oral health messages are provided.*	
8	Promote community water fluoridation	Community	Build partnerships and collaborate with dental care providers, medical providers, professional organizations, and businesses to promote community water fluoridation through education and policy change.	Build partnerships and collaborate with local governments, CCOs, DCOs, dental care providers, and dental professional organizations to promote community water fluoridation through education and policy change.
		Community	Develop culturally appropriate water fluoridation education materials, public service announcements, and social media messages for specific target audiences.	Develop culturally appropriate water fluoridation education materials, public service announcements, and social media messages for specific target audiences.
		Societal	Collaborate with the local City Council to fluoridate the city's water supply.	

MCH Strategy Table: Oral Health

*Examples of work at the different levels of influence

Level of influence	**Examples** (spectrum of prevention)
Individual/relationship	Strengthening individual knowledge and skills
Community	Promoting community education; fostering coalitions or networks
Institutional	Changing organizational practices, educating providers
Societal	Influencing policy and legislation

State-level only Strategies

Strategy	**Level of influence**	**Sample state level activities**
Integrate oral health into state Maternal and Child Health (MCH), Health Promotion, and Chronic Disease Prevention Programs	Institutional	Incorporate oral health across the lifespan into all state MCH, chronic disease prevention, and health promotion programs: • Perinatal health and infant mortality reduction • Injury prevention • Tobacco cessation • Cancer prevention • Immunizations • Obesity prevention • Diabetes, heart disease and stroke prevention
Advocate for policies that require dentists who accept Medicaid patients to provide services to pregnant women and young children	Institutional Societal	Collaborate with OHA and CCOs to establish organizational policies in provider contracts that require any dentist who accepts Medicaid patients to provide services to young children and pregnant women.
Advocate with OHA and the Metrics and Scoring Committee to add CCO measures and incentives for dental care	Societal	Collaborate with OHA and the Metrics and Scoring Committee to advocate for 1) adding CCO measures that align with the national Title V measures for dental visits for pregnant women and children, and 2) incentivizing CCOs for reaching benchmarks for those measures.

MCH Strategy Table: Oral Health

Strategy	Level of influence	Sample state level activities
Integrate Title V strategies and activities with other statewide strategic plans	Community	Collaborate with the Oregon Oral Health Coalition (OrOHC) and Oral Health Funders Collaborative to incorporate Title V strategies and activities into the *Strategic Plan for Oral Health in Oregon: 2014- 2020.*
	Institutional	Integrate Title V strategies and activities with the Public Health Division's State Health Improvement Plan and Modernization of Public Health work.

MCH Strategy Table: Smoking

Strategy Number	Strategy name/brief description	Level(s) of influence*	Sample local level activities	Sample state level activities
1	Develop a policy agenda that decreases youth exposure to tobacco products and decreases likelihood for initiation and use.	Societal Institutional	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.	Work w/HPCDP to decrease youth exposure to tobacco products. Work with Adolescent Health – SBHCs – to review policies regarding tobacco policies and messages for youth.
2	5As Intervention within MCH Programs including Home Visiting, Oregon MothersCare, Family Planning, and WIC (if applicable)	Individual Institutional	Train staff in 5As and Motivational interviewing (MI). Establish systems to track and record delivery of 5As counseling and quitline referrals Conduct the 5As intervention at each visit or encounter with MCH clients who smoke. Participate in continuous quality improvement regarding 5As provision to clients.	Provide and fund training opportunities Provide technical assistance Provide continuous quality improvement
3	Develop customized programs for specific at-risk populations of women who are smokers and of reproductive age.	Community Institutional	Choose a customized Evidence-Informed Program to implement for MCH population. Collaborate with existing smoking cessation providers to develop local systems for delivering customized population-specific programs. Develop and implement a work plan for conducting customized program.	Provide MCH Programs and Tribes with a menu of customized EI Programs. Provide technical assistance to local MCH Programs and Tribes in implementing programs.
4	Collaborate w/CCOs, DCOs, and medical and	Institutional	Engage CCOs, DCOs, ELC Hubs and/or medical and early childhood/education	Provide liaison between MCH Programs and Innovator Agents

MCH Strategy Table: Smoking

Strategy Number	Strategy name/brief description	Level(s) of influence*	Sample local level activities	Sample state level activities
	early childhood/education providers to build screening and intervention processes into their work practices, including workforce training.		providers as partners and encourage building screening and intervention processes into medical practices. Organize/provide 5As and Motivational Interviewing training for CCOs, DCOs, ELCs, and/or medical and early childhood/education providers. Work with local TPEP Program as a partner to apply for HPCDP SEARCH Grant	regarding CCO, DCO, ELC Hubs and/or medical and early childhood/education providers. Work w/HPCDP and CCOs to provide trainers for medical practice workforce.
5	Implement a media campaign that targets women during childbearing years.	Community	Collaborate with TPEP Programs to implement HPDCP media campaign, integrating a women's health and pregnancy component	Collaborate with HPCDP around their media campaigns (integrate a pregnancy component). Contract w/Social Marketing Firm to conduct media campaign. Utilize social marketing theory in campaign development.
6	Collaborate with the Oregon Quit Line Program to improve outreach and quit rates for pregnant and postpartum women	Community Institutional	Ensure that every MCH client who smokes receives quit line information. 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).	Work with HPCDP to improve collection of quit line data re: pregnant women Work with County MCH Programs to encourage quit line referral
7	Promote expansion and utilization health insurance coverage	Community Institutional	Ensure that MCH population is made aware of tobacco cessation benefits for the Oregon Health Plan	Work with HPCDP to insure that health systems are providing required coverage benefits.

MCH Strategy Table: Smoking

Strategy Number	Strategy name/brief description	Level(s) of influence*	Sample local level activities	Sample state level activities
	benefits for pregnant and postpartum women.		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.	Assist MCH Programs to promote knowledge about cessation benefits to MCH population in OR. Encourage PEBB plans to provide full health insurance tobacco coverage benefits for pregnant and postpartum women

*Examples of work at the different levels of influence

Level of influence	**Examples** (spectrum of prevention)
Individual/relationship	Strengthening individual knowledge and skills
Community	Promoting community education; fostering coalitions or networks
Institutional	Changing organizational practices, educating providers
Societal	Influencing policy and legislation

Sample Measures: Well Woman Visit

National Performance Measure: Percent of women with a past year preventive visit

Strategy #	Strategy	Activity	Measure	Numerator (if applicable)	Denominator (if applicable)
1	Case-management to improve utilization of well-woman care	Educate home visiting and/or other MCH clients on the importance of well woman and pre/interconception care and provide referrals as needed.	Percentage of home visiting clients who needed and received a referral to appropriate well-woman or pre/interconception care.	Number of home visiting clients not already receiving well woman care, who received a referral to appropriate well-woman or pre/interconception care.	Number of home visiting clients not already receiving well woman care.
4	Provide education/training on preconception/ interconception health for providers (providers could include primary care providers, MCH home visitors, WIC staff, family planning providers, community health workers)	Provide education/training to improve comfort, knowledge and skills to provide appropriate pre and interconception care. Encourage pregnancy intentional screening for well woman care.	Number of providers who have received education/training on preconception/ interconception health.	N/A	N/A
5	Provide access to well-woman care through Family Planning Clinics	Integrate well woman care, including reproductive life planning, in reproductive health visits.	Percentage of patients at family planning clinics who received pregnancy intention screening.	Number of patients at family planning clinics who received pregnancy intention screening.	Number of family planning patients at the local/tribal health agency.

Sample Measures: Breastfeeding

National Performance Measures: A. Percent of infants who are ever breastfed and B. Percent of infants breastfed exclusively through 6 months

Strategy #	Strategy	Activity	Measure	Numerator (if applicable)	Denominator (if applicable)
1	Increase the number of fathers, non-nursing partners and family members, especially grandmothers, who learn about the importance of breastfeeding.	Provide outreach to families to encourage accompanying mothers who attend breastfeeding classes / support.	Percentage of pregnant and breastfeeding women receiving services whose family member participated in breastfeeding classes/support.	Number of pregnant and breastfeeding women receiving services whose family member participated in breastfeeding classes/support.	Number of pregnant & breastfeeding mothers receiving services.
2	Fill unmet needs for peer support of breastfeeding.	Collaborate with local community–based organizations and hospitals to support creation &/or maintenance of mother-to-mother support groups.	Number of mother-to-mother peer support groups in county/tribe.	N/A	N/A
3	Education/training of health care providers about breastfeeding.	Ensure local staff meets minimum competency and skills in lactation care and support training and continuing education.	Percentage of staff who care for pregnant and postpartum women, who meet minimum competency in lactation care.	Number of staff who care for pregnant and post-partum women, who meet minimum competency for lactation care.	Number of staff who care for pregnant and post-partum women.

Sample Measures: Physical Activity

National Performance Measure: Percent of children ages 6 through 11 who are physically active at least 60 minutes per day

Strategy #	Strategy	Activity	Measure	Numerator (if applicable)	Denominator (if applicable)
1	Support physical activity in child care settings through policy, training and workforce development.	Promote and/or deliver specialized training to child care providers on increasing physical activity in child care.	Percentage of child care providers in county/tribe who have received specialized training on increasing physical activity in child care.	Number of child care providers in county/tribe who have received specialized training on increasing physical activity in child care.	Number of child care providers in county/tribe.
2	Support physical activity before, during and after school; support the implementation o fHB3141 (school physical education law for grades K-8)	Collaborate with partners to establish formal agreements to promote physical activity through shared use of public properties or facilities (joint use agreements).	Number of formal agreements between the local/tribal agency and other government entities for shared use of public properties or facilities (e.g., joint-use agreements).	N/A	N/A
		Collaborate with Healthy Communities, local school boards, PTAs, and other community organizations to adopt a comprehensive school physical activity program or policy that increases physical activity minutes	Percentage of schools (K-5, 6-8) that provide the required minutes of physical education each week.	Number of schools (K-5, 6-8) that provide the required minutes of physical education each week.	Total number of schools (K-5, 6-8).

Sample Measures: Adolescent Well Visit

National Performance Measure: Percent of adolescents with a preventive services visit in the last year

Strategy #	Strategy	Activity	Measure	Numerator (if applicable)	Denominator (if applicable)
1	Increase outreach to key populations in community.	Promote adolescent well visits with children aged 12-17 coming in to the local/tribal health agency for family planning visits, WIC, etc.	Percentage of adolescents aged 12-17 who receive messages promoting the importance of adolescent well visits while they are visiting the local/tribal health agency for other services.	Number of adolescents aged 12-17 who receive messages promoting the importance of adolescent well visits while they are visiting the local/tribal health agency for other services.	Number of adolescents aged 12-17 who visit the local/tribal health agency for other services.
2	Promote the practice of going beyond sports physical exams to wellness exams.	Partner with schools and CCOs to provide and promote adolescent well care visits in place of sports physicals.	Percentage of schools and CCOs with a documented commitment to promote adolescent well care visits in place of sports physicals.	Number of schools and CCOs with a documented commitment to promote adolescent well care visits in place of sports physicals.	Number of schools and CCOs within the county/tribe.
5	Leverage school based health centers (SBHC) to conduct outreach within the school and community.	Conduct education and awareness activities within the school (i.e. presentations in health classes, assemblies).	Percentage of adolescent student visits to the SBHC that were for a well care visit.	Number of adolescent students who received a well care visit at a SBHC.	Number of adolescent students who were seen at the SBHC.

Sample Measures: Oral Health

National Performance Measures: A. Percent of women who had a dental visit during pregnancy and B. Percent of infants and children, ages 1 to 17 years, who had a preventive dental visit in the last year

Strategy #	Strategy	Activity	Measure	Numerator (if applicable)	Denominator (if applicable)
1	Provide oral health services, education and referral/case management services through Oregon's Home Visiting System.	Provide oral health screenings and fluoride varnish applications (if trained), oral health education (including the reduction of risk factors in the home), and referral/case management services through integration into Oregon's Home Visiting System.	Percentage of pregnant women and children provided with oral health screenings and fluoride varnish applications, oral health education, and/or referral/case management services by Oregon's Home Visiting System.	Number of pregnant women and children provided with oral health screenings and fluoride varnish applications, oral health education, and/or referral/case management services by Oregon's Home Visiting System.	Number of pregnant women and children receiving services from Oregon's Home Visiting System.
2	Provide oral health services during well-child visits as recommended in the American Academy of Pediatrics Bright Futures Guidelines.	Collaborate with CCOs, FQHCs, rural health centers, tribal health centers, school-based health centers, and primary care providers to provide oral health services during well-child visits – e.g by implementing the First Tooth Program	Percentage of CCOs, FQHCs, rural health centers, tribal health centers, school-based health centers, and primary care providers that provide oral health services during well-child visits.	Number of CCOs, FQHCs, rural health centers, tribal health centers, school-based health centers, and primary care providers that provide oral health services during well-child visits.	Number of CCOs, FQHCs, rural health centers, tribal health centers, school-based health centers, and primary care providers.
			Percentage of children on Medicaid with an oral health assessment and/or fluoride varnish application (Medicaid codes D0191, D1206, and D9188).	Number of children on Medicaid with an oral health assessment and/or fluoride varnish application (Medicaid codes D0191, D1206, and D9188).	Number of children on Medicaid.

Sample Measures: Smoking

National Performance Measures: A. Percent of women who smoke during pregnancy and B. Percent of children who live in households where someone smokes

Strategy #	Strategy	Activity	Measure	Numerator (if applicable)	Denominator (if applicable)
2	5As Intervention within MCH Programs including Home Visiting, Oregon Mothers Care, Family Planning, and WIC	Conduct the 5As intervention at each visit with all MCH clients who smoke.	Percentage of MCH clients who smoke, and receive the 5As intervention at each visit.	Number of MCH clients who smoke, and receive the 5As intervention at each visit.	Number of MCH clients who smoke.
3	Develop customized programs for specific at-risk populations of women who are smokers and of reproductive age.	Collaborate with existing smoking cessation providers to develop systems for delivering customized population-specific programs	Percentage of eligible women who are enrolled in customized smoking cessation programs.	Number of eligible women who are enrolled in customized smoking cessation programs.	Number of eligible women.
4	Collaborate w/CCOs, DCOs, and medical and early childhood/education providers to build screening and intervention processes into their work practices, including workforce training.	Organize/provide 5As and motivational interviewing training for CCOs, DCOs, early learning hubs, and/or medical and early childhood/education providers.	Number of training activities for CCOs, DCOs, early learning hubs, and/or medical and early childhood/education providers.	N/A	N/A

MCH Title V Planning Worksheet: Well Woman Care

Strategies (see strategy table for more details and examples of activities associated with these strategies)

1. Case-management to improve utilization of well-woman care
2. Provide outreach for insurance enrollment and referral to services
3. Use traditional and social marketing to educate the population and promote well woman care
4. Provide education/training on preconception/ interconception health for providers (all types)
5. Provide access to well-woman care through Family Planning Clinics
6. Use of the postpartum health care visit to increase utilization of well-woman visits

What strategy do you plan to implement? (from the list above)	What is the need in your community that this strategy addresses?	What activities will you do to implement this strategy in your community?	What populations will be impacted?	How will you measure your progress? (see sample measures)	Where will you get the data to report on your measure?	Technical assistance needs?

Other notes…

MCH Title V Planning Worksheet: Physical Activity

Strategies (see strategy table for more details and examples of activities associated with these strategies)

1. Support physical activity in child care settings through policy, training and workforce development
2. Support physical activity before, during and after school; support the implementation of HB3141 (school physical education law)
3. Promote community-wide campaigns for physical activity
4. Improve the physical environment for physical activity
5. Increase safe and active transportation options
6. Promote policies and programs for healthy worksites, with a focus on physical activity
7. Promote partnerships with clinical care providers to provide anticipatory guidance about the importance of physical activity, as recommended in the American Academy of Pediatrics Bright Futures Guidelines

What strategy do you plan to implement? (from the list above)	What is the need in your community that this strategy addresses?	What activities will you do to implement this strategy in your community?	What populations will be impacted?	How will you measure your progress? (see sample measures)	Where will you get the data to report on your measure?	Technical assistance needs?

Other Notes:

MCH Title V Planning Worksheet: Breastfeeding

Strategies (see strategy table for more details and examples of activities associated with these strategies)

1. Increase the number of fathers, non-nursing partner and family members, especially grandmothers, who learn about the importance of breastfeeding
2. Fill unmet needs for peer support of breastfeeding
3. Education/training of health care providers about breastfeeding
4. Education of pregnant women about breastfeeding
5. Increase the availability of breastfeeding support from professionals
6. Increase access to workplace breastfeeding support
7. Increase the support of breastfeeding at child care settings through policy, training, and workforce development
8. Advocate for program policies that support breastfeeding

What strategy do you plan to implement? (from the list above)	What is the need in your community that this strategy addresses?	What activities will you do to implement this strategy in your community?	What populations will be impacted?	How will you measure your progress? (see sample measures)	Where will you get the data to report on your measure?	Technical assistance needs?

Other Notes:

MCH Title V Planning Worksheet: Adolescent well care visit

Strategies (see strategy table for more details and examples of activities associated with these strategies)

1. Increase outreach to key populations in community
2. Promote practice of going beyond sports physicals to wellness exams
3. Develop and strengthen partnerships with public and private entities invested in adolescent health
4. Raise awareness of the importance of adolescent well care
5. Leverage SBHC to conduct outreach within school and community
6. Engage adolescents as community health workers or peer health educators
7. Promote policies and practices to make health care more youth-friendly
8. Investigate barriers to adolescent well visits
9. Strengthen health care privacy and confidentiality policies and practices

What strategy do you plan to implement? (from the list above)	What is the need in your community that this strategy addresses?	What activities will you do to implement this strategy in your community?	What populations will be impacted?	How will you measure your progress? (see sample measures)	Where will you get the data to report on your measure?	Technical assistance needs?

Other Notes:

MCH Title V Planning Worksheet: Oral health

Strategies (see strategy table for more details and examples of activities associated with these strategies)

1. Provide oral health services, education and referral/case management services through Oregon's Home Visiting System
2. Provide oral health services during well-child visits as recommended in the American Academy of Pediatrics Bright Futures Guidelines
3. Collaborate with primary care providers to follow the American Congress of Obstetricians and Gynecologists (ACOG) oral health recommendations for pregnant women
4. Collaborate with Early Childhood Care and Education to plan and implement methods to increase preventive dental services for children
5. Incorporate oral health services for adolescents into School-based Health Centers (SBHCs) and adolescent well-child visits
6. Promote the provision of dental sealants and oral health education in schools
7. Educate pregnant women, parents/caregivers of children, and children 0-17 about oral health
8. Promote community water fluoridation

What strategy do you plan to implement? (from the list above)	What is the need in your community that this strategy addresses?	What activities will you do to implement this strategy in your community?	What populations will be impacted?	How will you measure your progress? (see sample measures)	Where will you get the data to report on your measure?	Technical assistance needs?

Other Notes:

MCH Title V Planning Worksheet: Smoking

Strategies (see strategy table for more details and examples of activities associated with these strategies)

1. Develop a policy agenda that decreases youth exposure to tobacco products and decreases likelihood for initiation and use.
2. 5As Intervention within MCH Programs including Home Visiting, Oregon MothersCare, Family Planning, and WIC (if applicable)
3. Develop customized programs for specific at-risk populations of women who are smokers and of reproductive age.
4. Collaborate w/CCOs, DCOs, and medical and early childhood/education providers to build screening and intervention processes into their work practices, including workforce training.
5. Implement a media campaign that targets women during childbearing years.
6. Collaborate with the Oregon Quit Line Program to improve outreach and quit rates for pregnant and postpartum women
7. Promote expansion and utilization of health insurance coverage benefits for pregnant and postpartum women.

What strategy do you plan to implement? (from the list above)	What is the need in your community that this strategy addresses?	What activities will you do to implement this strategy in your community?	What populations will be impacted?	How will you measure your progress? (see sample measures)	Where will you get the data to report on your measure?	Technical assistance needs?

Other Notes:

Technical Assistance and Resources for Title V Strategy Planning

OHA Public Health Division MCH Title V contacts

Role or topic	Name	Email	Phone
Title V Director	Cate Wilcox	cate.s.wilcox@state.or.us	971 673-0299
Title V Director for Children and Youth with Special Health Needs	Marilyn Hartzell	hartzell@ohsu.edu	503 494-6961
Title V Coordinator	Nurit Fischler	nurit.r.fischler@state.or.us	971 673-0344
Tribal MCH Coordinator	Julie McFarlane	julie.m.mcfarlane@state.or.us	971 673-0365
Adolescent Health Manager	Jessica Duke	Jessica.duke@state.or.us	971 673-0242
Measures development and tracking	Maria Ness	maria.n.ness@state.or.us	971 673-0383
Well woman care	Anna Stiefvater	anna.k.stiefvater@state.or.us	971 673-1490
Breastfeeding	Robin Stanton	Robin.w.stanton@state.or.us	971 673-0261
Child physical activity	Heather Morrow-Almeida	Heather.r.morrow-almeida@state.or.us	971 673-1883
Adolescent well care	Liz Thorne	elizabeth.k.thorne@state.or.us	971 673-0377
Oral health	Amy Umphlett	amy.m.umphlett@state.or.us	971 673-1564
Smoking	Lesa Dixon-Gray	lesa.dixon-gray@state.or.us	971 673-0360
Culturally and Linguistically responsive services	Wendy Morgan	wendy.morgan@state.or.us	971 673-0353
Food insecurity/nutrition	Robin Stanton	robin.w.stanton@state.or.us	971 673-0261
Toxic stress, trauma, ACEs	Nurit Fischler	nurit.r.fischler@state.or.us	971 673-0344
Nurse consultation	Anna Stiefvater Fran Goodrich	anna.k.stiefvater@state.or.us Francine.goodrich@state.or.us	971 673-1490 971 673-0262

MCH resources online

Oregon:

Oregon Public Health Division, MCH Title V website (includes information about Oregon's Title V needs assessment, priorities and measures): *http://Healthoregon.org/titlev*

Data from Oregon's survey of postpartum women (PRAMS):
https://public.health.oregon.gov/HealthyPeopleFamilies/DataReports/prams/Pages/index.aspx

Oregon Home visiting:
https://public.health.oregon.gov/HealthyPeopleFamilies/Babies/HomeVisiting/Pages/index.aspx

National

Association of Maternal and Child Health Programs (AMCHP):
http://www.amchp.org/pages/default.aspx

AMCHP archived webinars on Title V priorities and measurement:
http://www.amchp.org/AboutTitleV/Resources/Pages/State-Action-Plan.aspx

MCHB Strengthen the Evidence Base initiative – Johns Hopkins:
http://www.semch.org/

Priority Specific Resources

Well woman care:

CDC Preconception Health and Health Care	*http://www.cdc.gov/preconception/index.html*
CDC "Show Your Love" preconception health campaign	*http://www.cdc.gov/preconception/showyourlove/index.html*
CDC "PACT" for prevention of birth defects campaign	*http://www.cdc.gov/ncbddd/birthdefects/prevention-month.html*
Oregon's "Amor Y Salud" preconception health campaign	*http://public.health.oregon.gov/HealthyPeopleFamilies/Women/PreconceptionHealth/amorysalud/Pages/index.aspx*
National Preconception / Interconception Care Clinical Toolkit	*http://beforeandbeyond.org/toolkit/*
One Key Question Initiative	*http://www.onekeyquestion.org/*
ACOG Annual Women's Health Care	*http://www.acog.org/About-ACOG/ACOG-Departments/Annual-Womens-Health-Care*
Women's Preventive Services Guidelines	*http://www.hrsa.gov/womensguidelines/*

Breastfeeding

Public Health Division Breastfeeding website	*http://public.health.oregon.gov/HealthyPeopleFamilies/Babies/Breastfeeding/Pages/index.aspx*
United States Breastfeeding Committee	*http://www.usbreastfeeding.org/*
Centers for Disease Control and Prevention - Breastfeeding	*http://www.cdc.gov/breastfeeding/*

Physical Activity for Children

Let's Move!	*http://www.letsmove.gov/get-active*
ChangeLab Solutions	*http://www.changelabsolutions.org/landing-page/active-accessible-communities*
Institute of Medicine, Educating the Student Body	*http://iom.nationalacademies.org/Reports/2013/Educating-the-Student-Body-Taking-Physical-Activity-and-Physical-Education-to-School.aspx*
Oregon Health Authority, Physical Activity at Work	*https://public.health.oregon.gov/PreventionWellness/HealthyCommunities/HealthyWorksites/Pages/physactwk.aspx*
Oregon Public Health Institute, Wellness at Work	*http://www.wellnessatworkoregon.org/*

Adolescent well care visit

Adolescent Well Care Guidance Document for CCOs. This document covers commonly cited challenges to adolescent well care, and opportunities for improvement by CCOs and providers	*http://www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx*
Paving the Road to Good Health. Guide developed by Centers for Medicare and Medicaid Services (CMS) provides strategies for states to increase adolescent well care visits, highlights state and program models and new ways to partner to increase capacity.	*www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/Pavingthe-Road-to-Good-Health.pdf*
Minor Rights: Access and Consent to Health Care. Provides an overview of Oregon laws surrounding minor consent.	*http://public.health.oregon.gov/HealthyPeopleFamilies/Youth/Pages/index.aspx*

Priority Specific Resources

Smoking:

Customized Programs for Pregnant Women (smoking)

Baby and Me, Tobacco Free was published in the MCH Journal (Jan, 2011)	*http://www.babyandmetobaccofree.org/*
First Breath, Second Wind focuses on tobacco cessation for pregnant women in Native American communities.	*http://www.tobaccocessation.org/sf/pdfs/cpr/23%29%20Second%20Wind%20First%20Breath_Facilitator%20Guide.pdf*
The Smoking Cessation and Reduction in Pregnancy Treatment Program (SCRIPT).	*http://www.sophe.org/SCRIPT.cfm*
You Quit, Two Quit: Tobacco Cessation for Women of Reproductive Age.	*http://youquittwoquit.com/*

Customized provider clinical tools (smoking)

Clinical Effort Against Second-Hand Smoke Exposure (CEASE)	*http://www2.massgeneral.org/ceasetobacco/index.htm*
Smoking Cessation During Pregnancy. A Clinician's Guide to Helping Pregnant Women Quit Smoking, 2011.	*http://www.acog.org/~/media/Departments/Tobacco%20Alcohol%20and%20Substance%20Abuse/SCDP.pdf?dmc=1&ts=20140625T1024176820*

Policy Statements and Data (smoking)

The American College of Obstetricians and Gynecologists, Committee Opinion: Smoking Cessation During Pregnancy.	*http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Smoking-Cessation-During-Pregnancy*
Smoking Cessation Strategies for Women Before, During, and After Pregnancy. Recommendations for State and Territorial Health Agencies, 2013.	*http://imcoiin.community.nichq.org/sites/default/files/ASTHO%20Article.pdf*
Mapping applications showing tobacco use during pregnancy in Oregon from 2009 – 2013. Data reflected is from Oregon Vital Statistics using birth certificates.	*http://public.health.oregon.gov/BirthDeathCertificates/VitalStatistics/birth/Pages/birth-data-maps.aspx*
SmokefreeOregon – The OHA Health Promotion and Chronic Disease Prevention public website for tobacco cessation.	*http://smokefreeoregon.com/*

Priority Specific Resources

Oral Health

State Oral Health Program Website	*http://public.health.oregon.gov/PreventionWellness/OralHealth/Pages/index.aspx*
First Tooth Program	*http://www.orohc.org/first-tooth-program/*
American Congress of Obstetricians and Gynecologists (ACOG) oral health recommendations for pregnant women	*http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Oral-Health-Care-During-Pregnancy-and-Through-the-Lifespan*
National Maternal and Child Oral Health Resource Center (OHRC)	*http://mchoralhealth.org/*
Bright Futures Toolbox for Professionals and Families	*http://mchoralhealth.org/toolbox/index.php*

Food Insecurity

Partners for a Hunger Free Oregon	*https://oregonhunger.org/*
Oregon Food Bank	*http://www.oregonfoodbank.org/Our-Work*
Food Research and Action Center	*http://frac.org/*
Freedom from Hunger, 2015; The Hunger Commission	*http://cybercemetery.unt.edu/archive/hungercommission/20151217000051/https://hungercommission.rti.org/*

Culturally and Linguistically Appropriate Services (CLAS)

Think Cultural Health: National CLAS Standards	*https://www.thinkculturalhealth.hhs.gov/*
Making CLAS Happen: Overview (Massachusetts Health & Human Services)	*http://www.mass.gov/eohhs/docs/dph/health-equity/clas-intro.pdf*
Making CLAS Happen (In depth documents from Massachusetts Health & Human Services)	*http://www.mass.gov/eohhs/gov/departments/dph/programs/admin/health-equity/clas/making-clas-happen.html*

Toxic stress, trauma and Adverse childhood experiences (ACEs)

Portland State University, Trauma Informed Oregon (TIO)	*http://traumainformedoregon.org/*
ACEs Connection	*http://acesconnection.com*
ACES Too High	*www.acestoohigh.com*
Centers for Disease Control and Prevention	*www.cdc.gov/ace*
Center on the Developing Child	*www.developingchild.harvard.edu/resources*
Essentials for Childhood	*http://www.cdc.gov/violenceprevention/pdf/efc-01-03-2013-a.pdf*
Family Policy Council	*www.fpc.wa.gov*
Resilience Trumps ACEs	*www.resiliencetrumpsaces.org*
The Adverse Childhood Experiences Study	*www.acestudy.org*

MCH Title V Annual Plan Technical Assistance Webinar

March 10, 2016

Presenters, Oregon Public Health Division, MCH Section:
Anna Steifvater, MCH Nurse Consultant
Maria Ness, MCH Research Analyst
Nurit Fischler, MCH Title V Coordinator

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Webinar Agenda

- Welcome
- Brief recap of Title V Annual plan requirements
  - Implementation Guideline
  - Title V priorities and strategies (overview)
- Measure Development
  - Sample measures
- Process and tools for plan development:
  - Planning worksheet
  - MCH Title V strategies table (detail)
- Q&A
- How to complete the Annual Plan form and a sample plan
  - Annual plan template and sample
- Q&A
- Next steps and resources for additional help
  - Title V resources handout

Oregon MCH Title V Annual Plans

- All local Title V grantees will submit an annual plan by April 1st 2016 reflecting how they intend to use their Title V funds for State FY 2017 (July 1, 2016 – June 30, 2017)

- Title V annual plans will align with
  - Oregon Title V priorities and strategies
  - Title V implementation Guidelines

MCH Title V Priorities: 2016-2020

National Priorities	State Priorities
Well women care	Toxic Stress, trauma ACES
Breastfeeding	Culturally and linguistically responsive services
Physical activity for children	Food insecurity
Adolescent well visit	
Oral health	
Smoking	

Implementation Guidelines- Priority Selection

Title V Funding level	Minimum # of priorities
Less than $25,000 per year	1
$25,000 - $99,999 per year	2
$100,000 or more per year	3

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Implementation Guidelines: Strategy Selection

- Strategy Selection
  - Encouraged to use a variety of strategies from menu of options to address priorities
  - Grantees working on more than one priority and/or strategy must select at least one strategy at the community, institutional, or societal level

Level of influence	Examples (spectrum of prevention)
Individual/relationship level	**Strengthening individual knowledge and skills**
Community level	**Promoting community education; fostering coalitions or networks**
Institutional level	**Changing organizational practices, educating providers**
Societal level	**Influencing policy and legislation**

Implementation Guidelines: use of Title V funds

- At least 30% must be used for child or adolescent health
- No more than 10% for indirect costs
- Up to 20% of Title V funds can be used for locally-identified MCH work that falls outside of Oregon's Title V priorities and/or strategy menu if approved by OHA
- Can be used to contract with other programs or agencies

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Development of Measures

- Grantees must develop at least one measure per selected strategy.
- Measures can relate to a specific activity, or more broadly to a strategy.
- Measures should assist you in tracking your progress towards addressing the priority areas.
- Measures can be a rate (such as a percentage), or a simple count.
- Numerators and denominators must be specified if the measure is a rate.
- If the measure is only a count, such as the number of trainings provided, numerators and denominators do not need to be defined.

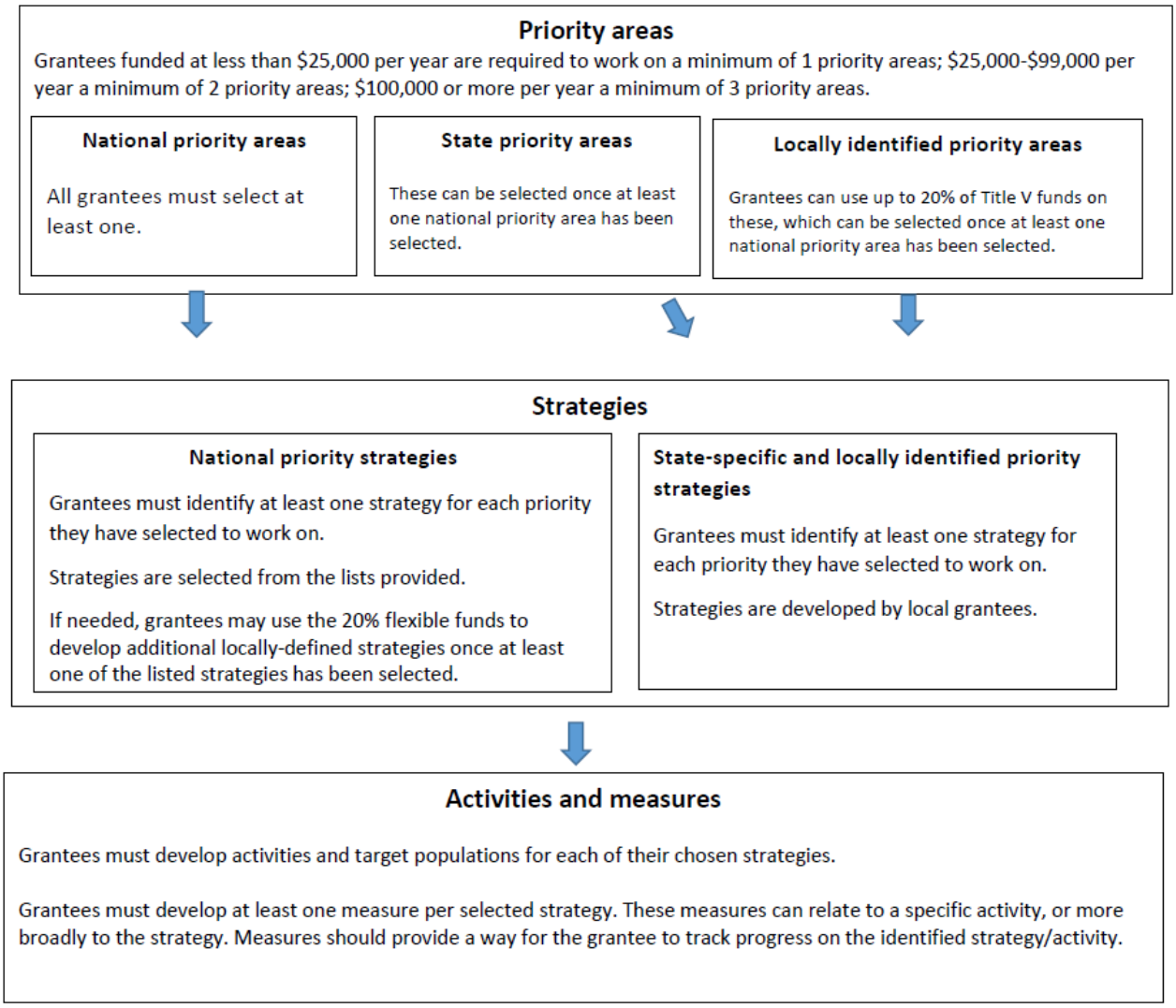
Sample Measures

Priority Area	Strategy	Activity	Measure	Numerator (if applicable)	Denominator (if applicable)
Breastfeeding	Education/ training of health care providers about breastfeeding.	Ensure local staff meets minimum competency and skills in lactation care and support training and continuing education.	Percentage of staff who care for pregnant and postpartum women, who meet minimum competency in lactation care.	Number of staff who care for pregnant and post-partum women, who meet minimum competency for lactation care.	Number of staff who care for pregnant and post-partum women.
Child Physical Activity	Support physical activity in child care settings through policy, training and workforce development.	Promote and/or deliver specialized training to child care providers on increasing physical activity in child care.	Percentage of child care providers in county/tribe who have received specialized training on increasing physical activity in child care.	Number of child care providers in county/tribe who have received specialized training on increasing physical activity in child care.	Number of child care providers in county/tribe.

Sample Measures, cont.

Priority Area	Strategy	Activity	Measure	Numerator (if applicable)	Denominator (if applicable)
Oral Health	Provide oral health services, education and referral/case management services through Oregon's Home Visiting System.	Provide pregnant women with oral health education through Oregon's Home Visiting System.	Percentage of pregnant women provided with oral education by Oregon's Home Visiting System.	Number of pregnant women oral health education by Oregon's Home Visiting System.	Number of pregnant women receiving services from Oregon's Home Visiting System.
Smoking	Collaborate w/CCOs, DCOs, and medical and early childhood/education providers to build screening and intervention processes into their work practices, including workforce training.	Organize/provide 5As and motivational interviewing training for CCOs, DCOs, early learning hubs, and/or medical and early childhood/ education providers.	Number of training activities for CCOs, DCOs, early learning hubs, and/or medical and early childhood/ education providers.	N/A	N/A

Key components of 2016 MCH Title V Block Grant plans:
Priority areas, strategies, activities and measures



MCH Title V Planning Worksheet: Breastfeeding

Strategies (see strategy table for more details and examples of activities associated with these strategies)

1. Increase the number of fathers, non-nursing partner and family members, especially grandmothers, who learn about the importance of breastfeeding
2. Fill unmet needs for peer support of breastfeeding
3. Education/training of health care providers about breastfeeding
4. Education of pregnant women about breastfeeding
5. Increase the availability of breastfeeding support from professionals
6. Increase access to workplace breastfeeding support
7. Increase the support of breastfeeding at child care settings through policy, training, and workforce development
8. Advocate for program policies that support breastfeeding

What strategy do you plan to implement? (from the list above)	What is the need in your community that this strategy addresses?	What activities will you do to implement this strategy in your community?	What populations will be impacted?	How will you measure your progress? (see sample measures)	Where will you get the data to report on your measure?

Questions?

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Completing the MCH Annual Plan template

- The MCH annual plan is to be completed and submitted electronically by April 1st. Submit completed plans to: Kalii.P.Nettleton@state.or.us
- Annual Plan Template can be found:
  - in the e-mail “MCH Title V Plan instructions” sent on February 16
  - On the MCH Title V website: http://Healthoregon.org/titlev
- Note: Tribal and LHA plan templates are slightly different, so please use the appropriate one for your type of agency.
- Questions? Contact Maria.N.Ness@state.or.us

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Sample MCH Annual Plan

Questions?

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Next Steps

- MCH Annual plans are due April 1, 2016. The period covered by the plan is July 1, 2016 – June 30, 2017.
- Complete your plan using the electronic template provided.
- Instructions for completing the plan are on the plan template.
- Once you have completed your plan, save the file with your agency's name in the file extension and email the finished plan to: Kalii.P.nettleton@state.or.us.
- See Title V TA Resources handout for Title V staff contact information and additional resources. Information will also be posted on the MCH Title V website: http://Healthoregon.org/titlev
- Don't hesitate to reach out to us with questions.

Additional questions and comments?

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