Maternal and Child Health Services Title V Block Grant

Oregon

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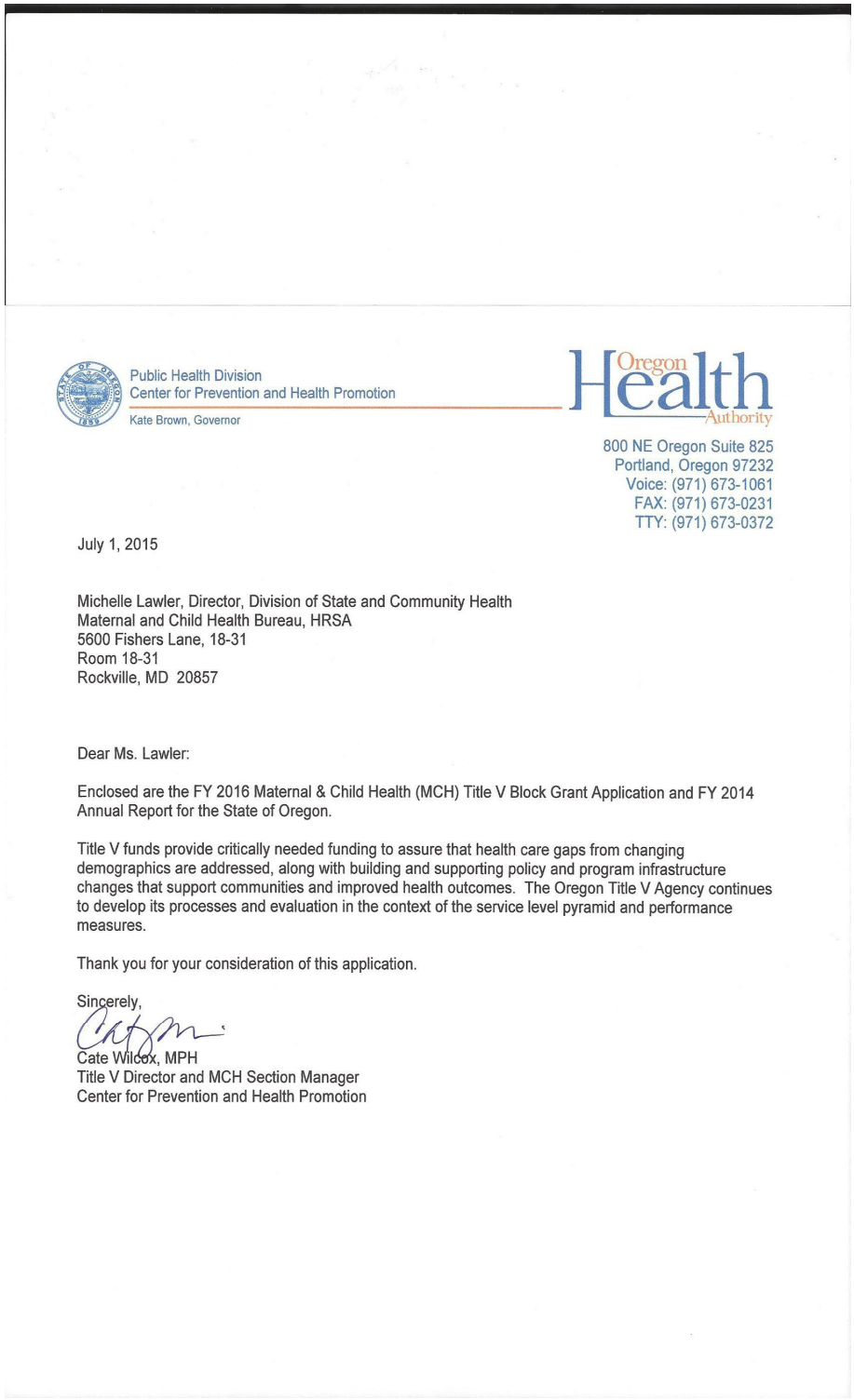
I. General Requirements

I.A. Letter of Transmittal



Public Health Division
Center for Prevention and Health Promotion
Kate Brown, Governor

Oregon Health Authority

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July 1, 2015

Michelle Lawler, Director, Division of State and Community Health
Maternal and Child Health Bureau, HRSA
5600 Fishers Lane, 18-31
Room 18-31
Rockville, MD 20857

Dear Ms. Lawler:

Enclosed are the FY 2016 Maternal & Child Health (MCH) Title V Block Grant Application and FY 2014 Annual Report for the State of Oregon.

Title V funds provide critically needed funding to assure that health care gaps from changing demographics are addressed, along with building and supporting policy and program infrastructure changes that support communities and improved health outcomes. The Oregon Title V Agency continues to develop its processes and evaluation in the context of the service level pyramid and performance measures.

Thank you for your consideration of this application.

Sincerely,

Cate Wilcox, MPH
Title V Director and MCH Section Manager
Center for Prevention and Health Promotion

I.B. Face Sheet

The Face Sheet (Form SF424) is submitted electronically in the HRSA Electronic Handbooks (EHBs).

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix C of the 2015 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2015; expires December 31, 2017.

I.E. Application/Annual Report Executive Summary

Overview

For the past 18 months, a major focus of Oregon's Title V program has been to conduct a needs assessment (NA) that would pave the way for aligning our state's Title V program with Block Grant 3.0 requirements, as well as with the needs of Oregon's women, infants, children, youth and families with/without special health care needs. The NA explored Oregon's needs in relation to each of the 15 national priority areas, as well as the currently identified state Title V priorities, and emerging Oregon Maternal, Child and Adolescent Health (MCAH) needs. Additional questions examined the changing MCAH landscape in Oregon including the impact of health and early learning system transformation on Title V programs and services, and Title V's role in addressing disparities and improving health equity. The Title V needs assessment served to both engage stakeholders around the state in the Block Grant transformation and to elucidate priority MCAH population needs. Results were used to inform Oregon's Title V priorities, including selection of 8 national performance measures and 3 state-specific priorities for the coming five years. Stakeholder engagement was central to all phases of the process, and will be further expanded over the coming year through the strategy design, ESM/SPM development, and implementation phases of BG 3.0. Work to align state and local level staffing, resource allocation and data collection with new Title V priorities and performance measures has begun and will continue through the beginning of the 2016 grant year. Key challenges for the Title V program relate to the need to modify work to accommodate: changing health and early learning systems, financing structures, and constraints on capacity and staffing at both state and local levels.

As needs assessment and Block Grant 3.0 transformation has been underway, work on the current national performance measures and state Title V priorities/performance measures is ongoing. Oregon's priority needs, key accomplishments and challenges in each domain are outlined below.

Maternal/Women's Health

Oregon's Title V program provides leadership for policy and system development efforts related to intimate partner violence, integration of SBIRT into health system transformation, and ensuring that health systems reform addresses the need for comprehensive, culturally responsive preconception and inter-conception services.

Emergent needs/highest ranked priorities

Family violence and alcohol use are Oregon's current state Title V priorities for maternal/women's health. Based on the 2015 needs assessment, high quality, culturally responsive preconception, prenatal and inter-conception services are a priority need for this population. This need will be addressed through work on NPM 1 well-woman care, as well

as NPM 13 oral health, NPM 14 smoking, and Oregon's new state performance measure on culturally and linguistically accessible services.

Accomplishments and significant challenges

The percent of family planning providers who screen for intimate partner violence has increased significantly since this measure became a Title V priority – from 12.4% to 38% in the past two years. Training and implementation of Screening, Brief Intervention and Referral to Treatment (SBIRT) for substance use and depression screening in adolescent well visits has become a priority across pediatric, school-based health center, and CCOs. Statewide use of SBIRT in CCOs has increased from 2% in 2013 to 7.3% in 2014.

Plan for coming year

State and local level strategies/ESMs for improving access, quality, and cultural/linguistic responsiveness of well woman care, oral health, and tobacco prevention/cessation services for women will be developed and launched by March 2016. SBIRT training for primary care providers will continue, as will work with partners to integrate intimate partner violence screening and referral into the health care system.

Perinatal/Infant Health

Oregon's Title V program provides leadership and technical assistance for the integration of maternal mental health, linkages to prenatal care and other perinatal services, and breastfeeding support into state and local level MCH programs and policies.

Emergent needs/highest ranked priorities

Maternal mental health is the current state Title V priority for perinatal/infant health. Based on the 2015 needs assessment, improved nutrition is a priority need for this population which will be addressed through work on NPM 4 breastfeeding, as well as Oregon's new state performance measures on food insecurity, culturally and linguistically responsive services, and toxic stress/trauma.

Accomplishments and significant challenges

Oregon has integrated screening for perinatal depression and anxiety into training for home visitors, and depression screening/follow up has become an incentive measure for Oregon's CCOs. Title V has worked with 211info to provide enhanced support and referrals for perinatal mental health around the state. Policies and guidelines that support breastfeeding have been added or modified in TANF and state agencies, and related outreach/training materials developed.

Plan for coming year

State and local level Title V strategies/ESMs for increasing breastfeeding initiation and duration among target populations will be developed and launched by March 2016. Efforts to integrate maternal mental health into preconception, prenatal and inter-conception care will continue in collaboration with the Oregon CoIIN and Maternal, Infant and Early Childhood Home Visiting (MIECHV) initiatives.

Child health

The Title V program's work in child health is focused on increasing community and caregiver capacity to promote the foundations of health: stable responsive relationships, safe supportive environments, and nutrition and healthy

behaviors.

Emergent needs/highest ranked priorities

Enhancing parent resources and support is the current state Title V priority for child health. Based on the 2015 needs assessment, enhancing physical activity is a priority need for this population, which will be addressed through work on NPM 8 physical activity, as well as Oregon's new state performance measures on culturally and linguistically responsive services and toxic stress/trauma.

Accomplishments and significant challenges

Title V has worked with partners across state agencies and parenting stakeholder groups to build parent skills and parent engagement, including training parent leaders and holding parent cafes around the state. Over the past year, this work has been integrated with statewide efforts to develop trauma-informed systems and reduce the impact of toxic stress and ACES on children and families. One major challenge of this work is the lack of consensus on a set of skills, strategies and measures that can help frame shared goals and outcomes related to parent skills and engagement.

Plan for coming year

State and local level Title V strategies/ESMs for increasing physical activity among children will be developed and launched by March 2016. Strategies will be coordinated with physical activity and healthy weight efforts in chronic disease prevention and WIC, across multiple settings including childcare and schools.

Adolescent Health

Title V strengthens policies and systems that support adolescent health in school-based health centers, schools, health systems, and communities. The program engages youth to develop policies and programs that reflect their needs through youth action research.

Emergent needs/highest ranked priorities

Increasing adolescent well-visits and decreasing overweight/obesity are the current state Title V priorities for adolescent health. Based on the 2015 needs assessment, high quality, confidential preventive health services for adolescents continues to be a priority need for this population. Title V will address this need through continued work on adolescent well-visit (NPM 10), as well as Oregon's new state performance measures on culturally and linguistically responsive services and toxic stress/trauma.

Accomplishments and significant challenges

Title V convened and provided leadership for policy work on confidentiality of adolescent health services, and development of a youth participatory action research curriculum. The percent of adolescents in CCOs with a well care visit has increased from 27% in 2011 to 32% in 2014, but remains a metric that has shown little improvement broadly. The teen birth rate (for 15-17 year olds) declined by 28% from 2010 to 2013. A significant challenge to working on the physical activity PM came with the elimination of state Title V staffing for adolescent physical activity/nutrition and the subsequent integration of the work into the chronic disease prevention program.

Plan for coming year

State and local level Title V strategies/ESMs for increasing quality, confidentiality and utilization of well-care visits will be developed and launched by March 2016. Ongoing work on confidentiality and alignment of school based health centers with health system transformation will be integrated into strategy/ESM development

Children and Youth with Special Health Care Needs (CYSHCN)

Title V CYSHCN provides leadership and support for the development of comprehensive, coordinated and integrated systems of care that are culturally responsive for CYSHCN and their families. It leads policies that support access to care for CYSHCN, and partners with families in policy and program development.

Emergent needs/highest ranked priorities

Medical home (MH) and youth transition to adult health care (TAHC) are Oregon's current state Title V CYSHCN priorities. In addition, culturally and linguistically responsive services are a state CYSHCN priority. Findings from the needs assessment showed that the population's complex needs require high quality, family-centered coordinated systems of care to meet their needs. The National Consensus Framework includes MH and TAHC as 2 of its 10 domains in the Standards for Systems of Care for CYSHCN. The priorities will be addressed through work on NPM 11 and 12.

Accomplishments and significant challenges

OCCYSHN was awarded one of 12 state implementation grants to improve systems of care serving Oregon's CYSHCN through a collaborative cross state effort. OCCYSHN increased the number of community-based family liaisons who are part of the Family Involvement Network (FIN) and Oregon Family to Family Health Information Center (ORF2FHIC) shared family network and it continues to partner with families in all decision-making efforts. The CaCoon home visiting and Community Connections Network (CCN) programs initiated a shared workforce development effort this year to increase local cross systems care coordination. OCCYSHN was significantly challenged this year by delayed hiring of key administrative and program staff due to an unsuccessful recruitment and internal institutional delays in releasing positions.

Plan for coming year

Work assignments will be aligned with Block Grant 3.0 priorities. Lead staff members, with support of Assessment and Evaluation staff and needed content expertise, will be assigned to the MH and THAC priority areas. Community-based partners' input will shape strategy development and implementation plans, including increased and more effective coordinated care. MH and TAHC strategies and ESMs will begin Spring 2016 and shape contracts with local partners extending 2016 through 2020.

Cross-cutting or Life Course

Oregon's Title V program uses a life course focus and equity lens to maximize investment in policies, systems and programs that will ensure community and caregiver capacity to support the foundations of lifelong health.

Emergent needs/highest ranked priorities

Improving oral health among children is a current state Title V priority/performance measure. Based on the 2015 needs assessment, improved oral health for pregnant women and children; reduced tobacco use and exposure among pregnant women and children; MCAH nutrition; safe and nurturing relationships/stable, attached families; and improved health equity and reduced MCH disparities are all high priority cross-cutting needs for Oregon's MCAH population. These will be addressed through work on NPM 13 oral health, NPM 14 smoking, as well as Oregon's new state performance measures on food insecurity, toxic stress/trauma, and culturally and linguistically responsive services.

Accomplishments and significant challenges

Significant accomplishments in Oral health began with the release of an updated State Oral Health Plan that will

guide the state's oral health work for the next five years. This spurred the hiring of Oregon's first ever state Dental Director in February 2015. The Oral Health Program continued to grow the State Dental Sealant program and initiated a Dental Sealant Certification Program whereby local programs can be trained and certified to provide high quality school-based dental sealant programs. MCH initiated a Dental Pilot program that will help advance workforce and access innovations. MCH is currently challenged by the inability to hire for the Oral Health Program Coordinator, vacant since February when the staff person resigned. All of the other cross-cutting priorities are newly identified.

Plan for coming year

State and local level strategies/ESMs for improving access, quality, and cultural/linguistic responsiveness of well woman care, oral health, and tobacco prevention/cessation services for women will be developed and launched by March 2016. SBIRT training for primary care providers will continue, as will work with partners to integrate intimate partner violence screening and referral into the health care system. State and local level Title V strategies/ESMs for oral health and tobacco will be developed and launched by March 2016. Ongoing work in perinatal and child oral health will be integrated into strategy/ESM development. New state performance measures and associated strategies will be developed for food insecurity, toxic stress/trauma, and culturally/linguistically responsive services during the coming grant year.

II. Components of the Application/Annual Report

II.A. Overview of the State

II A. Overview of the State

1. **Geography and environment**
   Oregon is located in the Pacific Northwest, and at 96,981 square miles it is the ninth largest state in the U.S. Oregon's landscape varies from rainforest in the Coast Range to barren desert in the southeast. Oregon's large size and geographic diversity creates challenges for the Maternal and Child Health system, including the concentration of services in urban areas, geographic and weather barriers to delivering and accessing health services, and issues related to workforce capacity and training needs varying vastly in different regions of the state.

2. **Demographics and racial/ethnic disparities**
   Oregon's population of 3.97 million makes it 27th in population among US states. Oregon has large rural and frontier areas, resulting in an overall population density of 40 people per square mile. However, about 75 percent of Oregonians live in urban areas and 25 percent in rural and frontier areas. Population density ranges from about 4,228 persons per square mile in Portland to 7 persons per square mile in frontier areas and 23 persons per square mile in areas with 50,000 or less population. Portland is the largest metropolitan area, with about 1.8 million people. Other urban centers include Salem, the state capital, Eugene, in the mid-Willamette Valley, and Medford, in Southern Oregon. There are 10 federally recognized tribes in Oregon and Indian people from over 100 tribes make up the approximately 45,000 Native Americans and Alaska Natives living in Oregon.

   Oregon's minority population has increased in recent years. In the 2010 Census, 83.6% reported as White only, a drop from 90.1% in 2008. Hispanics make up the largest minority population at 11.7%, a 64% increase since the 2000 Census. Other races have remained about the same, with Asians at 3.7%, African Americans at 1.8%, and American Indian/Alaska Natives at 1.4%. There are 9 federally recognized Oregon tribes and 43 member tribes participate in the Northwest Portland Area Indian Health Board.

   Oregon averages 45,000 births per year and 69% of births are White, followed by 20% Hispanic, 5.3% Asian, 2.3% African American, and less than 2% Native American. Birth rates in Oregon are lower than national average, with 66 births per 1,000 women ages 15-44 compared to the national average of 69.2. About 6.2% of the population is under 5 years of age. The median age is 38.4 years, and the median age of mothers for all births is 27.

   Children and Youth with Special Health Care Needs (CYSHCN)

   The 2011/12 National Survey for Children's Health (NSCH) estimated that 19% (166,596) of Oregon children 0 to 17 years have special health care needs. These CYSHCN are mostly White, non-Hispanic, 14% are of Hispanic ethnicity and 17% identified as Other, non-Hispanic.

   Children with cerebral palsy, Autism Spectrum Disorder (ASD), arthritis, Down's syndrome, Attention Disorder/Hypertension Disorder (ADHD), rare metabolic disorders, spina bifida, cleft lip and palate, and mental and behavioral disorders reflect the diversity of the population served by the Title V CYSHCN program

(Oregon Center for Children and Youth with Special Health Needs [OCCYSHN]). Nearly 30% of these children have a condition that affects their daily activities; over 48% experience 4 or more difficulties related to functionality (2009/10 National Survey of CSHCN [NS-CSHCN]). According to the most recent state-level prevalence rates from the 2009/10 NS-CSHCN, Oregon has one of the highest reported rates of ASD in the country, 11.4% vs. 8% nationally. Around 9,000 Oregon children and youth age 3 to 21, receiving special education, are currently identified with ASD (Oregon Department of Education [ODE], 2014).

Significant advances in science and technology have reduced the risk of mortality for CYSHCN, resulting in an increase in morbidity due to chronic illness. More youth and young adults with special health care needs (YSHCN) live longer and assume productive lives. However, only around 30% of YSHCN are employed (2011/12 NSCH), due to lack of experience in managing their own health and lack of awareness of available resources to support their health needs.

Birth Anomalies

Oregon's Birth Anomalies (birth defects) Registry tracks prevalence of select birth anomalies using birth certificate, hospital discharge, and Medicaid data. Children with risk factors or conditions that receive services through the CaCoon program are tracked through a statewide database. The most frequent risk factors and conditions cited for CaCoon recipients during FY2014 were developmental delay (DD), failure to thrive, heart condition, deaf/hearing, and asthma. Children can have more than one risk factor recorded. During FY2014, approximately 79% of children in the CaCoon program had multiple risk factors.

3. **Economy and poverty**

Oregon's economy impacts population growth and state revenues for public education and services. The top employers are in food services, administrative and support services, trade contractors and construction, health care and hospitals, computer and electronic manufacturing, and retail. Migration population change was about 48% in 2009, and recently an influx of migrants has boosted the state's labor force. The economy has been slowly growing, showing recovery from high unemployment rates in 2009.

Unemployment: Oregon's seasonally adjusted unemployment rate peaked in May 2009 at 11.6%. Since then, unemployment rates have improved with rates falling to 9.3% in 2011, 8.8% in 2012, 7.8% in 2013, and 6.9% in 2014. However, Oregon's unemployment rates remain higher than national average.

Income and Poverty: The three-year average median household income is $51,394 in Oregon, ranked 34th in the nation by the U.S. Census Bureau. The Small Area Income and Poverty estimates (SAIPE) report for 2008 estimated poverty at 13.5%, with 17.5% under age 18 and 21.1% under age 5 living below poverty. Ethnic and racial minorities are also more likely to live below poverty than non-Hispanic Whites. About one-quarter of CYSHCN ages 0-17 lives in households with incomes less than 100% of the federal poverty level (2011/12 NSCH).

State Revenues and Budgets: Over 90% of the state's general fund support core functions in three areas: education, health and human services, and public safety. Oregon does not have a sales tax, and as a result tax

revenue is vulnerable to fluctuation in employment rates. Slow recovery in jobs has resulted in reductions in General Fund budgets in recent years. The Oregon Health Authority (OHA) removed 37 positions to save $3.9 million in 2013. While the 2013-15 state budget was supported by slightly increased revenues, federal sequesters reduced the federal portion of public health funding. The overall economic forecast in 2015 is stronger due to an improved outlook for job growth and an anticipated annual growth rate of 2.4%.

4. **Housing and education**

Housing: Oregon has 1.6 million housing units estimated by the American Community Survey (U.S. Census Bureau). Of households that spend 30% or more of income on housing, 49% rented, 40% had mortgages, and 15% owned without mortgages. The median monthly housing cost for each group was $770 for renters, $1,551 for mortgaged owners, and $413 for owners. Four percent of households did not have a telephone service and 8% were without a car or vehicle for transportation.

Education: Over their lifespan, children in Oregon have access to private and public preschools, Head Start, public schools, community colleges, universities, and graduate education. In 2012, an Education Investment Board and an Early Learning Council were established to improve child education outcomes.

Oregon's Department of Education provides Early Intervention and Early Childhood Special Ed (EI/ECSE) and Head Start services. In a 2009 Individuals with Disabilities Education Act (IDEA) report, EI/ECSE programs enrolled 2,762 children in 9 service areas, representing 3.5% of the total child population ages birth to four. There are six Early Head Start sites in Oregon funded by the federal Office of Head Start and the Oregon Department of Education. 1,018 children or 3% of the eligible population were enrolled in Early Head Start services and 12,582 children or 68% of the eligible population were enrolled in Head Start in 2009, including Native American children and children of seasonal farm worker families. In addition, Migrant / Seasonal Head Start services were provided for 1,877 farm worker children ages 0-5.

Oregon has 198 public school districts, 1,306 public schools, and 561,698 students enrolled from kindergarten through grade 12. Oregon's 4-year high school graduation rate is 72%, up slightly in past two years.

In 2014, Oregon's higher education system enrolled 179,678 students in seven public universities and the Oregon Health & Science University, 17 public community colleges, 67 private colleges and universities, and hundreds of private career and trade schools.

Every child in Oregon identified as needing special education has at least one of the disabilities defined in the Individuals with Disabilities Education Act (IDEA). In Oregon, children must have an established diagnosis of developmental delay in order to receive Early Intervention (EI) services; EI or Early Childhood Special Education does not serve children who are at risk of DD. More than 1 in 8 Oregon students receive special education services, 86,739 Oregon children age 0-21, are in special education and 3,532 children age 0-3, received EI service (ODE, IDEA Part B and C, 2014-15).

5.Insurance Coverage

Oregon's uninsured rate has dropped dramatically since implementation of the ACA.The Office of Health Analytics'

"Recontact Study" reports that three out of four Oregonians that were uninsured in 2013, gained insurance coverage in 2014. For public insurance, enrollment increased nearly 60 percent, or about 360,000 people. As of June 30, 2014, 201,794 Oregonians, or 5 percent, continued to lack health insurance. Over half of those who remained uninsured stated that cost was the main barrier to obtaining coverage. Those who are newly insured are more likely to have incomes below 200 percent of the Federal Poverty Level (Recontact Study. 2014).

Oregon Health Plan (Medicaid) services, including medical, dental and mental health care, are provided primarily through Coordinated Care Organizations, Oregon's version of Accountable Care Organizations. CCOs currently serve nearly 90% of Oregon Health Plan clients. The innovative structure and function of Coordinated Care Organizations is a central component of health reform in Oregon, and is described in detail in section II.F4.

Oregon has expanded Medicaid coverage so that those whose income is 133% of the Federal Poverty Level (FPL) are now eligible. Pregnant women are covered to 185% FPL, and children to 300%. The Oregon Health Plan (OHP), Oregon's Medicaid Program, pays for medical, dental and mental health services for low-income Oregonians. Since ACA implementation, OHP enrollment has grown by 380,000 people, and OHP now covers 990,000 Oregonians. OHP pays for 53% of Oregon births, including prenatal and delivery coverage for approximately 3100 undocumented women covered through the state-funded prenatal expansion program and Citizen Alien Waived Emergent Medical (CAWEM). About 20 percent of all Medicaid enrollees are Hispanic, 3 percent African American, 1.5 percent American Indian/Alaskan Native, 3 percent Asian or Pacific Islander, 58.5% Caucasian, and 14% "Other" or "Unknown" . In 2014, 45% of all Medicaid Coordinated Care Organization (CCO) members were age 18 or younger.

6. Safety net and health system

The Oregon Health Authority (OHA) is responsible for most state-level health-related programs in Oregon, including Public Health, Medicaid, Addictions and Mental Health, the Public Employees and Oregon Education Benefit Boards. The Oregon Health Policy Board oversees the OHA and is a nine-member, citizen-led board appointed by the Governor and confirmed by the Senate.

Oregon's public health statutes and programs are administered by the Public Health Division within OHA, and each of 36 county jurisdictions is the designated local health authority (LPHA). Currently, there are 33 county health departments (LPHAs) and 1 health district serving 3 small rural county populations. Local health departments are legislatively mandated to provide 10 core public services. The Coalition of Local Health Officials represents and advocates for local health departments in negotiations with the state, and works to assure that they have the skills and resources necessary to carry out their work.

Primary care and safety net health services are available through private medical providers and through the following facilities.

- Total Health Care Facilities: 263 Clinics and 58 Hospitals in 116 Sites
- Federally Qualified Health Centers: 93 Clinics in 46 Cities and 25 Counties
- Rural Health Clinics: 57 Clinics in 43 Cities and 24 Counties
- Migrant Health Centers: 15 centers in 12 cities in 10 Counties
- Tribal and Indian Health Service: 11 Clinics among 9 Tribes and 9 Counties
- School Based Health Centers: 54 Clinics in 20 Counties

- Oregon Community Sponsored/Other Clinics: 33 Clinics in 12 Cities and 10 Counties

Oregon's Primary Care Office (PCO) works closely with the non-profit Primary Care Association (OPCA) and the Office of Rural Health to support Oregon's safety net services. Oregon has 102 designations for primary care Health Professional Shortage Area (HPSA), and 76 dental HPSAs. More than 300 sites have been approved as part of the National Health Service Corps (NHSC) to provide health care to all, regardless of ability to pay. Safety net clinics cared for nearly 360,000 patients in 2013, providing 950,000 medical visits, over 261,000 mental/behavioral health visits, and 202,000 oral health visits. Nearly 30,000 migrant/seasonal farm workers and 32,000 homeless clients were served.

Oregon's safety net includes a robust network of school based health centers which are statutorily defined, certified and funded. During the 2013-2014 service year, there were school based health centers in 38 high schools, 6 middle schools, 11 elementary schools and 13 combined-grade campuses. During the 2013-2014 services year, SBHC's provided services to 23,797 clients.

Geography presents a significant barrier to obtaining care for CYSHCN. Twenty-three percent of CYSHCN live in rural areas of Oregon (2011/12, NSCH). Families living in rural and frontier counties of central and eastern Oregon, experience challenges obtaining the services they need, particularly specialty care. Specialty care services for children are concentrated in urban areas along the Interstate 5 corridor, especially in Portland where the only teaching hospital, Oregon Health & Science University (OHSU), is located. Mental health services are one of the most difficult services to access geographically for CYSHCN and their families, due to a lack of mental health providers for CYSHCN in rural and frontier communities.

7. Current and emerging state issues impacting MCH

Key state issues impacting Maternal and Child Health include: health systems transformation (state and national), Oregon's Early Learning System transformation, medical home and autism for CYSHCN, and the modernization of Oregon's Public Health system. Upstream drivers, including the state of Oregon's economy, employment, equity, education and the environment (described in II.A.1-5) are also key drivers of Maternal and Child Health across the lifespan.

Oregon Health systems transformation

Oregon's health systems transformation efforts have been ongoing since before the Federal Affordable Care Act (ACA) implementation, and alignment of public health, including Maternal and Child health work with health system transformation is a key priority for the state. Oregon's Health system transformation is described in detail in section II.F.

CYSHN needs and health systems transformation

About half of Oregon's children are covered or enrolled in Medicaid. Coordinated Care Organizations (CCOs) are responsible for providing care for people covered by Medicaid. Despite Oregon's healthcare transformation rollout with its commitment to the Triple Aim, families and partners across the state still report unmet needs of CYSHCN, as well as confusion experienced by families about which entities are responsible for coordinating care for CYSHCN across multiple systems. CCO incentive metrics do not propel primary care providers (PCPs) to prioritize CYSHCN

within their practices, due to insufficient payment for care coordination. Also, there are no consistent policies across CCOs regarding the type and amount of services covered, with the exception of the Applied Behavioral Analysis (ABA) mandate for children with ASD.

Although there have been appropriate changes in the system regarding screening, development of health teams, emphasis is on care coordination for older adults with chronic conditions, these efforts are not specifically targeted for CYSHCN. In addition, CCO's global budget may impact the delivery of OCCYSHN's public health nurse home visiting programs serving CYSHCN (CaCoon). This new system moves payment from a primarily "fee for service" model to an outcomes based model. The CCO becomes the payer to the Local Public Health Authority (LPHA), according to terms between the LPHA and CCO. LPHAs and other government providers who contribute local funds for targeted case management programs must limit growth in the program. Under this model, payment for CaCoon visits to Medicaid-enrolled clients will be determined by the negotiated terms between the LHD and its CCO.

Early Learning System Transformation

Oregon's Early Learning System transformation, guided by the Early Learning Council (ELC), is another critical partner whose work is shaping the changing role of MCH in our state. The vision for early learning system transformation is to: 1) Ensure all children are ready for kindergarten, ready to read in 1st grade, and reading at grade-level by 3rd grade; 2) Children are raised in stable and attached families and 3) Integrate resources and services statewide. Major activities of the Early Learning Council include: 1) state-level governance consolidation (Early Learning Division) 2) connection to healthcare, K-12, and early intervention; 3) community-based coordinators of early learning services (Hubs) 4) kindergarten readiness assessment; and 5) tiered quality rating improvement system (TQRIS). This work has potential to be particularly salient to CYSHCN as it develops systems for universal screening. The ELC's plan to achieve these goals includes: building a system for targeting and identifying Oregon's children with high needs through a system of early and universal screening and risk-assessment; ensure that there is a range of high-quality programs that can effectively meet the needs of different families and populations of children with high needs; and support families to make choices about programs that will best ensure the school readiness of their children.

Medical Home for CYSHCN

The goal of the OCCYSHN Medical Home Initiative (OMHI) is to increase the opportunity for CYSHCN to receive coordinated, ongoing, comprehensive care within a medical home. Two primary goals are to inform and ensure CYSHCN population needs are integrated into both OHA Health Home policies and the policies and practices of CCOs. The OMHI objectives are to incorporate the needs of CYSHCN into the state's definition of medical home, support the implementation of medical home standards, and incorporate the needs of CYSHCN into reimbursement policies. Activities include informing policy development, workforce development, education and dissemination activities, and active participation in the Oregon Pediatric Improvement Partnership's (OPIP) in support of its inclusion of CYSHCN in all their activities.

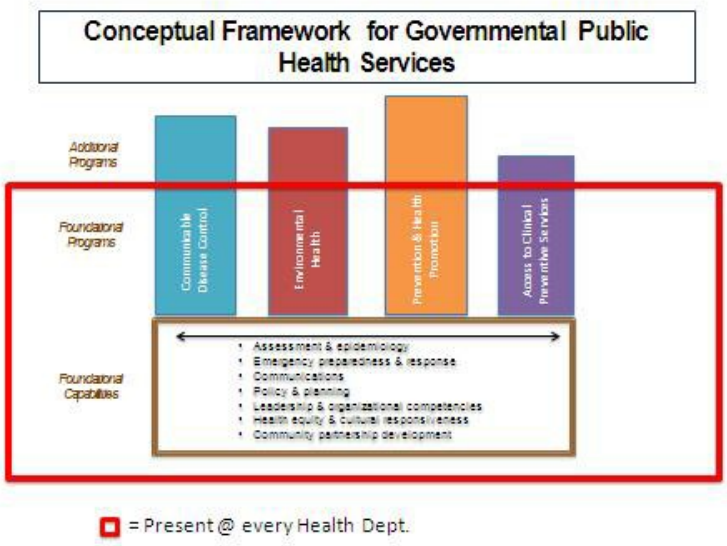
Autism

The Oregon Commission on Autism Spectrum Disorder (OCASD) was created by Executive Order of the Governor in 2009. The OCASD's charge was to build from information and recommendations of the 2008 Oregon Autism Project and to create a 10-year plan for Oregon to improve services to all individuals and families experiencing ASD.

OCCYSHN implements the ACCESS Project (Assuring Comprehensive Care through Enhanced Service Systems for children with ASD and/or Other Developmental Delays) through a 3-year HRSA grant to support the development and implementation of community-based medical-educational teams in rural/semi-rural communities, in alignment with the recommendations of the OCASD Autism State Plan. The project is focused on increasing community capacity to provide timely and valid team evaluations for the identification of ASD in children, age 0 to 5, and will improve medical home practices' delivery of comprehensive, coordinated healthcare and related services for children with ASD and other DDs.

Modernization of Public Health

The Oregon Legislature is currently considering a major restructuring and modernization of governmental public health based on the recommendations of a legislative Task Force on the Future of Public Health. HB 3100, the Modernization of Public Health Bill is based on the Task Force Report and uses a framework of foundational capabilities and programs that are needed throughout the state and local public health system. The changes focus on the need to achieve sustainable and measurable improvements in population health; continue to protect individuals from injury and disease; and be fully prepared to respond to public health threats. If adopted, the modernization of public health will change the capabilities, programs, funding, and governance of Oregon's public health system.



8. Alignment with Oregon Health Authority, Public Health Division, and Institute for Developmental Disabilities' priorities and initiatives

Oregon's Title V's work is interwoven with the priorities and initiatives of OHA and the Public Health Division, the OHSU Institute for Developmental Disabilities, and those of the local health departments and tribes. At the state level, Title V aligns with the OHA Triple Aim, Institute for Developmental Disabilities (IDD) priorities, the Oregon State Public Health Improvement Plan, and the Public Health Division Strategic Plan, as well as with the priorities of the Coordinated Care Organizations.

Oregon Health Authority (OHA) Triple Aim

OHA is the central agency which oversees health transformation in Oregon, guided by the triple aim of: improving the lifelong health of Oregonians; increasing the quality, reliability, and availability of care for all Oregonians; and lowering or containing the cost of care so it's affordable to everyone. Title V's prevention and health promotion work supports the triple aim through interventions with vulnerable populations at critical stages of the life course. Section II.F.4 describes Title V's work in support of health system transformation and the partnership with CCOs in more detail.

Institute for Developmental Disabilities (IDD)

The Institute on Development & Disability (IDD) improves the lives of individuals with disabilities or special health needs through leadership and effective partnership with individuals, families, communities, and public and private agencies. IDD honors individual and family perspectives, provides clinical services, communicates complete and unbiased information, and partners and encourages individuals and families to participate in care and decision making. In addition, IDD is committed to excellence in interdisciplinary clinical practice, research, education, policy development, and community service.

State Public Health Improvement Plan

As part of Public Health Accreditation, Oregon created a state health profile and developed a State Health Improvement Plan in 2012. The State Health Improvement Plan is currently being updated based on revised input obtained through community engagement sessions held in 2014. The revised State Health Improvement Plan will focus on 7 priority areas including: prevent & reduce tobacco use; slow the increase of obesity; improve oral health; reduce substance abuse; prevent deaths from suicide; eliminate the burden of vaccine preventable diseases; and protect the population from communicable diseases.

PHD Strategic Plan

The Public Health Division's Strategic Plan lays out a concrete set of goals and objectives for State Public Health to achieve measurable improvements in population health in Oregon, in alignment with the CCOs. Title V work supports achievement of the PHD's strategic goals: improve quality of life and increase years of healthy life; promote and protect safe, healthy and resilient environments, and strengthen public health's capacity to improve health outcomes. Title V work aligns closely with objectives included in each of the 3 goals.

CCO Community Health Improvement Plans and Outcome Metrics

Title V work also aligns with and supports the community health improvement plans of the CCO's, as well as their performance metrics. Each of the 16 CCOs has developed a community health improvement plan (CHIP) which details their commitment to improving population health. CHIP priorities include access to medical and oral health, care coordination, as well as early childhood, chronic disease prevention, and work on social determinants and health equity. The CCOs are also being measured on their health outcomes in key MCH areas such as access to prenatal care, preventive oral health, depression screening, and family planning. Title V works with the CCOs as a provider of: technical assistance, data, and contracted public health and prevention services.

9. State statues with relevance to Title V

The following are key state statutes for Oregon's Title V program

a. **ORS 413** defines to the Oregon Health Authority (OHA) and the Oregon Health Policy Board, which were created by the Oregon Legislature in 2009. Most health-related programs in the state are under the OHA including Public Health, Medicaid, Addictions and Mental Health, the Public Employees and Oregon Education Benefit Boards. OHA is overseen by the Oregon Health Policy Board.
b. **ORS 431.375** governs the policy on local public health services; local public health authority, and the provision of maternal and child public health services by tribal governing council.
c. **HB 3650,** passed in 2011, sets the framework for health system transformation and the Coordinated Care Organizations which are a cornerstone of Oregon health system transformation and provide care to Oregon's Medicaid (OHP).
d. **Senate Bill 909 (2011)** established the Oregon Education Investment Board (OEIB) and Early Learning Council, a nine-member Governor-appointed committee. The council assists OEIB in overseeing a unified system of early learning services for the purpose of ensuring that children enter kindergarten ready to learn. Subsequent bills (HB 5165 (2012) and HB 2013 (2013) further define implementation of Oregon's Early Learning Transformation.
e. **ORS 444.010, 444.020 and 444.030**, the Oregon Health and Science University (OHSU) is designated to administer a program to extend and improve services for children with special health needs, including the administration of federal funds made available to Oregon for services for children with disabilities and children with special health needs.
f. Oregon is one of 39 states who passed ASD mandates that require health insurers to provide the behavioral therapy Applied Behavior Analysis (ABA) to children with ASD and other developmental disorders under 18 years old who have health insurance.

10. Title V Administration priority setting process

As the availability of flexible state funding streams has become more limited in recent years, it has become necessary to more narrowly focus Title V work. Changing funding and budgetary constraints and alignment with State as well as Federal Agency priorities also impact priority-setting. Both the MCH and CYSHCN Title V Directors have multiple ongoing mechanisms for determining the importance, magnitude, value, and priority of competing factors which impact maternal and child health in the state. These include the 5-year needs assessment, ongoing assessment of health status data, and participation (either directly or through their staff) in many state and local level policy groups (see section II.B.2.c.).

II.B. Five Year Needs Assessment Summary

II.B.1. Process

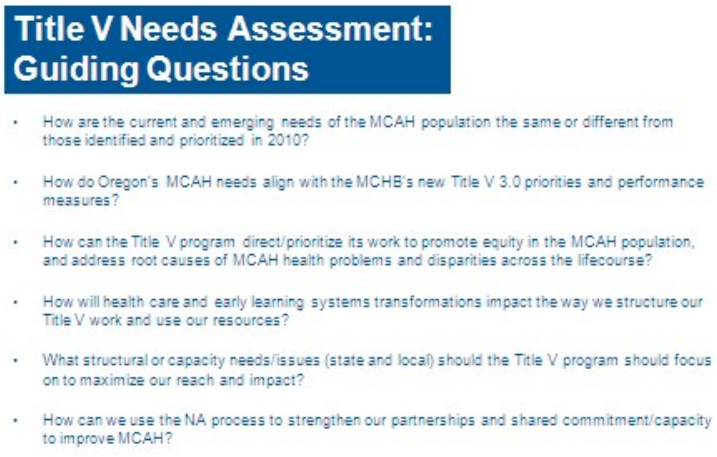
IIB.1 Process

Oregon's Title V needs assessment synthesized information about MCH population needs relative to the 15 national priorities areas, current Title V priorities, and emerging Oregon MCH priorities. Methods included: a scan of 53 recent community assessments conducted across Oregon; analysis of health status data from a range of sources including vital statistics, Pregnancy Risk Assessment Monitoring System (PRAMS), PRAMS 2, Oregon Behavioral Risk Factor Surveillance System (BRFSS), Oregon Healthy Teens, Medicaid; and surveys of 750 MCAH and 554 CYSHCN partners. Issues related to infrastructure, partnerships, systems, workforce, and Oregon's changing MCH landscape were explored through an online discussion forum, stakeholder listening sessions, key informant interviews, a webinar, and a CYSHCN stakeholder panel.

1. Process goals, framework and methodology

Goals

The goals of the Needs Assessment process were to engage stakeholders and community members in examining Oregon's current and emerging MCAH needs, and in determining areas in which Title V can most productively focus its work to improve maternal and child health and health equity. See below for needs assessment guiding questions.



OCCYSHN, Oregon's Title V CYSHCN program, assessed CYSHCN and their families' needs in partnership with OHA's statewide Title V Block Grant needs assessment. Two key questions guided OCCYSHN's needs assessment:

(1) What are the current needs of Oregon CYSHCN and their families, and

(2) What are the challenges and strengths of the system of care serving CYSHCN?

Within these questions, OCCYSHN staff identified a set of topics on which to focus: Access to Needed Services and Family Supports, Medical Home, Care Coordination, and Transition to Adulthood. The last three topics were

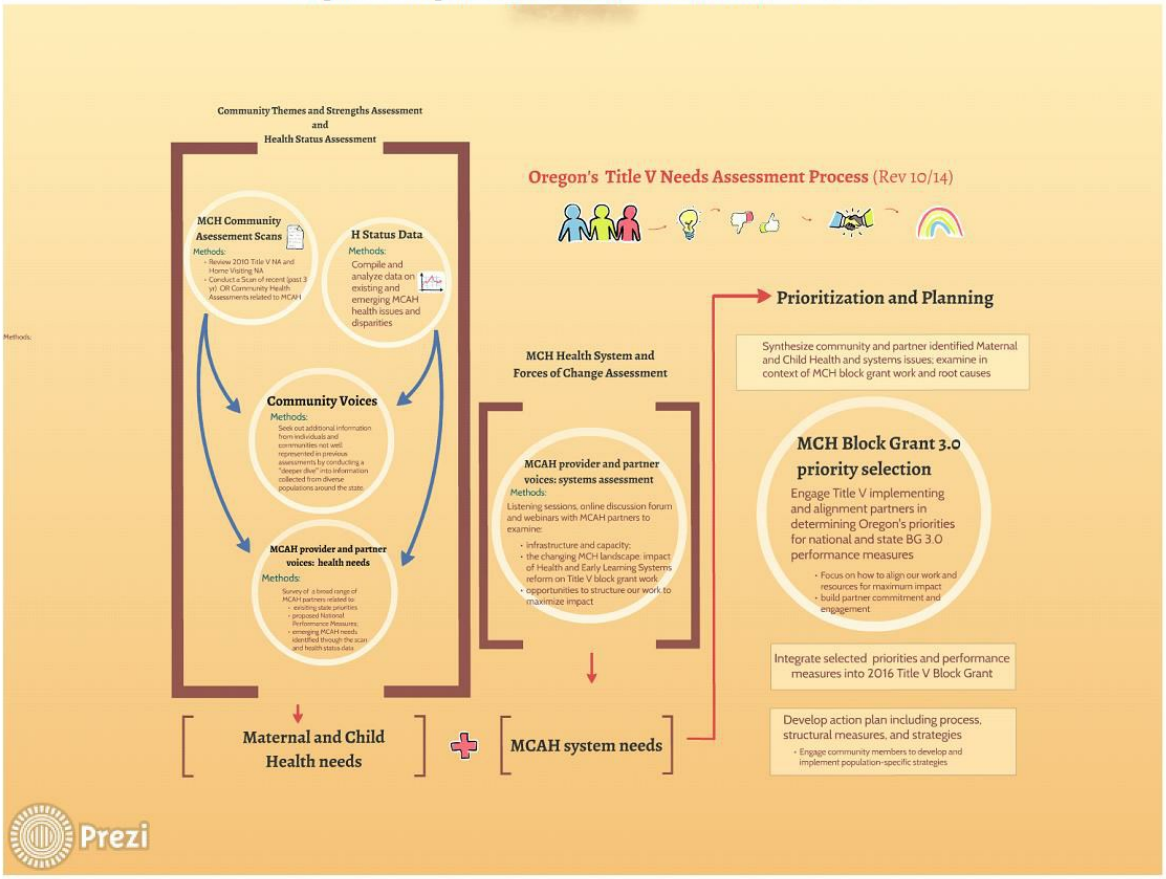
selected to align with the overarching state needs assessment goals and to explore priority areas (Medical Home and Transition) on which Oregon has performed poorly. OCCYSHN focused on care coordination because of its importance to CYSHCN and a well-functioning medical home (e.g., National Consensus Framework for Systems of Services for CYSHCN, VanLandeghem et al, 2014) and because of the changing landscape of care coordination.

Framework

The framework for Oregon's Title V Needs Assessment is captured in Figure 1. There were three major phases:

1. Community themes and strengths assessment and health status assessment
2. Maternal and child health system and forces of change assessment
3. Prioritization and planning

Figure1. Oregon's Title V Needs Assessment Process



Methodology

The assessment methodology used was a mixed methods design, including:

1. A review of previous needs assessments
2. Environmental scan – a qualitative analysis of recent county and community health assessments from across the state
3. Survey of partners and providers

4. Online discussion forum
5. Key informant interviews
6. Listening sessions
7. Webinar with tribal MCH representatives

The framework shown in Figure 1 also guided OCCYSHN's needs assessment, although phase 1 and 2 were less sequential in data collection. OCCYSHN used a mixed methods design to understand the needs of, and the strengths and limitations of, the systems serving CYSHCN and their families.

2. Stakeholder involvement

The Title V Needs Assessment engaged families and consumers through a variety of mechanisms. Fifty-three community assessments conducted in Oregon over the past 3 years were analyzed to ensure that the voices and concerns of families across Oregon were reflected in the needs assessments. Although funding/staffing constraints precluded conducting family focus groups, listening sessions were held with parenting educators working in rural and minority communities, Tribal representatives, as well as Regional Equity Coalition members, to engage them in defining the needs of their MCH communities. Group participants included parents as well paraprofessional and professional staff.

Key stakeholders

1) The Needs Assessment planning team included the Title V Director, the Title V CYSHCN Director, the MCH Assessment & Evaluation Manager, the OCCYSHN Assessment & Evaluation Coordinator; county health department representatives; the Title V Tribal liaison, and representatives from Adolescent Health. Each planning team member was responsible for liaising with their constituency throughout the NA process.

2) Title V implementing partners included: county health departments and tribal maternal and child health agencies. These stakeholders provided input to the following parts of the needs assessment:

a. Environmental scan of community needs assessments (53 county and community assessments)

b. Survey of partners and providers (718 respondents)

c. Online discussion forum (28 participants)

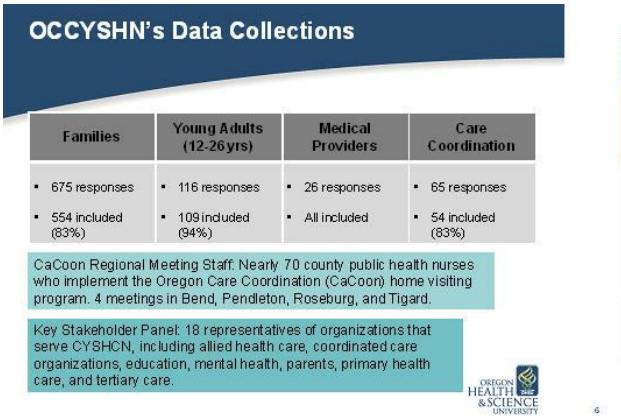
Eighty-eight Title V partners were invited to participate in the MCH online discussion forum. This moderated web-based discussion was conducted over a two-week period, and allowed Title V partners to respond to a set of prompts and react to each other's comments.

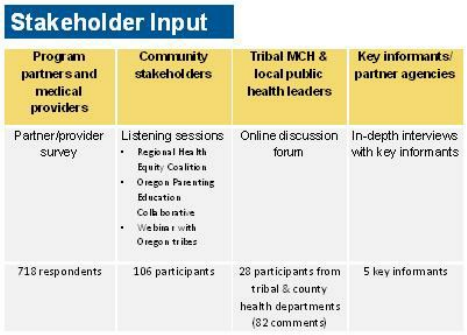
d. Listening sessions and webinar (106 participants)

e. Stakeholder prioritization meetings

3) Service providers, community members, and organizations that serve the MCAH population across the state contributed input through the community needs assessments scanned, surveys, and listening session described above. Section II.F.6 further describes stakeholder engagement in the Needs Assessment; a complete list of partners engaged in the MCH Needs Assessment is provided in the Attachment 3.

OCCYSHN involved stakeholders in the development of data collection instruments, all data collections, interpretation of survey results, and in the selection of the state's priorities. These stakeholders included: Oregon Family to Family Health Information Center family liaisons and program coordinator; OHSU's Child Development and Rehabilitation Center Family Navigators; OCCYSHN community-based program staff and medical consultant; public health nurses serving CYSHCN and their families through home visiting; representatives from CCOs, county developmental disability services, early and special education, families of CYSHCN, family resource organizations, mental health, public health, the state pediatric improvement partnership, the state chapter of American Pediatric Society, and a tertiary care clinic. The stakeholders surveyed were: families of CYSHCN, young adults with special health care needs, and medical providers and care coordinators who serve CYSHCN and their families.





3. Methods

Quantitative methods

Quantitative methods were used to assess strengths and needs of each population domain, MCH capacity, and partnerships/collaboration. These included analysis of health status and survey data, which were synthesized along with qualitative findings into data tools (see table below and attachment 4 for complete tools).For each tool, we analyzed data for each national, state and emerging priority area from the sources listed in Table 2. Our analysis included comparing Oregon to the US, disparities among racial and ethnic groups, and trends over time. We also analyzed the results of a survey of Title V partners and service providers to compare the level of need in different areas of concern. In addition to including results from national surveys, OCCYSHN included results from its stakeholder surveys, listening sessions, and key stakeholder panel in the CYSHCN data tools.

Table 1: Data Tools

National Priority Areas	*State Priority Areas*
Adolescent Health Population/Domain:	Adolescent Health Population/Domain:
Adolescent Health Overview	Adolescent Well Visit
Adolescent Well Visit	Obesity
Adolescent Safety/Injury	Population/domain: Cross-cutting/Lifecourse Population/Domain:
Bullying	Oral Health
Child Health Population/Domain:	Child Health Population/Domain:
Child Health Overview	Parent Resources and Support
Child Safety/Injury	
Developmental screening	Women's and Maternal Health Population/Domain:
Physical Activity	Drug and Alcohol Use
Children and Youth with Special Health Care Needs Population/Domain:	Family Violence
Overview	Mental Health
Transition to Adulthood	
Medical Home	*Emerging Issues*
Cross-cutting/Lifecourse Population/Domain:	Adolescent Mental Health
Overview	Cross-systems Coordination of Services
Adequate insurance coverage	Culturally Responsive Services
Oral Health	Drug Abuse/Misuse
Smoking	Food Insecurity
Perinatal and Infant Health Population/Domain:	Toxic Stress and Trauma
Overview	
Safe Sleep	
Breastfeeding	
Perinatal Regionalization	
Women's and Maternal Health Population/Domain:	
Overview	
Well Woman Care	
Low Risk Cesarean Deliveries	

Qualitative methods

Qualitative analysis of 53 county and community health assessments was conducted using Nvivo qualitative analysis software to identify and group topics and themes. Using this method, we were able to identify unmet maternal and child health needs, needs of children and youth with special health care needs and other themes. Similar qualitative analysis methods were used to analyze the results of the online discussion, listening sessions and the webinar.

OCCYSHN hosted a series of 4 regional facilitated discussions with public health nurses serving CYSHCN, and conducted a facilitated panel discussion with key stakeholders. OCCYSHN conducted thematic analyses of these data and integrated the findings into its data tools and reporting products.

4. Data sources that were utilized in the Needs Assessment are listed in Table 2 below

Table 2: Needs Assessment Data Sources

American Fact Finder, United States Census Bureau
Behavioral Risk Factor Surveillance System Survey
National Immunization Survey
National Survey of Children with Special Health Care Needs
National Survey of Children's Health
National Vital Statistics
Oregon Center for Health Statistics
Oregon Department of Education
Oregon Health Authority Center for Health Statistics
Oregon Health Teens Survey
Oregon hospitalization data
Oregon State Health Profile
Pregnancy Risk Assessment Monitoring System
Title V Information Center
U.S. Department of Health and Human Services, Maternal & Child Health Bureau
Youth Risk Behavior Surveillance System
53 Oregon county health assessment and health improvement plans
- Baker County Health Department Annual Plan 2013-2014
- Benton County Community Health Assessment
- Roadmap to Healthy Communities. A Community Health Assessment 2012 Update
- Healthy Columbia Willamette
- The Public Health Foundation of Columbia County Annual Plan 2013-14
- Crook County Annual Plan
- Central Oregon Regional Health Assessment
- Clatsop County community Health Assessment
- Clatsop Pacific Coordinated Care Organization (CCO), Clatsop County Data Summary
- Coos County Community Health Assessment
- Curry County Public Health Annual Plan FY 2013-2014
- Deschutes County Annual Plan
- Community Health Assessment Douglas County
- North Central Health District Annual Plan 2013-2014
- Grant County Community Health Needs Assessment 2012-2013
- Summary Report Community Health Needs Assessment
- Hood River County Public Health Annual Plan 2013-2014
- Community Health Assessment 2013 Jackson County Josephine County
- Jefferson County Annual Plan
- Klamath County Community Health Assessment 2013
- The 2011 Lake County Community Health Assessment
- Lane County Community Health Assessment
- Community Health Assessment 2013
- Community Health Assessment 2012
- Linn County Annual Plan 2013
- Annual Plan for Malheur County
- Marion County Community Health Assessment 2011
- Marion-Polk County Health Care System Capacity and Access Assessment 2013
- Polk County Annual Plan
- Morrow County Public Health Department Annual Plan 2013-2014
- Local Public Health Authority fir Multnomah County FY 2013/2014 Annual Plan
- Tillamook Regional Medical Center Community Health Needs Assessment
- Tillamook County Health Department Comprehensive Local Public Health Authority Plan 2013-2014
- Umatilla County Public Health Division Annual Plan 2013
- Union County Oregon Community Health Assessment and Community Health Improvement Plan
- Wallowa Memorial Hospital Community Health Needs Assessment Summary Report April 2013
- Washington County Annual Plan
- Wheeler County Public Health Comprehensive Plan Update July 1, 2013 through June 30, 2014

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5. Interface between the Needs Assessment, Title V priority needs and state's Action Plan.

A group of stakeholders met for two day-long sessions to consider the needs assessment results and to make recommendations for Oregon's priority needs. After presentation of the findings of the needs assessment, stakeholders participated in small group and full group discussions and recommended priority for Title V focus which were used to create the state's Action Plan. In addition, OCCYSHN asked its key stakeholder panel to recommend priority areas for CYSHCN, which were incorporated into the state prioritization process. The priority setting process is further described in Section II.C.

II.B.2. Findings

II.B.2.a. MCH Population Needs

a. MCH Population Needs

Needs assessment findings for each domain are summarized below. The process and rationale for selecting Title V priorities based on Needs Assessment results is described in Section II.C. Full needs assessment findings can be found in attachment 3.

1) Maternal/Women's Health

a) Overview of health status

Through the course of the needs assessment we identified several issues of concern for this domain. They included healthy weight, nutrition and food insecurity, stress and depression, tobacco use and intimate partner violence.

- Healthy weight: In 2011, 46.3% of Oregon women were overweight or obese just before getting pregnant.
- Nutrition and food insecurity: Nutritional risk due to poor dietary quality can persist across periods of food insecurity, and may increase the risk of nutritional deficiencies. At least one-quarter of Oregon women of reproductive age are food insecure.
- Stress and depression: In 2011, 28.4% of pregnant women in Oregon reported depressive symptoms. Stress is significantly associated with self-reported depression.
- Intimate partner violence: In 2010, 35.6% of adult women aged 18 years and older reported having experienced rape, physical violence, and/or stalking by an intimate partner in their lifetime.

b) Strengths/needs

Well woman care

A well woman care visit is supported in Oregon and nationally as a chance to screen for diseases and risk factors, and promote health before and between pregnancies. The Public Health Division's Maternal and Child Health and Reproductive Health Sections are working on providing guidelines for preconception health visits for the Coordinated Care Organizations (CCOs) as part of the Oregon Reproductive Health Advisory Council (ORHAC).

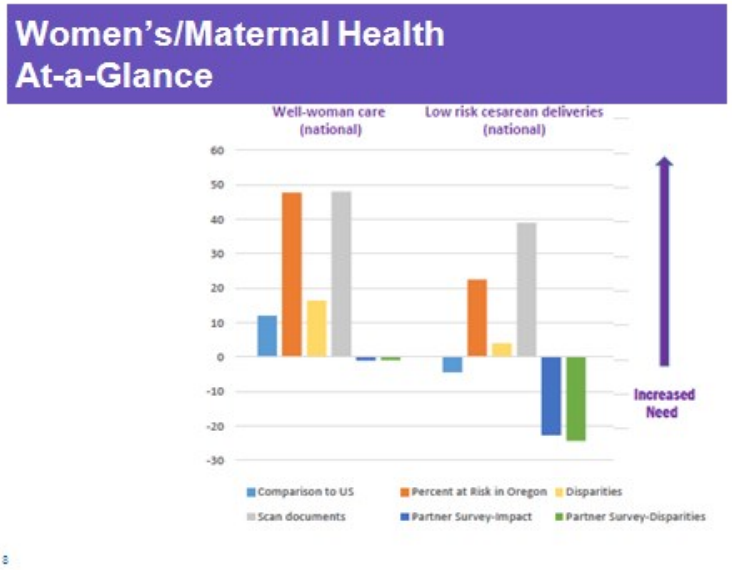
Low risk cesarean births

Many Oregon hospitals have started to implement practices and quality improvement efforts aimed at reducing cesarean rates. Oregon's success in decreasing early elective deliveries through a "hard stop" campaign led by the Oregon Perinatal Collaborative offers a model for a reduction in cesarean deliveries among low-risk women.

c) Success/challenges/gaps/disparities

In the prioritization phase of the needs assessment, we compared the two national priority areas in this domain in terms of:

- how Oregon compares to United States in terms of proportion of affected individuals
- the number of Oregonians at risk in that priority area
- the level of disparities
- the level of interest in that priority area at the county and community level
- survey-rated perception of health impact, disparities, resources currently being applied, and the potential for additional impact with state resources



Oregon has a higher percentage than the general US percentage of women who do not receive well woman care and women at risk for low-risk cesarean births. In our qualitative analysis of recent community health assessments across the state, categories of need related to well woman care were discussed a larger number of documents, compared to low-risk cesarean births, and had the largest disparities.

In the survey of partners and providers, 29 health areas were rated in terms of their impact on health, importance for addressing equity, the amount of time and resources currently being applied, and the potential for additional impact with state resources. This survey indicated that in Oregon, well-woman care is a higher need than low-risk cesarean deliveries.

2) Perinatal/ Infant Health

a) **Overview of health status**

Issues of concern for this domain include insurance coverage, depression, anxiety and stress, and oral health.

- Insurance coverage - Women without insurance coverage often experience delays in accessing prenatal care.
- Depression, anxiety, and stress - These and other psychosocial factors affect the health of women and their pregnancy outcomes. Depression is widespread, particularly among low-income women.

- Oral health is key to overall health and well-being. Many Oregon women face barriers to receiving oral health care during pregnancy.

b) Strengths/needs

Safe sleep

Oregon's Public Health Division partners with child fatality review teams, home visiting programs, WIC, hospitals, primary care, early care and education to provide consistent, clear, evidence-based safe sleep messages that can reduce the risk of all sleep-related infant deaths.

Breastfeeding

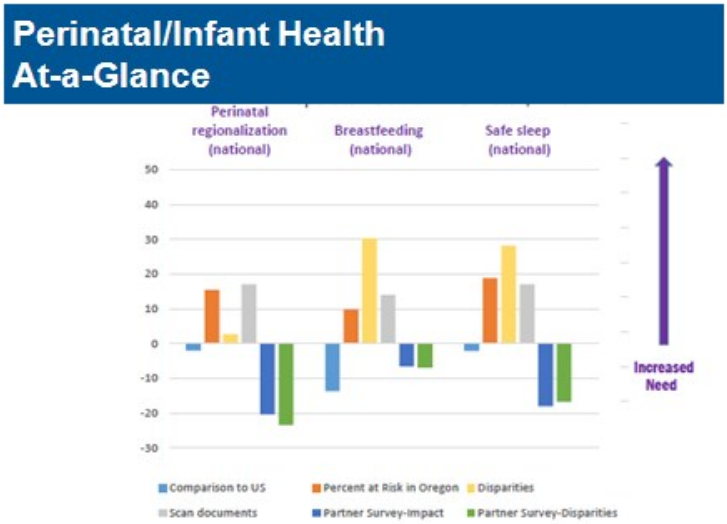
Oregon has among the highest breastfeeding rates in the US; most Oregon mothers initiate breastfeeding, however rates of exclusive breastfeeding at 6 months are much lower. Oregon hospitals have better than the national average of maternity care practices that support breastfeeding. Oregon has many supports in place to encourage women to initiate and continue breastfeeding, but further work is needed to address barriers among specific populations, as well as to promote continuation of breastfeeding beyond the initial weeks postpartum.

Perinatal regionalization

Oregon has a slightly higher percentage of very low birth weight infants who were born at a facility with a Level III NICU than the median percentage for 59 states, territories, and the District of Columbia. However, there is no uniform standard for calculating these rates.

c) Success/challenges/gaps/disparities

In the prioritization phase of the needs assessment, we compared the three national priority areas in this domain. The percentage of the population at risk in Oregon was lower than that of the US for all three of the national priority areas. Safe sleep had the highest percentage at risk, followed by perinatal regionalization. Breastfeeding had the highest level of disparities, followed by safe sleep.



In comparing the partner and provider survey ratings of impact on health and importance for addressing equity, all three national priority areas had ratings considerably below average. Breastfeeding had the highest ratings for impact on health and potential for addressing equity.

In the statewide scan of community health assessments, the broader topic of mental health was discussed in considerably more documents than any of the other health priority areas in this domain. In the survey of partners and providers, maternal mental health was the only health priority area in this domain that had higher than average ratings for impact on health and importance for addressing equity. The mean ratings for both impact and equity for this domain were highest for maternal mental health, followed by breastfeeding, perinatal regionalization, and then safe sleep.

3) Children's Health

a) Overview of health status

Issues of concern for this domain include developmental screening, and childhood obesity.

- Developmental screening - About 1 in 4 children ages 0-5, are at moderate or high risk for developmental, behavioral, or social delay. The percentage of children with developmental disorders has been increasing, yet overall screening rates remain low.
- Childhood obesity - Children who are overweight or obese are at risk for becoming overweight or obese adults, increasing their risk for chronic disease, poor emotional wellbeing and depression.

b) Strengths/needs

Child injury

Since 2000, injury has been the leading cause of death for Oregon children ages 1-19, and the 4th leading cause for children under age 1. Effective interventions to reduce injury exist but are not fully implemented in systems of care

that serve children and families. Motor vehicle traffic deaths and injuries to children under fifteen have declined steadily since 2000, but other child injury issues have not.

Developmental screening

There is widespread acknowledgement of the value of developmental screening. Developmental screening has been conducted in public health, home visiting, early childhood and pediatric settings across the state for many years. Initiatives to promote developmental screening include a focus on:

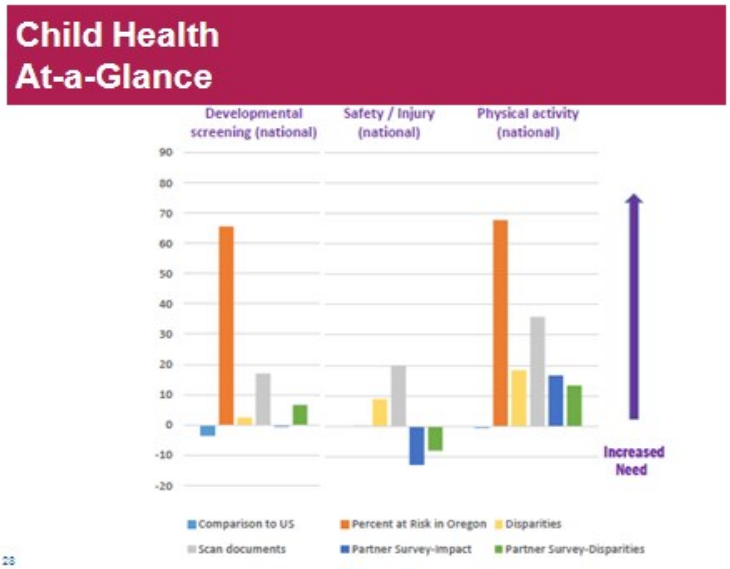
- Coordination of developmental screening results across providers.
- Reduction of screening process burden for families

Physical activity

In 2007, new physical education standards for public schools specified that all elementary and middle schools will be required to provide K-5 students 150 minutes per week of physical education and grades 6-8 225 minutes per week by 2017. The number of schools that meet requirements for PE has actually declined 54% from the 2008-2009 to the 2009-2010 school year.

c) Success/challenges/gaps/disparities

For all three of the national priority areas in the child health, Oregon had slightly lower rates of individuals at risk than the US. The absolute levels of risk were very high for physical activity and developmental screening, but very low for injuries (measured by mortality rates). It is important to keep in mind that although injury mortality rates are very low, they are the leading cause of child death. For the three national priority areas, disparities were the greatest for physical activity, followed by injuries. Disparities were relatively small for developmental screening.



Among the three national priority areas, physical activity was mentioned in the most documents in the scan of community health assessments, followed by safety/injury, and then developmental screening. In our survey of partners and providers, the only priority area in this domain receiving above average ratings for impact on health was physical activity. Physical activity and developmental screening both received high ratings for their importance for addressing

equity from a larger than average portion of respondents, while a slightly lower percentage gave high ratings to developmental screening.

4) Adolescents/Young Adults

a) Overview of health status

Issues of concern for this population include teen pregnancy, depression and suicide, and alcohol use.

- Teen pregnancy rates among Oregon females aged 15–17 years have declined almost by half over the past five years, although racial and ethnic disparities still exist. Almost half of all 11th graders have had intercourse.
- One out of three girls and 1 out of 5 boys reported being depressed in the past year. Suicide is the 2nd leading cause of death among Oregon youth.
- While alcohol use is on the decline statewide, it is still the most commonly used substance.

b) Strengths/needs

Physical activity

In 2007 the Oregon Legislature passed physical education standards for public schools, requiring schools to provide K-5 students 150 minutes per week of physical education and grades 6-8 225 minutes per week. The number of schools that meet these requirements has declined 54% between the 2008 and 2009.

Adolescent well visit

Increasing the number of youth receiving a preventive visit in the past year has been a Title V state priority since 2010. The adolescent well-visit was selected as an incentive measure for Coordinated Care Organizations (CCOs).

Adolescent safety/injury

Since 2000, injury has been the leading cause of mortality for Oregon children ages 1-19. For children ages 10-19, traumatic brain injury, suicide and motor vehicle traffic are leading causes of death.

Bullying

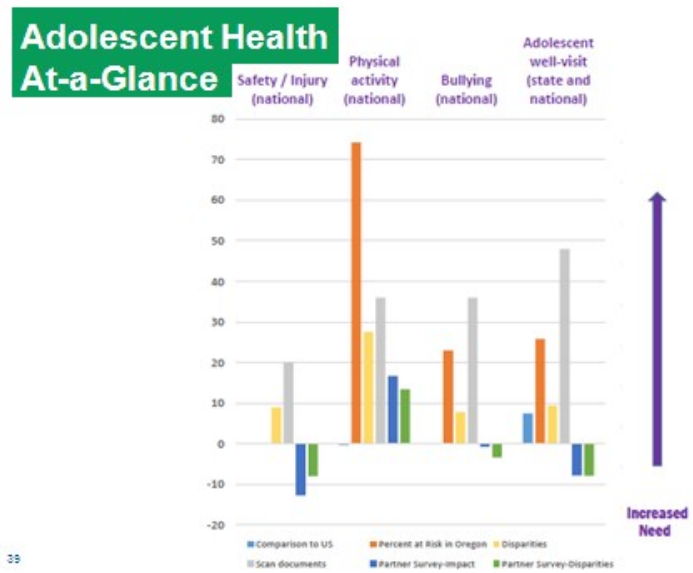
Oregon law mandates that all schools have policies prohibiting bullying, harassment and cyber-bullying. It is not clear whether the policies have impacted behaviors and outcomes in the school environment.

c) Success/challenges/gaps/disparities

For adolescents, death rates from injuries are somewhat greater for adolescents than for young children. For physical activity, the data for 11th grade students are similar to those of 8th grade students, except that the percentage engaging in adequate physical activity falls between 8th and 11th grade.

Of the four national priority areas in this domain, we found that physical activity has the greatest percentage of adolescents at risk, followed by adolescent well-visit and bullying. Injury has a very low percentage at risk, mostly because the indicator is injury mortality rate. In the review of community health assessments, the categories of

access to health insurance, medical care, specialty care, and urgent care were used as surrogates for adolescent well visit, and compared to the other priority areas, and these areas were mentioned in the largest number of documents. Physical activity has the largest level of disparities of the four national health priority areas.



In the survey of partners and providers, physical activity received above average ratings for impact on health and importance for addressing equity. The rank order of the ratings for the national priority areas was physical activity, bullying, adolescent well-visit, then safety / injury. The rank order of national priority areas was: physical activity, bullying, adolescent well-visit, followed by safety/injury.

5) Children with Special Health Care Needs (CSHCN)

Needs in Oregon revolve around developing *high quality, family-centered, coordinated and integrated systems of care for CYSHCN*. Key stakeholders recommended both Medical Home and Transition to Adulthood as priorities, emphasizing that both priorities are needed to assure a comprehensive and integrated approach to transition for CYSHCN, currently implemented in a siloed manner. Summary results follow; Attachment 1 contains OCCYSHN's full Title V Needs results.

Transition to Adulthood

a) Overview of health status

About 36% of Oregon YSCHN received necessary transition services (NS-CSHCN, 2009-10). The survey sample sizes were too small to confidently discern whether racial or ethnic differences exist.

b) Strengths/needs

YSHCN do not receive the needed preparatory assistance to transition to adult models of health care. Very few YSHCN reported that their health care provider talked with them about how their relationship will change after age 18; about half reported that their provider gives them "a lot of" or "some" help learning how to manage their own health. Less than one-third of family respondents reported that their child's primary care provider talked with them about how their child's care changes after 18. Less than half of medical providers assess transition readiness; only

one-fifth had a written policy addressing transition; none had a program to foster the development of self-management skills or transition knowledge.

c) Success/challenges/gaps/disparities

Health care providers are not current on health care transition practices and not prepared to provide transition direction. Transition to adulthood is primarily addressed by focusing on education and employment for those YSHCN who will have some independence in living. However, these efforts do not address health care transition or transition processes for CYSHCN who will not have any independence in living.

In the survey of partners and providers, transition to adulthood ranked: 3rd in how much the issue impacts community health; 8th in importance to improve health equity; 28th in the amount of time and resources currently being applied to the issue; and 10th in the likelihood that application of more time and resources by public health agencies would make an impact on the issue. This is a substantive area that will require new strategies and increased programmatic emphasis.

Medical Home

a) Overview of health status

As of 2009-2010, 41% of CYSHCN received care in a medical home. As of 2011-12, 34% of CYSHCN families who needed care coordination (CC) did not receive 1 or more CC elements and one-fifth had 1 or more unmet needs for care during the past 12 months.

b) Strengths/needs

Most medical providers did not have, or know if they had, a process for including family feedback on their practice's care. Most young adults reported that their care providers listened carefully to what they have to say and explained things in a way that is easy for the youth to understand. Results showed that 47% of families reported that they "rarely" or "never" receive as much help as they want coordinating care. Less than one-third of parents reported that their child has a care plan.

c) Success/challenges/gaps/disparities

Oregon's Patient-Centered Primary Care Home (PCPCH) Program lacks explicit CYSHCN care standards. Primary care, education, and mental health providers need to be coordinating CYSHCN care. Not all practices that develop care plans actually use them, and families do not expect their child's providers to supply a care plan.

In the survey of partners and providers, medical home was ranked: 18th in how much the issue impacts community health; 21st in importance to improve health equity; 4th in the amount of time and resources currently being applied to the issue; and 17th in the likelihood that application of more time and resources by public health agencies would make an impact on the issue. This is a substantive area that will require new strategies and increased programmatic emphasis.

6) Crosscutting/Life Course

a) Overview of health status

Cross-cutting issues of concern found in the needs assessment included smoking, oral health, and adequate insurance coverage, as well as a wide range of social determinants of health (see emerging issues)

b) Strengths/needs

Adequate insurance coverage

In 2009, the Oregon Legislature expanded access to the Oregon Health Plan by creating the Healthy Kids Program, expanding eligibility for state-covered health insurance. By 2013, only 5% of Oregon children were uninsured. There are disparities in health insurance coverage based on race, ethnicity and other characteristics. Newly pregnant women are more likely to be uninsured, which impedes their timely access to prenatal care.

Oral health

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

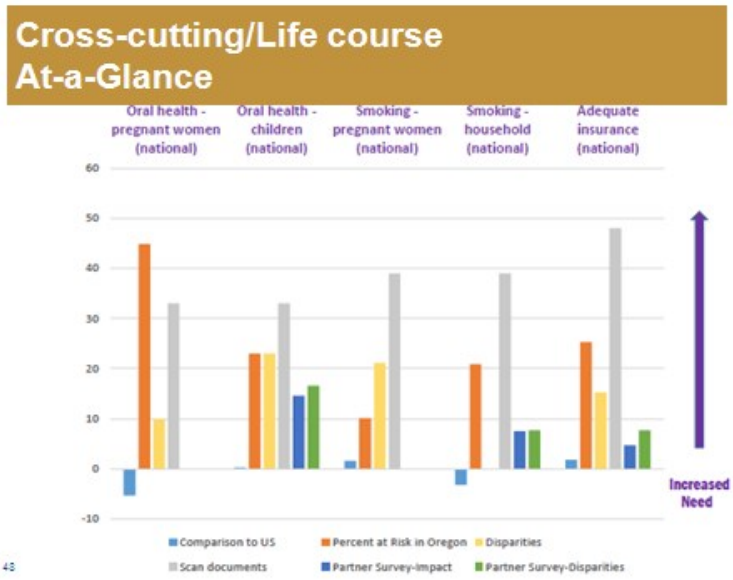
• Children residing in rural and frontier areas have less access to care and higher rates of decay.

Smoking

The Oregon Public Health Department uses a variety of strategies to protect Oregonians from secondhand smoke in their homes, workplaces and communities, and to help smokers, including those who are pregnant, to quit smoking.

c) Success/challenges/gaps/disparities

Oregon has a higher percentage of women with dental visits during their pregnancy than the US, and a lower percentage of children in households with someone who smokes. For the other health priority areas in this domain, Oregon's risk rates were slightly higher than the US. For this domain, the highest percentage for individuals at risk was for oral health of pregnant women, followed by those without adequate health insurance. The two highest levels of disparities occur for children's oral health and for smoking among pregnant women.



In the scan of community health assessments, inadequate insurance (health insurance/medical care/specialty care/urgent care) was discussed in the largest number of documents. In the survey of partners and providers, there was no item for oral health of pregnant women. Children's oral health had the largest percentages of respondents rating that area as having a large impact on health and importance for addressing equity of all of the included health priority areas in this population domain. The next highest percentages in the partner survey related to impact on health were for household smoking followed by adequate insurance. Household smoking and adequate insurance were tied for importance for addressing equity.

7**) Emerging priorities**

In addition to examining Oregon's MCH needs related to current state Title V priorities and the new National Priority/Performance Measures, Oregon's Title V Needs Assessment explored emerging MCH needs. Seven issues that were most commonly identified across needs assessment data sources (including scan of community assessments and health improvement plans, partner and provider surveys, community stakeholder listening sessions, expert panel and webinars, key informant interviews, demographic and health data, and state/national policy forums) were further explored as emerging issues for Oregon. These included: mental health for CYSHCN; adolescent mental health, depression and suicide; drug abuse and misuse; food insecurity; toxic stress and trauma, culturally and linguistically responsive services; and systems coordination and integration. Findings related to the emerging priorities are discussed in Section II.F.5. of this report.

II.B.2.b Title V Program Capacity

II.B.2.b.i. Organizational Structure

II.B.2.i. Organizational Structure

a. Organizational structure of OHA, Public Health, Title V, and OCCYSHCN

Oregon is one of several states in which the Title V Block Grant is administered by two separate agencies. The designated Title V Agency is the Center for Prevention &Health Promotion (CP&HP) in the Public Health Division, Oregon Health Authority (OHA). The Director of OHA is appointed by the Governor and sits on the Governor's Cabinet. OHA has fiscal responsibility for the Block Grant, and transfers 30% of total funds required for children with

special health care needs to Oregon Health and Sciences University (OHSU).

As of March 2015, Lynne Saxton is the Director of the Oregon Health Authority under Governor Kate Brown. OHA has responsibility for health-related programs in the state including Public Health, Medicaid, Addictions and Mental Health, the Pubic Employees and Oregon Education Benefit Boards. The attached organizational chart shows the Public Health Division as one of 6 Divisions within OHA. Under the leadership of Director Saxton, OHA is being re-structured and the new structure will include the following Divisions: Operations, Equity and Inclusion, Health Systems (includes Behavioral Health/AMH/MAP), External Relations, Health Policy and Analytics, Public Health, and State Hospital. Title V will remain under the Public Health Division (PHD), which is led by State Public Health Director Lillian Shirley. The PHD is made up of three centers, and Title V sits within the Center for Prevention and Health Promotion (CP&HP).

Title V CYSHCN services are administered through the Institute on Development & Disability (IDD) within the Oregon Health & Science University (OHSU) School of Medicine, by the Oregon Center for Children and Youth with Special Health Needs (OCCYSHN). Under Oregon statutes 444.010, 444.020 and 444.030, OHSU is designated to administer services for CYSHCN. IDD's goal is to unite clinical, educational, research, and public health programs to improve the lives of individuals with disabilities. IDD is directed by Brian Rogers, MD. IDD is composed of 2 "arms":

- Child Development & Rehabilitation Center (CDRC) clinical program, under the direction of Brian Rogers MD includes CDRC clinics located in Portland and Eugene.

- Public Health, Research and Education, under the oversight and direction of Kathleen Humphries, PhD, Associate Director of IDD, includes OCCYSHN, the Oregon Office on Disability & Health (OODH), UCEDD, and the Disability & Health Research Group.

b. Responsibility for programs funded under Title V (federal and state)

Oregon's Title V program sits within the Center for Prevention and Health Promotion of the Public Health Division, under State Title V Director, Cate Wilcox. Ms. Wilcox also serves as the Manager for the Maternal and Child Health Section, and works closely with the CP&HP Center Director (currently vacant) and Section Managers for Adolescent, Genetic & Reproductive Health, WIC, Injury & Violence Prevention, and Health Promotion & Chronic Disease Prevention to administer and coordinate the Title V state/federal partnership programs conducted across the Center (see organizational chart).

Federal Title V Block Grant funds administered by the Title V Director are allocated as described above to OCCYSHN for delivery of services to children and youth with special health care needs. The remaining funds allocated to state level Title V activities are delivered through the Center for Prevention and Health Promotion, and local level Title V activities are delivered through Oregon's designated local health authorities and Tribes. The Title V Program in the OHA and the Title V Program for CYSHCN in OHSU have an interagency agreement to document the roles of each agency and to directly transfer 30% of the Title V allocation. State Title V Agencies in CP&HP and OCCYSHN collaborate in coordinating service delivery, building partnerships, identifying gaps and opportunities in delivery systems, and advocating for actions and policies that improve health among maternal and child populations. The state Title V programs support community MCH/CYSHCN programs through intergovernmental agreements and formula grants with county health departments and tribal governments. County governments are the designated health authorities delivering health and mental health services and/or linking the public to health and mental health services, through county or regional health departments.

The Title V Director administers state and local level Title V grant-funded activities across the Center for Prevention and Health Promotion, as well as through the MCH warmline contract with 211info. Additional state/federal MCH partnership programs such as home visiting, early hearing detection, women's health, violence prevention, MCH assessment, evaluation and informatics, oral health are also under the direct oversight of the Title V Director. In addition, a wide range of MCH programs not directly Block Grant funded are conducted across the Center, and disseminated to communities around the state. These programs and activities are a critical part of the State investment in maternal and child health, and make up the larger state/federal MCH Title partnership. They include state and federally funded programs in tobacco prevention for women and children, adolescent health, school-based health centers, reproductive health, injury and violence prevention, WIC, and chronic disease prevention. These programs are under the direct management of the Section managers referenced above, and administration of cross-Center-Title V partnership activities is overseen by the Title V Director and the CP&HP Director.

OCCYSHN has 6 programs and 2 projects (See Attachment 2), including 2 statewide community-based programs receiving Title V funds:

- **CaCoon** is a public health nurse home visiting care coordination program serving CYSHCN age 0 to 21.

- **Community Connections Network (CCN)** serves CYSHCN, age 0 to 21, with unresolved health or health related issues and their families. CCN teams provide community-based multidisciplinary evaluation, consultation, and care coordination services.

Organization Charts may be found in Attachment 5.

II.B.2.b.ii. Agency Capacity

a. Agency capacity to promote health for each population domain

Capacity for Maternal and Women's Health

- The **Reproductive Health Program** assures access to preconception and reproductive health services across the state through several federal and state programs including the Conception Care program (CCare) under a HCFA 1115 waiver and the federal Title X Family Planning programs.
- The **Breast and Cervical Cancer Program** (BCCP) helps women access screening programs for early detection of breast and cervical cancers.
- The **WISEWOMAN Program** promotes early detection, risk factor screening, risk reduction and access to medical treatment for low-income, uninsured and underinsured women aged 40 to 64.
- Oregon's **CoIIN initiative** for infant mortality reduction collaborates with Family Planning, Title V and a variety of external partners to improve preconception health.
- The **Women's Health Program** is a systems development program to raise awareness, engage stakeholders, and improve resources for women's health concerns across the lifespan including domestic and sexual violence prevention.

Capacity for Perinatal and Infant Health

- The MCH Section's **Assessment and Evaluation unit** conducts PRAMS and PRAMS2 (2-year follow back survey), and ensures the translation of perinatal data to practice.
- The **Perinatal Health Program** promotes of optimal prenatal care and other pregnancy related services for all pregnant women. Title V resources support statewide policy development, surveillance, and local funding for

improving the health of peri-conceptual and pregnant women. Activities include technical assistance and consultation with local health departments and CCOs, the CoIIN infant mortality initiative, maternal mental health iniative, administration of the **Maternity Case Management (MCM)** and **Nurse Family Partnership (NFP)** home visiting program (delivered by county health departments), and the **Oregon MothersCare** (OMC) **Program** which links pregnant women to essential perinatal services.

Capacity for Child Health

- **The Early Hearing Detection and Intervention Program** facilitates Oregon's Newborn Hearing Screening legislation (ORS 433.321) which mandates that all infants born in facilities with 200 or more births be screened for hearing loss within 6 months of birth. The program receives federal grant support from the CDC grant for EHDI.
- **Babies First! Program** is a public health nurse home visiting program that provides home visit assessment of the mother and infant attachment and the home environment, screening for developmental delays, vision and hearing, counseling, case management, advocacy and education, and referral/follow-up for infants and children up to age 5 and their families.
- The **NFP** program provides home visiting to first birth pregnant women, mothers and infants through 23 months in 10 Oregon counties.
- **Title V's Infant and Child Nutrition Consultant** provides consultation and leadership to build environments and public policies that increase nutrition and physical activity of infants, children and adolescents, and prevent obesity and overweight conditions; promotes the Breastfeeding Mother Friendly Employer laws; integrates nutrition into all existing MCH programs to increase support healthy eating, access to healthy foods, and physical activity; coordinates between MCH and WIC for healthy eating and breastfeeding.
- The State **WIC Program** contracts with 34 local health agencies to provide WIC services to over 109,000 pregnant and postpartum women, infants, and preschool children each month in all geographical areas of the state. WIC also administers the farmer's market program, and WIC data provides essential information about nutritional status and trends in Oregon.
- The **Child Injury Prevention Program** within the Injury & Violence Prevention section provides information and technical assistance to communities and groups in Oregon; trains local health department staff as certified safety seat technicians; and supports local capacity development to deliver safety seat clinics and distribute safety seats. The program also convenes the Safe Kids Coalition and integrates motor vehicle, suicide, poisoning, and falls prevention efforts with early childhood educators and home visiting.

Capacity for Adolescent Health

- The **Adolescent Health Section** administers the Title V and other funds dedicated to support leadership and policy development for adolescent health at the state level; health promotion and infrastructure development in LHDs, and ongoing assessment, data collection and technical assistance (including Oregon Healthy Teens survey) to guide statewide policies and programs related to adolescent health.
- **School Based Health Center** (SBHC) Program administers Oregon's 63 SBHCs, in which comprehensive physical, mental and preventive health services are provided to youth and adolescents in a school setting. SBHCs see children who otherwise would not get care; help students get back to the classroom faster; lessen the time parents take off for children's health needs, and improve students' health.
- The **Healthy Kids Learn Better (HKLB) Program** (Coordinated School Health model) is a statewide initiative to help local schools and communities form partnerships and reduce physical, social and emotional barriers to learning.

- **The Youth Suicide Prevention Program** in the Injury and Violence Prevention Section, collaborates with the Adolescent Health Section to develop and implement the Statewide Youth Suicide Prevention Plan, and administers **Oregon Violent Death Reporting System.**

Capacity for Children and Youth with Special Health Care Needs

- OCCYSHN provides leadership in **Systems and Policy development,** and advocacy and education on the needs of CYSHCN including a focus on nutrition and genetic services, access to CSYHCN oral health and childcare needs, and advocacy to needed services.
- The **CaCoon** program is a public health nurse home visiting program providing and/or assuring coordinated care for CYSHCN birth to 21.
- The **CCN** program supports multidisciplinary child health teams in 9 rural communities that bring together the local systems of care needed to address the unmet needs of CYSHCN.
- The **Family Involvement Network** assures family involvement and partnership in all OCCYSHN program activities at the state and community level.
- The **assessment and evaluation** section of OCCSYHN conducts surveillance, program evaluation, and special studies to support OCCYSHN activities.

Medicaid covers all children eligible for SSI in Oregon, which further increases OCCYSHN's capacity to serve CYSHCN. Attachment #2 has detailed information about OCCYSHN's programs.

Capacity for Cross-cutting or Lifecourse Health

The Title V program's co-location with WIC, Adolescent and Women's Health, and Chronic Disease Prevention programs in the Center for Prevention and Health Promotion provides a unique opportunity to expand capacity and coordinate on lifecourse health.

- The **Tobacco Prevention and Education Program** supports the tobacco quitline, social marketing, and support to communities and tribes to implement policy and system change;
- The **integrated Chronic Disease Prevention Program** includes physical activity, breastfeeding and nutrition, diabetes and asthma prevention;
- The **Oral Health Program** strengthens statewide policy, access to preventive care, and conducts oral health surveillance. It conducts policy development for fluoridated community water systems, school-based sealant programs, school-based fluoride supplement program, and an early childhood cavities prevention program.
- The **Assessment and Evaluation Unit** of the MCH section conduct surveillance, evaluation, assessment and analysis to support core MCH capacity on both the state and community level.

b. Title V support for statewide coordinated system of MCH services

1. **Collaboration with other state agencies.** The state Title V program collaborates extensively with other state agencies and private organizations as described in Section II.C. Title V has collaborative relationships with the federal programs housed in the Public Health Division, Addictions and Mental Health Division, and the Division of Medical Assistance Programs (Medicaid agency), as well as social service providers such as the Department of Human Services, and the Department of Education's Early Learning Division. These collaborations provide expertise to link individuals to care, improve quality of care, promote behaviors and actions that reduce risk and improve health outcomes, and improve efficiencies in public services and health

care.

2. **State support for communities** is ensured through a combination of state level technical assistance, surveillance and policy support, with Title V funding disseminated local communities through local public health departments and tribes across Oregon. Title V support for local communities is determined through a funding formula that ensures that communities with highest MCH population needs receive commensurate Title V support.

3. **Coordination with health systems.** Title V and public health are recognized as critical partners for the success of health transformation efforts in Oregon – and coordinate extensively with health systems on both the state and local levels. On the state level, collaboration with Medicaid, Addictions and Mental Health, the Office of the Public Health Director, and the OHA Transformation Center help to ensure that the needs of the MCH population are addressed within the state health system. At the local level, Title V grantees address the role of MCH as both a referral source and provider of services such as home visiting, surveillance and assessment, and preventive services.

4. **Local coordination of MCH services** is conducted by Title V grantees through an extensive network of public and private partners. In smaller counties, health, mental health, early childhood and social services are often co-located.

5. **Coordination for CYSHCN.** OCCYSHN ensures a coordinated and integrated system of services reflecting comprehensive, community-based, coordinated, and culturally competent family-centered care. It collaborates with state agencies and organizations including: Addictions and Mental Health, Early Intervention, Medicaid, the Oregon chapter of the AAP, and the Oregon Pediatric Improvement Partnership. OCCYSHN supports community efforts through grants to LHDs, providers and other community providers to assure community-based services. It includes in these community-based initiatives local healthcare providers and specialists, as well as other services at the community level such as mental health, education, and family organizations. Attachment 2 has detailed information about OCCYSHN's programs.

   In 2014, OCCYSHN was awarded a HRSA/MCHB funded State Implementation Grant (SIG) to improve systems of care serving Oregon's CYSHCN (SOS Grant), so the population receives better care and enjoys better health. This is a collaborative effort among state partners and seeks to address integration and coordination of systems of care serving CYSHCN. The Association of Maternal & Child Health Programs (AMCHP) National Consensus Framework's Standards for Systems of Care for CYSHCN, is central to OCCYSHN's efforts on the grant.

II.B.2.b.iii. MCH Workforce Development and Capacity

II.B.2.iii.. MCH Workforce Development and Capacity

a. Strengths and needs of the MCH Workforce

State level staffing

The Oregon Title V Director, Cate Wilcox, MPH, has been the Title V Director since 2013, and has 30 years of MCH experience. Other key MCH management staff include: Home Visiting Manager Lari Peterson, and Assessment and Evaluation manager Kathryn Broderick both with over 25 years of MCH experience. Key MCH staff in OHA include

the Child Health Director and the Dental Director. MCH program and policy staff include the Title V Coordinator, MCH policy specialists, the MCH epidemiologist, research analysts, informaticists, public health educators, public health nurses, state home visiting system specialists, oral health specialists, an audiologist, and adolescent and school health specialists. Most of the MCH staff have graduate level degrees in public health, health policy, public administration or medical or dental professional degrees and many years' experience in public health planning, implementation and evaluation. A total of 214 FTE staff are employed within the Center for Prevention and Health Promotion, 56 FTE of which are in the MCH Section, and 18 of those are supported directly by the Federal Title V grant funds.

Marilyn Sue Hartzell, M.Ed. has been the Title V CYSHCN Director since 2008 and has over 25 years of CYSHCN experience. OCCYSHN employs 21 staff with 10.99 FTE, and 20 community-based Family Liaisons. Staff have expertise in public health nursing, developmental pediatrics, genetics, nutrition, special education, community engagement and development, family professional partnerships, health policy, assessment and evaluation, and cultural competency. OCCYSHN is currently recruiting a full-time Systems and Policy Specialist and an Administrative Assistant, with plans to recruit a Research Assistant.

OCCYSHN hires, contracts with, and supports family representatives from diverse cultural and linguistic backgrounds, including Russian, Spanish and ASL. OCCYSHN is staffed with a Registered Nurse as CaCoon Program Lead Consultant, 3 Community Consultants (one a special education specialist; 2 are specialists in learning disabilities and community development), Nutrition Consultant, Family Involvement Network Coordinator and ORF2FHIC Coordinator (both parents of CYSHCN), public health genetics consultant, Communications Coordinator, developmental pediatrician as the OCCYSHN Medical Consultant, A&E Coordinator and Research Associate, an Administrative Program Manager and 2 administrative staff. Additional consultative resources are available within IDD including developmental pediatricians, speech pathologists, occupational therapists, physical therapists, etc.

Local Level staffing

The direct delivery of MCH programs is provided by staff at local health departments and tribes, funded by Title V and other federal and state funds through grants to counties. There are approximately 2,000 county public health staff in Oregon, not including staff at non-profit or tribal health centers. This includes 34 health department administrators, 510 public health nurses and nurse practitioners, and 130 other health professionals in Oregon LHDs. Title V MCH services are also delivered by five of Oregon's nine federally recognized tribes.

OCCYSHN's core program staff is augmented by an extensive array of contracted time and effort delivered by PHNs, community-based physicians, other health and health related professionals and FLs who implement community-based programs around the state.

Changing MCH workforce A variety of forces are driving changes in the MCH workforce in Oregon. Health systems reform is changing the role of state and local MCH, the skillsets needed for success, and the funding mechanisms that support MCH services. The changing demographics of Oregon's MCH population and Title V's commitment to health equity will also drive changes in both the skills and profile of the MCH workforce. The public health nurse workforce is significantly older than the nursing workforce in general, with half of Oregon's PHNs nearing retirement as compared to one third of other nurses. Although this is a time of great opportunity and potential for maternal and child health within the evolving health and early education system, it is also a time of great uncertainty and constrained funding – both of which contribute to high levels of workplace stress and turnover. High levels of

turnover in both state and local level MCH supervisors, administrators, and staff will likely continue in the coming 5 years as experienced staff retire and take new positions in the evolving health system. As a result, a focus on workforce recruitment, skill development and support will be critical to Title V's successful implementation of BG 3.0.

b. Mechanisms that promote culturally competent service delivery

Oregon's Title V program focuses on integrating a health equity focus across all of our work – on both the state and local level.

Title V Needs Assessment and community engagement The needs assessment included as one of its guiding questions how Title V resources could be used to address health equity in the MCH population. Toward that end, all health status data were analyzed for race, ethnicity, economic, and geographic disparities when possible. Each topic was assessed for Title V's potential to impact disparities. Listening sessions were held with Oregon tribes, Oregon's health equity coalitions and parenting educators from diverse communities, and an online forum was structured to ensure the participation of rural MCH voices. Development of ESMs and state performance measures over the coming year will further enhance this focus by ensuring that strategies are targeted to communities experiencing disparities and that community voices are central to the development and selection of those strategies and measures.

MCH infrastructure, policy and guidelines

The MCH section has developed a Health Equity Workgroup focused on the development of structures, policies, and standards to address health equity across 6 MCH areas including: community engagement, workforce development, policy and infrastructure, culturally and linguistically accessible programs and services, data and surveillance, and communications.

Culturally and linguistically responsive MCH services were identified in the needs assessment as a key MCH priority, and will be the focus of strategy development across all domains, and a specific state performance measure in the coming year. This will include development of contract and data collection standards, as well as processes for compliance review. Language access was a primary concern voiced in the needs assessment, especially for rural MCH programs in communities with increasing diversity of clients and limited staffing resources. Cultural competency skill development has also been identified as a core home visiting competency, and development of associated training and standards is underway.

OCCYSHN promotes cultural competency on community teams. It included cultural diversity in the training and hiring of FLs. Promotoras assist in the CaCoon program in 4 rural counties providing culturally competent care to Latino families. OCCYSHN will emphasize health literacy in its community-based training efforts and through its communications. OCCYSHN also identified culturally and linguistically responsive CYSHCN services as a key CYSHCN priority.

II.B.2.c. Partnerships, Collaboration, and Coordination

II.B.2.c. Partnerships, Collaboration, and Coordination

OCCYSHN values a high level of collaboration among its partners including state and community-based agencies and organizations, healthcare and community based providers, and families of CYSHCN. Located within OHSU's IDD, OCCYSHN benefits from collaborative relationships with CDRC clinics, DCH and the NICU, Department of Pediatrics within the School of Medicine, Oregon Pediatric Improvement Partnership (OPIP), and Shriners Hospital. It partners with local health departments, ESDs, and local health providers and professionals to implement 2 statewide community-based programs. OCCYSHN FIN and the ORF2FHIC partnered to establish relationships with parent organizations around Oregon. FIN and ORF2FHIC collaborate with these organizations to identify families to provide input into, and participate in projects, meetings, trainings, and planning efforts. These relationships bring critical perspectives to state level system, policy, and program development and implementation efforts. They inform OCCYSHN of the unmet needs of families of CYSHCN.

Two HRSA-funded grants increased OCCYSHN's network of partners: a State Implementation ASD grant and a D70 Systems of Services grant. To implement the D70 grant, OCCYSHN initiated a high level State Advisory Committee and a State Implementation Team to advise on prioritized changes to the system of care for CYSHCN. Partners across the 2 groups include: Medicaid, Title V MCH and CYSHCN, OHA Policy Director, families of CYSHCN, health care providers, and OPIP. See attachment # 2 for more information about OCCYSHN's partnerships.

Oregon's Title V program is strongly committed to working collaboratively with a wide range of partner agencies to expand the capacity and reach of the state Title V MCH and CYSHCN programs. These partnerships and collaborations span public and private sector entities across the state, as well as MCHB and other Federal programs which serve the MCH population. The table below provides a summary of key collaborations and partnerships for the MCH Title V program

i. Other MCHB investments	
State Systems Development Initiative (SSDI)	Oregon's SSDI grant enables the informatics staff of the MCH Section, working in collaboration with Title V staff, to build and expand MCH data capacity to support Title V program efforts and contribute to data driven decision making; support the Collaborative Improvement and Innovation Network (CoIIN) efforts to reduce infant mortality through improved availability and reporting of timely data; and advance the utilization of both the minimum and core data sets for Oregon Title V MCH programs.
Maternal, Infant and Early Childhood Home Visiting (MIECHV)	Oregon has received 5 MIECV grants including the formula, development, expansion, and competitive grants, which are administered jointly with Title V through the MCH section. MIECV and Title V collaborate to strengthen the home visiting system in Oregon, develop the home visiting workforce, and expand evidence-based home visiting services (including Nurse Family Partnership, Early Head Start, and Healthy Families America).
Infant Mortality CoIIN	Oregon's Infant Mortality CoIIN is under the leadership of Title V staff and has mobilized partners around the state to develop policy and program interventions in the areas of safe sleep, preconception health, and social determinants of health. The CoIIN priorities and work support Title V priorities and vice versa.
Early Childhood Comprehensive Systems of Care (ECCS)	The ECCS grant is administered through the OHA Transformation Center, and partners with Title V to increase coordination of health and early learning system to provide developmental screening for children 0-3.
Healthy Start Grants	Title V partners on a variety of initiatives with Oregon's two Healthy Start grants – the Multnomah County Health Department's Healthy Birth Initaitive, and the Health Care Coalition of Southern Oregon's Healthy Start Program.
ii. Other Federal investments	
Nutrition Program for Women, infants and Children (WIC)	The WIC Program is co-located with Title V in the Center for Prevention and Health Promotion. WIC collaborates and coordinates with Title V at both state and local levels.
Early Hearing Detection and Intervention Program (EHDI)	Oregon's EHDI Program is funded by a grant from the CDC, focused on the development, maintenance and enhancement of EHDI information systems and surveillance programs; and one from HRSA, focused on reducing loss to follow-up at the 1-3-6 milestones, and use of quality improvement methodology. Title V funding provides critical research analyst and evaluation staff support to the EHDI program.

Project Connects	Projects Connects, funded by the DHHS Office on Women's Health through Futures Without Violence, collaborates with Title V on domestic violence screening and prevention efforts.
Rape Prevention Education	Title V coordinates with the CDC Rape Prevention Education grant to support the work of the Oregon Sexual Assault Task Force.
PREP Teen pregnancy grants	The Adolescent, Reproductive and Genetic Health Section within the Center for Prevention and Health Promotion is implementing Cuidate!, a Latino-specific teen pregnancy prevention program using PREP funding.
Pregnancy Risk Assessment Monitoring System (PRAMS)	Funding for both PRAMS and PRAMS2 is shared between Title V and the CDC PRAMS grant, and the PRAMS program is administered by the MCH Section under the direction of the Title V Director.
Title X Family Planning	The Title X Family Planning program is co-located with Title V in the Center for Prevention and Health Promotion. Title X collaborates and coordinates with Title V on access to reproductive health services, as well as prevention initiatives.
CDC Immunizations	The CDC-funded Immunization program is housed within the Center for Health Practice, and collaborates extensively with Title V on issues related to immunization access and vaccine preventable illness.
CDC Chronic disease prevention	The CDC' State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health grant collaborates extensively with Title V on activities related to obesity prevention and school health.
Project LAUNCH	SAMHSA has funded two project LAUNCH (Linking Actions for Unmet Needs for Child Health) initiatives in Oregon over the past 5 years, one administered jointly with Title V and the other in partnership through Multnomah County.
Race to the Top	Title V partners on a variety of health and early learning initiatives with the the Department of Education's Race to the Top Early Learning grant, administered through the Early Learning Division.
i. Other HRSA Programs	
FQHCs	Oregon's Title V program partners on a variety of MCH prevention and access to care initiatives with the Oregon Primary Care Association and local grantees partner on the community level with many of Oregon's 154 Federally Qualified Health Centers.
ii. Local MCH programs	
Local Public Health MCH Programs	Title V funds are distributed to local health departments(LHDs) across Oregon, which, administer their Title V programs together with other state, federal and locally funded public health activities. LHD Title V programs partner extensively with a wide range of local, state and Federal partners in addition to the state Title V program.

	Federal partners in addition to the state Title V program.
Conference of Local Health Officials (CLHO)	CHLO is the coalition which represents the interests of local health agencies in negotiations with state Public Health. Title V works closely with the MCH arm of CLHO – CLHO Healthy Families, as well as the CLHO Funding formula committee on all matters pertaining to contracts with local health departments for Title V services.
i. Other State Department of Health Programs	
Tobacco Prevention and Education Program	The Tobacco Prevention and Education program is co-located with Title V in the Center for Prevention and Health Promotion and collaborates on a variety of tobacco prevention initiatives with Title V.
Chronic Disease Prevention	The integrated chronic disease program (asthma, diabetes, heart disease and obesity prevention) is co-located with Title V in the Center for Prevention and Health Promotion and collaborates on a variety initiatives with Title V.
HIV/STD	Oregon's HIV/STD programs, administered through the Center for Public Health Practice, partner with and are co-located with Title V in the Public Health Division and with many local Title V grantees in local health departments.
Newborn Metabolic Screening Program	Oregon's Public Health Laboratory administers newborn screening to all Oregon births and collaborates with the Title V program on follow-up for high risk infant tracking.
Medicaid and CHIP	Oregon's Medicaid and CHIP programs are housed with Public Health in the Oregon Health authority and collaborate with Title V on the provision of access to care and prevention services for the MCH population.
Mental Health and Addiction Services	Oregon's Mental Health and Addictions programs are housed with Public Health in the Oregon Health Authority and collaborate with Title V to address the mental health and addiction needs of the MCH population.
State Public Health Director's Office	Title V partners closely with the community liaison, performance management, and policy/planning programs within the Public Health Director's office for cross-agency and cross-systems work.
Office of Equity and Inclusion	The Office of Equity and Inclusion, housed within the OHA Director's Office is a key partner with Title V in addressing health equity and reducing disparities.
ii. Other Governmental agencies	
Social Services and Child Welfare	State Social service programs are delivered through the Department of Human Services, which partners extensively with Title V on both the state and local levels. Programs administered by DHS include self-Sufficiency and Child Protective Services, TANF, SNAP, teen pregnancy

	prevention, foster care, adoption, developmental disabilities, and employment-related child care programs.
Department of Education	Title V partners with the Department of Education on initiatives such as the early learning system transformation, school nutrition, safe bike/walk to school, and Healthy Kids Learn Better.
Department of Justice	Title V partners with the Department of Justice on initiatives related to domestic and sexual violence prevention.
i. Tribes, tribal organizations and Urban Indian Organizations	
Oregon Tribes	Oregon has nine Federally recognized tribes, which function as sovereign nations. Five of the 9 are currently Title V grantees, and Title V partners with all 9 tribes to support MCH assessment and services for Tribal MCH populations
Northwest Portland Area Indian Health Board	Title V partners with the Northwest Portland Area Indian Health Board to support work on MCH health in Oregon's 9 tribes.
ii. Professional educational programs and Universities	
Title V partners with the schools of Public Health, Urban Affairs, Medicine, Nursing, Human Development, and Education at Oregon Health and Sciences University, Portland State University, Oregon State University, and the University of Oregon. Title V provides internship and field placement opportunities to graduate and undergraduate students, as well as partnering with University faculty on research and community programming.	
iii. Health systems	
On the state level, Oregon's Title V program works closely with health system partners on the state level through the Oregon's Transformation Center, CCO Oregon, Medicaid, and individual health system partners (Kaiser, Providence, OHSU, etc.). Locally, Title V grantees partner with each of Oregon's 16 Coordinated Care Organizations to implement coordinated systems of care for MCH populations.	
iv. Community and non-profit organizations	
Title V maintains partnerships and collaborative relationships with over 100 community and non-profit agencies to coordinate services and improve MCH population health. Key among these are: March of Dimes, Oregon Food Bank, Oregon Primary Care Association, the Northwest Health Foundation, Postpartum Support International, 211info, Children First for Oregon, the Oregon Oral Health Coalition, Safe Kids Coalition, Oregon Community Foundation, Ford Family Foundation, and the Oregon Parent Education Collaborative.	
v. Advisory Board and inter-agency work groups	
Title V staff and leadership both convene and participate on multiple advisory boards and inter-agency work groups at the State and National level to represent the needs of the MCH population. Key among these are: the Oregon Coalition against Domestic and Sexual Violence, Trauma-informed Oregon work group, the Oregon Perinatal Collaborative, the Oregon Pediatric Improvement Partnership, the School-based Health Alliance, the Children's Health Policy team, and the Home Visiting Steering Committee.	

	employment-related child care programs.

II.C. State Selected Priorities

No.	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure
1	High quality, culturally responsive preconception, prenatal and inter-conception services.	New	
2	Improved maternal, infant, child, adolescent and family nutrition.	New	
3	Physical activity throughout the lifespan.	New	
4	High quality, confidential, preventive health services for adolescents	New	
5	High quality, family-centered, coordinated systems of care for children and youth with special health care needs.	New	
6	Improved oral health for pregnant women and children.	New	
7	Reduced tobacco use and exposure among pregnant women and children.	New	
8	Safe and nurturing relationships; and stable, attached families.	New	State Performance Measure to be developed this year.
9	Improved health equity and reduced MCH disparities.	New	State Performance Measure to be developed this year.

II.C. State Selected Priorities

Determination of Oregon's priority needs

Oregon's Title V needs assessment synthesized information about MCH population needs relative to the 15 national priorities areas, current Title V priorities, and emerging Oregon MCH priorities. Methods included: a scan of 53 recent community assessments from across Oregon; analysis of health status data from sources including vital statistics, Pregnancy Risk Assessment Monitoring System (PRAMS), PRAMS 2, Oregon Behavioral Risk Factor Surveillance System (BRFSS), Oregon Healthy Teens, Medicaid; and surveys of 750 MCAH and 554 CYSHCN

partners. Issues related to infrastructure, partnerships, systems, workforce, and Oregon's changing MCH landscape were explored through an online discussion forum, stakeholder listening sessions, key informant interviews, a webinar, and a CYSHCN stakeholder panel. (See section II.B.1.)

Based on the above, 29 priority areas were identified for potential Title V focus (See table below).

Oregn MCH Title V Stakeholder Meeting Priority Recommendations

National Title V priority area	Current State MCH priority area	Oregon emerging priority area
MATERNAL AND WOMEN'S HEALTH		
Well woman care		
Low risk cesarean births		
	Family violence	
	Alcohol use	
PERINATAL AND INFANT HEALTH		
Perinatal Regionalization		
Breastfeeding		
Safe sleep		
	Maternal mental health	
CHILD HEALTH		
Developmental screening		
Physical Activity		
Injury		
	Parent resources and support	
ADOLESCENT HEALTH		
Injury		
Physical activity		
Adolescent well-visit		
Bullying		
	Overweight and obesity	
		Mental health, depression and suicide
CYSHN		
Medical home		
Transition		
	Access to Mental Health Services	
	Access to specialized health and related services	
	Family Support	
CROSS-CUTTING OR LIFECOURSE		
Oral health		
Smoking		
		Toxic stress and trauma

		Nutrition and food insecurity
		Drug misuse/abuse
SYSTEM		
		Culturally and linguistically responsive services
		Cross system coordination

Emerging priorities were solicited throughout the needs assessment and the top 6 were included in the prioritization process. Each of these was assessed for its importance to population health, disparities, potential Title V impact, potential to address equity, and alignment with partners. Data summaries were developed for each population domain and 29 potential priority areas (attachment 4). Two half-day meetings of key stakeholders (including Title V grantees and state agency partners) were held to develop recommendations for Title V Block Grant priorities. Needs Assessment findings were presented and discussed; selection parameters and criteria provided, and recommendations were developed through a facilitated group process. Criteria for priority selection included: impact on maternal and child health; Oregon need as indicated by health status data; potential to promote health equity/reduce disparities; and alignment with partners' strategic priorities. State Title V Leadership then met to consider the stakeholder recommendations, and select the priorities. Draft priorities were disseminated to stakeholders and posted on the Title V website for public comment before being finalized.

Selected priority needs

Oregon's highest priority MCH needs, as identified through the needs assessment and stakeholder prioritization process are:

1. **High quality, culturally responsive preconception, prenatal and inter-conception services**
   Domain: Maternal and women's health

   Rationale: The emerging science related to life course, developmental origins of health and disease, and early brain development recognize the critical role of women's preconception and inter-conception health in setting the trajectory for their healthy pregnancies and their infant's health. Over the past 10 years extensive work has been done to develop clinical guidelines for preconception care. The expansion of health care coverage with health reform, as well as the implementation of Coordinated Care Organizations with their focus in prevention and coordination of services paves the way for improved preconception and inter-conception care. Oregon's Title V program has a unique opportunity to work with partners across health and human service systems to promote the quality, accessibility and content of pre and inter-conception care; and to reach women and families with information about preconception health and the value of preconception care.

2. **Improved maternal, infant, child, adolescent and family nutrition**
   Domain: Perinatal and infant health

   Rationale: The emerging science of life course, the developmental origins of health and disease, and early brain development recognize the critical role of nutrition in setting the lifelong trajectory of health. Perinatal and infant nutrition is essential for healthy prenatal development, physical and brain development of infants and children, and chronic disease prevention. In Oregon, a wide range of needs related to nutrition emerged through both the Title V needs assessment and the other community health assessments. These included access to healthy foods and food insecurity for Oregon families, as well as breastfeeding duration and child nutrition/obesity. With its state Public Health infrastructure and co-location with Women, Infants and Children

(WIC), and network of local health public health and tribal partners and home visiting programs, Title V is well placed to partner with a wide range of partners to improve maternal, infant and child nutrition in Oregon.

3. **Physical activity throughout the lifespan**
   Domain: Child health

   Rationale: Physical activity is essential to health and development in childhood, as well as to the prevention of obesity and chronic disease. Physical activity also plays a key role in management of stress/anxiety and emotional self-regulation across the life course. Establishing healthy patterns of physical activity in childhood has short-term benefits and sets a trajectory for lifelong health. In Oregon, Title V, WIC, school health, and chronic disease prevention programs are co-located within the Public Health Division, and share a network of state and local partners with a focus on child health and physical activity. Interest in creating a context to support physical activity across community, school and childcare settings is widespread and Title V is well positioned to take a leadership role in this work.

4. **High quality, confidential preventive health services for adolescents**
   Domain: Adolescent health

   Rationale: Adolescence is one of the periods of greatest development and transition in the life course. Adolescents are establishing health behaviors that lay a foundation for their health in adulthood. This is a critical time to empower, educate and engage youth as they begin to transition to being independent consumers of health care services. A unique set of preventive health services delivered in accessible and confidential settings is vital to adolescent health. Oregon has a strong network of school-based health centers providing access to both physical and mental health services, and is working closely with other state agencies and the CCOs to ensure confidentiality and youth-sensitive services in the transformed health delivery system. Title V's continued investment in this work over the coming five years will help to assure that the needs of adolescents are addressed in the evolving health delivery system.

5. **High quality, family-centered, coordinated systems of care for children and youth with special health care needs**
   Domain: Children and youth with special health care needs

   Rationale: CYSHCN require a type or level of service for chronic physical, developmental, behavioral, or emotional conditions beyond that required by children generally (McPherson et al., 1998). Research shows that CYSHCN make more than twice as many physician visits, have 1.5 times as many emergency department visits, have more than 3 times as many hospitalizations, and spend about 7 times as many days in hospitals as children without special health care needs (Newacheck & Kim, 2005). Oregon families of CYSHCN continue to share stories of systems' inadequacies to meet their child's needs even as healthcare transformation moves forward. The complex needs of this population require a high quality, family-centered coordinated systems of care to meet the needs of CYSHCN and their families. OCCYSHN, in a collaborative effort with state partners through its D70 grant, is developing a shared vision for Oregon's system of care serving the health and health-related needs of CYSHCN – including a focus on both medical home and transition to adulthood. This priority aligns with the standards within the Medical Home and Transition to Adulthood domains of the national Standards for Systems of Care for CYSHN, the Public Health Division Strategic Plan, and the CCO measure addressing Patient Centered Primary Care Home (PCPCH) enrollment.

6. **Improved oral health for pregnant women and children**
   Domain: Cross-cutting or life course

   Rationale: Oral health is a vital component of overall health throughout the lifespan. Access to oral health care, good oral hygiene and adequate nutrition are essential to help women and children achieve good oral health. Oral health remains one of the greatest unmet health needs for pregnant women and children in Oregon; only 55% of pregnant women had an oral health visit during pregnancy, and 58% of third graders have had a cavity. Furthermore, non-traumatic dental needs are one of the most common reasons for emergency department visits. Oral health was one of the highest ranked unmet MCH needs in the Title V needs assessment. Oregon has built a strong public health oral health program, and is poised to expand that work in the coming five years. Integration of dental care into the CCOs, inclusion of a dental sealant metric, the hiring of a permanent state dental director, the release of the state Oral Health Strategic Plan, the expansion the First Tooth program, and the designation of oral health as one of six state Public Health Improvement Plan priorities all demonstrate the timeliness of Title V work on this priority in alignment with our many partners across the state.

7. **Reduced tobacco use and exposure among pregnant women and children**
   Domain: Cross-cutting or life course

   Rationale: Tobacco use is the No. 1 preventable cause of death and disability among Oregonians, and those with lower incomes are disproportionately affected. Almost one in three Oregonians who make less than $15,000 per year smoke, compared to one in 10 who make more than $50,000 (2009 BRFSS). Women who smoke during pregnancy are more likely to experience a fetal death or deliver a low birth weight baby. Children who are exposed to second hand smoke in their homes have increased frequency of health conditions from ear infections to sudden infant death syndrome. Although rates have declined, 11% of Oregon women smoke during their last 3 months of pregnancy, and 21% of Oregon children live in a household with someone who smokes. Reducing tobacco use is a priority for the Public Health Division, the State Health Improvement Plan, Oregon's Tobacco prevention and Education Program, and is a CCO performance measure. Adoption of this priority for Oregon's Title V program aligns with these key partners' work, and provides an opportunity for Title V to provide leadership around tobacco use and exposure during critical sensitive periods of pregnancy and childhood.

8. **Safe and nurturing relationships; stable, attached families**
   Domain: Cross-cutting or life course

   Rationale: The emerging science of life course, epigenetics, toxic stress and trauma, and early brain development all recognize the critical role of safe and responsive relationships in setting the lifelong trajectory of lifelong health. The experiences of the first three years of life lay down the neurological pathways and connections which are critical to social-emotional as well as physical and cognitive development. Adverse childhood experiences (ACEs) resulting in toxic levels of stress and trauma are associated with negative adult health outcomes including depression, obesity, diabetes, cardiovascular disease, and asthma. Recognition of the importance of safe and nurturing relationships and stable, attached families is growing across health, mental health, public health, education, and early childhood systems. The need to address ACEs and toxic stress was the highest ranked need in Oregon's Title V Needs assessment partner survey. Title V's work to address parenting supports, as well as the MIECHV-funded home visiting programs have evolved to include a focus on ACEs and toxic stress prevention, building resilience, and developing trauma-informed systems of care in Oregon. Title V work on this priority will build upon this work with partners across systems to strengthen

the foundation of safe and nurturing relationships and stable attached families in Oregon.

9. **Improved health equity and reduced MCH disparities**

   Domain: Cross-cutting or life course

   Rationale: Improving health equity and reducing disparities in maternal and child health is essential to achieving Title V's vision of healthy women, infants, children, youth and families – as well as healthy communities. The need for a focus on health equity was evident in every phase of the Title V needs assessment, and is a key component of health system transformation and the State Public Health Improvement Plan. Oregon's Title V MCH/CYSHCN programs integrate health equity in: infrastructure and funding; diverse and culturally competent MCH/CYSHCN workforce; community engagement/capacity building; linguistically and culturally competent MCH/CYSHCN programs and policies; communications; and assessment, planning, and data. Title V leadership and stakeholders selection of health equity as an MCH/CYSHCN priority will strengthen health equity work at both the state and local levels, as well as highlight our Title V program's commitment to improving health equity for Oregon's MCH/CYSHCN populations.

Rationale for priorities not selected

Stakeholder meeting participants and Title V leadership carefully considered all 29 potential priorities. Final selections were based on the weighing of all the criteria to determine where investment of the limited Title V funding and resources was most needed, and had most potential to generate a positive impact in the lives of Oregon's MCH population. Some priorities – such as developmental screening and children's mental health were seen as critical to Maternal and Child Health but given that they have substantial funding and champions among other partners, were not deemed critical as Title V priorities at this time. Others, such as low risk cesarean births and perinatal regionalization did not rise to the top as concerns for Oregon due to the structure of our health systems and previous system development and policy work already conducted in the state, as well as our health status data.

Among our 10 current state MCH priorities, two (oral health and adolescent well care) were selected to carry forward into the new five-year Title V cycle as ongoing priority state MCH needs. The family violence, alcohol, maternal mental health, and parent support priorities were all viewed as important continuing MCH needs. However, the evolution of health system transformation and the science of early childhood and trauma led to the decision to address work on those topics through the new priority work on women's and adolescent preventive health care and toxic trauma/ACES. Similarly, the evolution of the health system work and the new CYSHCN standards of care led to the natural replacement of the three previous CYSHCN priorities with "high quality, family-centered, coordinated systems of care for children and youth with special health care needs", which will in turn relate to the new CYSHCN National Performance Measures of medical home and transition.

II.D. Linkage of State Selected Priorities with National Performance and Outcome Measures

NPM 1-Percent of women with a past year preventive medical visit

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	53.3	53.7	54.1	54.6	55.0

NPM-4 A) Percent of infants who are ever breastfed

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	92.0	92.2	92.4	92.6	92.8

NPM-4 B) Percent of infants breastfed exclusively through 6 months

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	26.0	26.6	27.0	27.4	27.8

NPM 8-Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	34.2	34.7	35.2	35.7	36.2

NPM 10-Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	74.2	78.4	79.6	80.8	81.9

NPM 11-Percent of children with and without special health care needs having a medical home

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	45.8	49.0	51.0	53.0	55.0

NPM 12-Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	35.6	38.0	40.0	42.0	44.0

NPM-13 A) Percent of women who had a dental visit during pregnancy

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	56.7	57.5	58.4	59.2	60.1

NPM-13 B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	77.0	78.3	78.7	79.2	79.6

NPM-14 A) Percent of women who smoke during pregnancy

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	9.9	9.6	9.4	9.1	8.8

Annual Objectives					
	2016	2017	2018	2019	2020

NPM-14 B) Percent of children who live in households where someone smokes

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	20.9	20.4	19.9	19.4	18.9

II.D. Linkage of State Selected Priorities with National Performance and Outcome Measures

Overview

The nine Oregon MCH/CYSHCN needs outlined above will be addressed through work on 8 national and three state-specific performance measures. State performance measures will be determined in the coming year. Several of the National performance measures address more than one of the state's priority MCH needs. These linkages between Oregon's state priorities and the National performance measures are described below.

Domain: Maternal and Women's Health

National Performance measure #1: Well woman care

State Priority needs addressed by this measure: This national performance measure (NPM) addresses Oregon's state priority need #1 to ensure that women receive high quality, comprehensive preconception, prenatal and inter-conception services. Work on this NPM will also address need #9 to improve health equity and reduce maternal, child and adolescent health disparities. Furthermore, the preventive services delivered in the well-woman visit have potential to impact Oregon's priority needs of nutrition (2), physical activity (3), oral health (6), and tobacco use (7) among women of childbearing age.

Rationale: A well woman or preconception visit provides a critical opportunity to receive recommended clinical preventive services as well as anticipatory guidance to ensure the health of future pregnancies. An annual well woman visit is endorsed by American Congress of Obstetricians and Gynecologists (ACOG), and is a required preventive service in the Affordable Care Act. Through health care reform, 95% of Oregonians now have health insurance. However, in 2013 only 54% of Oregon women received a well-woman visit. The increase in numbers of insured women, combined health system transformation's focus on access to preventive care, coordination of services, and quality of care makes this ideal timing for Oregon to work on both access to and quality of well woman care. Furthermore, work on this NPM aligns with Oregon's work on preconception health as part of the infant mortality Collaborative Improvement and Innovative Network (CoIIN), as well as the CCO's incentive measure for effective use of contraceptives for women at risk of unintended pregnancy.

Domain: Perinatal and Infant Health

National Performance measure #4: Breastfeeding

State Priority needs addressed by this measure: This national performance measure (NPM) addresses Oregon's state priority need #2 to improve maternal, infant and child nutrition. Work on this NPM will also address need #9 to improve health equity and reduce maternal, child and adolescent health disparities.

Rationale: The American Academy of Pediatrics recommends that all infants exclusively breastfeed for about six months as human milk supports optimal growth and development during that time. Oregon has among the highest breastfeeding initiation rates in the US, with approximately 90% of infants ever breastfed. However, there are significant racial disparities in this rate and the percent of infants' breastfed exclusively at 6 months drops to 24%. Title V work focused on increasing duration of breastfeeding will have potential to impact infant nutritional status, maternal and infant bonding, toxic stress and chronic disease prevention.

Domain: Child Health

National Performance measure #8: Child Physical Activity

State Priority needs addressed by this measure: This national performance measure (NPM) addresses Oregon's state priority need # 3 to increase physical activity throughout the lifespan. Work on this NPM will also address need #9 to improve health equity and reduce maternal, child and adolescent health disparities.

Rationale: Physical activity in children reduces risk factors for chronic disease early in life, and contributes to achieving healthy weight and reducing stress and increasing self-esteem. In Oregon, despite legislation mandating physical activity in public schools, the number of schools meeting the requirement has declined by 54% from 2009 to 2010. In Oregon, as in the US, the percent of children ages 6-11 who are physically active at least 20 minutes per day in only 38%. Oregon's Title V work to support physical activity among children aligns with partner priorities including the Public Health Division's strategic plan, CCO incentive measures and community health improvement plans, and the CDC's State Public health grant to prevent obesity (1305).

Domain: Adolescent Health

National Performance measure #10: Adolescent well-visit

State Priority needs addressed by this measure: This national performance measure (NPM) addresses Oregon's state priority need #4 to ensure that adolescents receive high quality, confidential preventive health services. Work on this NPM will also address need #9 to improve health equity and reduce maternal, child and adolescent health disparities.

Rationale: Adolescence is a key transition period in the life course that requires a unique set of health care services. The Bright Futures guidelines recommend that adolescents have annual well-visit to address preventive service and health-related behaviors. At 74%, Oregon's rate of adolescent well visits is significantly lower than the National rate of 81.7%. Disparities across both racial/ethnic and income groups further exacerbate the problem. Nationally, only about half (46%) of adolescents on Medicaid received a well-visit in the past year, but in Oregon the rate is even lower at 29%. Title V is aligned with Oregon's CCOs and Oregon's school based health centers to improve the percent of adolescents with annual preventive well-care visits.

Domain: CYSHN

National Performance measure #11: Medical Home

State Priority needs addressed by this measure: This national performance measure (NPM) addresses

Oregon's state priority need #4: High-quality, family-centered coordinated systems of care for children and youth with special health care needs.

Rationale: An effective medical home requires high-quality, family-centered coordinated systems of care for CYSHCN. The National Consensus Framework, which proposes a set of standards for systems serving CYSHCN and their families, includes Medical Home as one of its 10 domains. As of 2009-10, 41% of CYSHCN received care in a medical home. Results from OCCYSHN's needs assessment survey showed that 47% of families reported "rarely" or "never" receiving as much help as they want coordinating care for their CYSHCN. A key effort to increase medical homes in Oregon is the Patient-Centered Primary Care Home (PCPCH) program. The distribution of certified PCPCHs is not consistent throughout the state. The majority are clustered along the I-5 corridor between Portland and Eugene, particularly sparse in central and eastern Oregon, and nearly non-existent in Southeastern Oregon. In addition, the program's certification does not require the practice to meet standards specific for CYSHCN. OCCYSHN's work with this measure aligns with the standards for systems of care for CYSHCN, the public health division strategic plan, and the CCO incentive measure around PCPCH enrollment.

National Performance measure #12: Transition

State Priority needs addressed by this measure: This national performance measure (NPM) addresses Oregon's state priority need #4: High-quality, family-centered coordinated systems of care for children and youth with special health care needs.

Rationale: Youth transition to adulthood is one of 10 standards for systems serving CYSHCN, as proposed by the National Consensus Framework. In 2009-10, about 36% of Oregon youth with special health care needs (YSHCN) received necessary transition services. Findings from OCCYSHN's needs assessment suggest a shortage of adult providers who are prepared to care for transitioning CYSHCN; providers are not current on transition practices and not prepared to provide transition direction. Therefore, YSHCN do not receive the needed preparatory information to transition to adult health care. Current efforts within Oregon address education and employment for YSHCN who will have some independence but these efforts exclude health. For YSHCN to successfully transition into an adult model of care, a high-quality family-centered coordinated system of care is essential. OCCYSHN's youth transition work aligns with the standards for systems of care for CYSHCN, the public health division strategic plan, and the CCO incentive measure around patient-centered primary care home (PCPCH) enrollment.

Domain: Cross-cutting or life course

National Performance measure #13: Oral Health

State Priority needs addressed by this measure: This national performance measure (NPM) addresses Oregon's state priority need #6 to improve oral health for pregnant women and children. Work on this NPM will also address need #9 to improve health equity and reduce maternal, child and adolescent health disparities.

Rationale: Oral health is a vital component of overall health, and access to oral health care is an essential component to helping women and children achieve good oral health. Despite recognition of the value of preventive oral health, only 55% of pregnant women and 77% of children had a preventive dental visit in 2011. Furthermore, disparities exist with children residing in rural and frontier areas having less access to care and higher rates of decay. Oregon's Title V oral health work aligns with the state oral health strategic plan, as well as the Public Health Division's strategic plan, the State Health Improvement Plan, and the CCO incentive measure for dental sealants in children.

National Performance measure #14: Smoking

State Priority needs addressed by this measure: This national performance measure (NPM) addresses Oregon's state priority need #7 to protect pregnant women and children from tobacco exposure. Work on this NPM will also address need #9 to improve health equity and reduce maternal, child and adolescent health disparities.

Rationale: Tobacco use during pregnancy is a special concern because of the effects of smoking on the mother and the fetus. Women who smoke during pregnancy are more likely to experience a fetal death or deliver a low birth weight baby. Parental smoking has multiple adverse effects on children, and has been a public health concern for decades. In Oregon, 11% of women smoked during the last 3 months of pregnancy in 2011, and 21% of children live in a household with someone who smokes. Racial and ethnic, as well as income disparities exist in both populations, with 16% of American Indian women smoking and 25% of children who are not white or Hispanic exposed to household tobacco. Oregon's Title V work on this measure will align with the Public Health Division's strategic plan, the State Health Improvement Plan, and the CCO metrics.

II.E. Linkage of State Selected Priorities with State Performance and Outcome Measures

States are not required to provide a narrative discussion on the State Performance Measures (SPMs) until the FY2017 application

II.F. Five Year State Action Plan

II.F.1 State Action Plan and Strategies by MCH Population Domain

This section contains the 2014 report on Oregon's Title V work on current (2010-2015) State and National performance measures (PMs), as well as an initial 2016 plan for work on our 8 newly identified Block Grant 3.0 NPMs. Work on the current PMs will conclude in September 2015, therefore there is no future year plan included for those measures. Given that the 2016-2020 NPMs have been recently selected (based on the outcome of the Needs Assessment and stakeholder prioritization process), the first six months' plan for FY 2016 will focus largely around developing the evidence-based/informed strategies that will be implemented for each measure, their associated measures (ESMs) and tracking systems, and transitioning state/local level Block Grant resources to focus on that work. Oregon's plan for 2016 also includes development of state specific performance measures to address Oregon's priority needs #2 (maternal, infant and child nutrition), # 8 (safe and nurturing relationships and stable, attached families), and #9 (health equity and maternal, child and adolescent health disparities). Several strategic alignment activities will take place during the remainder of FY 2015 to lay the essential groundwork for implementation of BG 3.0. These include: alignment of state level block grant staffing and formation of priority/PM teams; development of briefs on each selected national priority area, and engagement of local level partners to jointly develop strategies and ESMs.

State Action Plan Table						
Women/Maternal Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
High quality, culturally responsive preconception, prenatal and inter-conception services.	Increase the accessibility, quality and utilization of well-woman care	1. By August 2015, align state MCH staffing; develop Title V priority teams. 2. By September 2015 recruit local partners to Title V priority teams. 3. By October 2015, launch Title V priority teams. 4. By November 2015 develop	Rate of severe maternal morbidity per 10,000 delivery hospitalizations Maternal mortality rate per 100,000 live births Percent of low birth weight deliveries (<2,500 grams) Percent of very low birth weight deliveries (<1,500 grams)	Percent of women with a past year preventive medical visit		

State Action Plan Table						
Women/Maternal Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
		potential strategies and ESMs. 5. By January 2016 determine state strategies, ESMs, and data collection plans. 6. By February 2016 local implementing partners select NPMs, strategies/ESMs to implement. 7. By April 2016 begin implementing strategies and tracking of ESMs. 8. April 2016-September 2020, implement strategies; track ESMs and NPMs; revise objectives, strategies and ESMs as needed.	Percent of moderately low birth weight deliveries (1,500-2,499 grams) Percent of preterm births (<37 weeks) Percent of early preterm births (<34 weeks) Percent of late preterm births (34-36 weeks) Percent of early term births (37, 38 weeks) Perinatal mortality rate per 1,000 live births plus fetal deaths Infant mortality rate per 1,000 live births Neonatal mortality rate per 1,000 live births Post neonatal mortality rate per 1,000 live births Preterm-related mortality rate per 100,000 live births			

State Action Plan Table						
Women/Maternal Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**

Women/Maternal Health

Women/Maternal Health - Plan for the Application Year

2015/2016 Plan: NPM 1 - Well woman care

Objective: Increase the accessibility, quality and utilization of well-woman care

Performance measure #1: Percent of women with a past year preventive visit.

Strategy 1. By August 2015, align state MCH staffing with new Block Grant 3.0 priorities and develop Title V priority teams consisting of a lead/coordinator, research analyst, and additional subject matter experts for each national priority area/performance measure.

Strategy 2. By September 2015 recruit local partners to participate in Title V priority teams.

Strategy 3. By September 30, 2015, launch Title V priority teams to guide development and implementation of Title V's work on well-woman care (including strategies, evidence-based/informed strategy measures (ESMs), and grant-required detail sheets).

Strategy 4. By October 1, 2015 develop a background brief on well-woman care in Oregon, including potential strategies and ESMs. Include results of the following 4 activities:

- Activity 1. Summarize information about barriers and contributing factors to quality and accessibility of well-woman care.
- Activity 2.Analyze and summarize available data (Oregon and/or national) on well-woman care including demographics and characteristics of populations at risk for not receiving care.
- Activity 3. Conduct a review of evidence-based/informed strategies and measures related to well woman care, their cost, effectiveness for different populations, etc. (Build on MCHB evidence briefs)
- Activity 4. Conduct a survey of Oregon Title V implementing partners and stakeholders to solicit information about the strategies that they or their community partners are using or would like to see Title V use to improve the accessibility, quality and utilization of well-woman care.

Strategy 5. By January 1, 2016 Title V priority team and Title V leadership identify one or more strategies, associated measures (ESMs), and a data collection/tracking plan for Title V's work on well woman care in Oregon.

- Activity 1. Determine target populations.
- Activity 2. Gather additional community input related to potential strategies/ESMs and their appropriateness, acceptability and viability - particularly from communities at highest risk.
- Activity 3. Priority team integrates community input and hones the list of recommended strategies to no more than 4 – including both state and local level.
- Activity 4. Priority team presents strategy/ESM recommendations to December 2015 stakeholder meeting(invitees tbd)
- Activity 5. State Title V leadership and priority teams make final determination of strategies and ESMs to be implemented.

Strategy 6. By February 1, 2016 local implementing partners select which 2-4 Title V national performance measures and associated strategies they will implement using Title V funds.

- Activity 1. State and local Title V partners establish parameters for strategy selection, implementation, and ESM tracking/reporting.
- Activity 2. Local implementing partners incorporate their chosen NPMs and ESMs into their Title V MCH report/plan due to the state by March 1.

Strategy 7. By March 30, 2016 state and local level implementation of evidence-informed strategies and tracking of ESMs begins.

- Activity 1. By January 30, simple template for LHD and tribal Title V annual report and plan developed
- Activity 2. During February and March state and local implementing partners identify TA, workforce development and other needs related to implementation.
- Activity 3. During February and March State and locals Title V partners establish and test systems for collecting ESMs.

Strategy 8. April 1, 2016 through September 30, 2016 implement state and local level strategies and collect/track outcomes through monitoring of ESMs and NPMs. Revise objectives, strategies and ESMs as needed.

Women/Maternal Health - Annual Report

NPM 1 - Percent of women with a past year preventive medical visit

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	53.3	53.7	54.1	54.6	55

2014 Report: Family violence

State Performance Measure 1: Percent of family planning clinic encounters in which relationship safety was discussed with the client

Report on strategies and activities October 2013 – present:

Oregon's statewide numbers for Family Planning providers screening for Intimate Partner Violence (IPV) has gone up significantly since screening for IPV among family planning providers became a Title V priority and Project Connect started. In 2013 the percentage went from 12.4% reporting to 35.2% and in 2014 it continued to rise to 37.9%.

The MCH Section received funding from Futures without Violence for a three-year Project Connect grant, which began in January 2013. This work directly supports this Title V Priority. The focus of the work is on implementing an IPV screening and referral intervention in public health family planning clinics, and changing policy to support on-going screening and referral in the health care setting.

Staff began an Ad Hoc Committee to plan IPV screening and quality referrals through Coordinated Care Organizations (CCOs) that is covered under the Preventive Health Services for Women list of the Affordable Care Act (ACA). Domestic Violence (DV) advocates explored the possibility of reimbursement for their referral services through the non-traditional workers category in the CCOs. This committee has continued to be active however their focus has changed more towards informing and educating DV advocates on how to work with health care partners.

The Project Connect intervention became fully implemented in the three clinic sites and the training, quality assurance, and evaluation pieces of the grant have been a focus for IPV screening in family planning clinics thereafter. In this last year, we have been fortunate to have trainers from Futures without Violence come to Oregon and provide two train the trainer session to our Health Care Providers and advocates on the Improving the Health Care Response to IPV curriculum. These trainings have allowed Oregon to have a cadre of trainer teams that will then train other providers in their area to conduct the screening and referral intervention.

This current year we are focusing on building a sustainability plan for Project Connect. We hope the work will continue in the pilot sites, and other clinics and communities will be able to be trained in implementing the intervention. In addition the IPV and Health Care work group and the Project Connect Leadership Team have been a forum to get some policy work done when it needs to be addressed.

Data Collection and Evaluation:

Data Collection on IPV Screening in our three Project Connect intervention sites will continue as it is also part of their Title X reporting system. We also look forward to having results from our Provider surveys, the Client Satisfaction Survey and the Client Outcome Survey, which will give us insight into the quality of the care.

Data continued to be collected from family planning client visit data and from the public health surveys BRFSS, PRAMS, PRAMS-2, Oregon Healthy Teens Survey, and the CDC National Intimate Partner Violence, Sexual Violence & Stalking Surveillance System (NISVSS). As part of the Project Connect Grant Oregon has also been collecting data on the number of family planning clients who received the Project Connect screening and referral. We also are now tracking data on provider knowledge and practice on screening for IPV and customer satisfaction related to family planning services and IPV screening.

Finally, as part of the Project Connect grant we are conducting a Client Outcomes Survey together with the University of Pittsburgh. The goal is that 150 clients complete a post family planning appointment survey about their experience with violence and how they were screened and treated in the visit. We have recruited two interns to conduct the survey and University of Pittsburgh will be analyzing the data. Results should be available the fall of 2015.

Plan for upcoming work through September 2015:

In late June 2015 The Statewide OCADSV Conference for Domestic Violence service providers will be taking place. This year the theme is working with the health care system. This is a goal we have worked for the last few years. We have arranged for speakers from the State and local public health, Futures without Violence, the State Attorney General, and Project Connect sites. This is a unique opportunity for collaboration and networking between IPV and Health Care providers.

We will be working with the Project Connect clinics to finalize state and local sustainability plans for screening and referral to continue and build a statewide trainer network.

We plan to complete the data collection phase of the Client Outcomes Survey we are conducting in June. Then we will conduct a six week post visit follow up survey and hope to have the results of the surveys by fall of 2015.

Critical Partnerships:

- Futures without Violence
- Oregon Coalition Against Domestic and Sexual Violence
- OR Department of Justice, Safer Futures Grant and local sites
- Local DV Service Agencies
- Oregon Title X Family Planning Program and Providers
- Other Health Care Providers
- Oregon Preventive Reproductive Health Advisory Council
- PHD Office of Adolescent Health

2014 Report: Alcohol use

State Performance Measure 2: Percent of 11th grade students who were 14 years old or younger when they had more than a sip or two of beer, wine, or hard liquor for the first time.

Report on strategies and activities October 2013 – present:

The "Adolescent Health Project", co-funded by the Addictions and Mental Health Division, is a performance improvement project directed toward adolescent primary care providers to increase utilization of Screening, Brief Intervention, and Referral to Treatment (SBIRT) for substance use, and depression screening within the context of an adolescent well visit. The training is conducted through the Oregon Pediatric Society's Screening Tools and Referral Training (START) Program, with the Oregon Pediatric Improvement Partnership (OPIP) providing technical assistance related to quality improvement, implementation and evaluation.

The first cohort of clinics included four pediatric practices across the state and five SBHCs. Each clinic participated in a regional day-long training covering best practices in delivering adolescent well visits, use and scoring of screening tools, brief intervention techniques, implementation strategies and time with representatives from addictions and mental health providers in the community. An Office Report Tool was developed to assess changes in clinic practices and policies as it relates to the well visit, screening for substance use and depression, and follow up. Baseline data showed that few sites had standardized, universal screening procedures. Preliminary follow up data indicate that all sites have made improvements in this area. Concerns around patient confidentiality and a lack of standardized procedures for tracking referrals continue to be challenges. Evaluation of the first cohort will end June 2015. A more in-depth report of the Adolescent Health Project can be found in the fall 2014 Northwest Bulletin (http://depts.washington.edu/nwbfch/PDFs/NWBv28n2.pdf). Modifications to the project for the second cohort based on learnings include: selection of fewer sites to be able to more fully support implementation; enhanced focus on client confidentiality; and enhanced focus on referral tracking and follow up.

MCH is also continuing to participate on the Advisory Committee for Oregon's Strategic Prevention Framework – State Incentive Grant (SPF-SIG) focusing on reducing underage drinking and preventing alcohol use by young adults.

Plan for upcoming work through September 2015:

Participants in the first cohort of the SBIRT/depression screening project delivered by the Oregon Pediatric Society, and funded by Title V, will complete their learning communities by June, 2015. Final outcome evaluation data will be collected and reported. Participants for the second cohort will be selected. We anticipate training the second cohort of participants in the spring/summer of 2015.

Oregon has also received a no-cost funding extension from SAMHSA for the Strategic Prevention Framework – State Incentive Grant (SPF-SIG), at which the MCH Section represents the Public Health Division on the Advisory Committee. MCH will continue to be a participant through September, 2015. In addition, the Substance Abuse and Mental Health Services Administration (SAMHSA), has provided Oregon with additional funding for a Partnership for Success Grant which provides additional funding for counties and tribes to engage in alcohol prevention work with adolescents and young adults. The Adolescent Health and Maternal and Child Health Sections are active participants in the advisory planning and implementation of this grant, and will continue to participate beyond September, 2015.

Critical partnerships:

Both the MCH Section and Adolescent Health Section of the Public Health Division collaborate closely on issues around alcohol use and abuse. In addition, we share information with our Injury Prevention partners, also in PHD, and our prevention partners within the OHA-Addictions and Mental Health Division. Other critical partnerships include the local public health authorities, for whom we provide technical assistance and consultation. We have also

provided consultation to the MIECHV Program regarding alcohol screening as part of home visit assessments.

State Action Plan Table						
Perinatal/Infant Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
Improved maternal, infant, child, adolescent and family nutrition.	Increase initiation and duration of breastfeeding among target populations.	By August 2015, align state MCH staffing; develop Title V priority teams. By September 2015 recruit local partners to Title V priority teams. By October 2015, launch Title V priority teams. By November 2015 develop potential strategies and ESMs. By January 2016 determine State Title V strategies, ESMs, and data collection plans. By February 2016 local implementing partners select NPMs, strategies/ESMs to implement. By April 2016 begin	Post neonatal mortality rate per 1,000 live births Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months		

State Action Plan Table						
Perinatal/Infant Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
		implementing strategies and tracking of ESMs. April 2016 - September 2020, implement strategies; track ESMs and NPMs; revise objectives, strategies and ESMs as needed.				

Perinatal/Infant Health

Perinatal/Infant Health - Plan for the Application Year

2015/2016 Plan: NPM 4 - Breastfeeding

Objective: Increase initiation and duration of breastfeeding among target populations

Performance measures: A) Percent of infants who are ever breastfed; B) Percent of infants who were breastfed exclusively through 6 months.

Strategy 1. By August 2015, align state MCH staffing with new Block Grant 3.0 priorities and develop Title V priority teams consisting of a lead/coordinator, research analyst, and additional subject matter experts for each national priority area/performance measure.

Strategy 2. By September 2015 recruit local partners to participate in Title V priority teams.

Strategy 3. By September 30, 2015, launch Title V priority teams to guide development and implementation of Title V's work on breastfeeding (including strategies, evidence-based/informed strategy measures (ESMs), and grant-required detail sheets).

Strategy 4. By October 1, 2015 develop a background brief on breastfeeding in Oregon, including potential strategies and ESMs. Include results of the following 4 activities:

- Activity 1. Summarize information about barriers and contributing factors to initiation and duration of breastfeeding.
- Activity 2.Analyze and summarize available data (Oregon and/or national) on breastfeeding including demographics and characteristics of populations at risk.
- Activity 3. Conduct a review of evidence-based/informed strategies and measures related to breastfeeding,

their cost, effectiveness for different populations, etc. (Build on MCHB evidence briefs).
- Activity 4. Conduct a survey of Oregon Title V implementing partners and stakeholders to solicit information about the strategies that they or their community partners are using or would like to see Title V use to improve initiation and duration of breastfeeding.

Strategy 5. By January 1, 2016 Title V priority team and Title V leadership identify one or more strategies, associated measures (ESMs), and a data collection/tracking plan for Title V's work on breastfeeding in Oregon.

- Activity 1. Determine target populations.
- Activity 2. Gather additional community input related to potential strategies/ESMs and their appropriateness, acceptability and viability - particularly from communities at highest risk.
- Activity 3. Priority team integrates community input and hones the list of recommended strategies to no more than 4 – including both state and local level.
- Activity 4. Priority team presents strategy/ESM recommendations to December 2015 stakeholder meeting(invitees tbd)
- Activity 5. State Title V leadership and priority teams make final determination of strategies and ESMs to be implemented.

Strategy 6. By February 1, 2016 local implementing partners select which 2-4 Title V national performance measures and associated strategies they will implement using Title V funds.

- Activity 1. State and local Title V partners establish parameters for strategy selection, implementation, and ESM tracking/reporting.
- Activity 2. Local implementing partners incorporate their chosen NPMs and ESMs into their Title V MCH report/plan due to the state by March 1.

Strategy 7. By March 30, 2016 state and local level implementation of evidence-informed strategies and tracking of ESMs begins.

- Activity 1. By January 30, simple template for LHD and tribal Title V annual report and plan developed.
- Activity 2. During February and March state and local implementing partners identify TA, workforce development and other needs related to implementation.
- Activity 2. During February and March State and locals Title V partners establish and test systems for collecting ESMs.

Strategy 8. April 1, 2016 through September 30, 2016 implement state and local level strategies and collect/track outcomes through monitoring of ESMs and NPMs. Revise objectives, strategies and ESMs as needed.

Perinatal/Infant Health - Annual Report

NPM-4 A) Percent of infants who are ever breastfed

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	92.0	92.2	92.4	92.6	92.8

NPM-4 B) Percent of infants breastfed exclusively through 6 months

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	26.0	26.6	27.0	27.4	27.8

2014 Report: Maternal mental health

State Performance Measure 3: Percent of women who reported that they received education about depression during their most recent pregnancy from a prenatal care provider.

Report on strategies and activities October 2013 – present:

Title V has been working with 211Info MCH staff to improve the database, protocols, and training of 211 staff in maternal mental health and assure the quality of information and referrals for maternal mental health issues.

Title V has continued to maintain and improve the maternal mental health patient and provider education website and supporting materials.

Oregon PRAMS has included questions about depressive symptoms both during pregnancy and postpartum which allows ongoing surveillance of maternal mental health status and needs through Oregon PRAMS. As PRAMS is revised, Oregon will continue to prioritize the inclusion of maternal mental health questions.

Title V is collaborating with other state agencies, Coordinated Care Organizations (CCOs) and the Early Learning Division to identify opportunities to integrate maternal mental health education, screening, assessment, referral, and/or treatment to existing state programs serving women, children and families.

There is continued support to integrate maternal mental health screening and support in Oregon's home visiting programs including ongoing training and technical support. All home visitors receive an orientation with training specific to maternal mental health screening, referral and support. With funding from Maternal, Infant and Early Childhood Home Visiting (MIECHV), Oregon is exploring supporting an infant mental health endorsement system for Oregon professionals serving infants, toddlers and their families.

The Oregon Collaborative Improvement & Innovation Network (CoIIN) to Reduce Infant Mortality chose pre/interconception care as one of its strategies to improve birth outcomes. The Oregon team plans to focus on improving the value of postpartum care for women and recognizes that postpartum care includes promoting mental wellness for women. Oregon's 2 Healthy Start sites are partners in the CoIIN work.

Plan for upcoming work through September 2015:

The Oregon CoIIN team will continue to participate in collaborative learning and work to develop activities aimed at improving postpartum care for women. We will continue to maintain and improve the maternal mental health patient and provider education website.

Critical partnerships:

Oregon MIECHV, the Oregon CoIIN team, Coordinated Care Organizations and the Early Learning Division are important partners in this work.

2014 Report: Breastfeeding

National Performance Measure 11: Percentage of mothers who breastfeed their infants at 6 months of age.

Report on strategies and activities October 2013 – present:

The MCH Nutrition Consultant (NC) provides TA about breastfeeding for programs including WIC and Chronic Disease as well as Right from the Start coalition with focus to implement breastfeeding promotion in childcare. Technical assistance about workplace lactation accommodation has been provided to Healthy Community grantees, toolkit of resources has been developed, and questions about lactation accommodation have been added to existing surveillance within the CDC 1305 grant. State agency breastfeeding policy has been developed and is waiting for approval which has been prolonged. Breastfeeding support has been added to agency Healthy Meetings Guidelines. Promotion of mother's rights to breastfeed / express milk at work occurred through educational events, lobby display, and revision of print and online materials. Collaboration with Temporary Aid for Needy Families (TANF) resulted in revision of policy, outreach materials and staff training curriculum.

WIC continued its breastfeeding pump project, breastfeeding peer counselor program, education for health professionals in breastfeeding management and sponsorship of staff to take the International Board of Lactation Consultants Exam. Year 2 activities from 3-Year Breastfeeding Strategic Plan are being implemented. Updated guidance about breastfeeding supplies and support services have been adopted by the Health Agency Review Commission for MAP. The Breastfeeding Learning Community continues its focus on collaborating across programs; addressing maternity care practices, home visiting, and impact of marijuana on pregnancy and breastfeeding. Nutrition consultation staff in MCH and WIC continue involvement with the Breastfeeding Coalition of Oregon and participated in their statewide listening sessions. MCM and Babies First nurse home visiting programs will support public health nurse practice guidelines for breastfeeding.

Plan for upcoming work through September 2015:

The activities within the Center for Prevention and Health Promotion will continue in the next fiscal year. These include: the Breastfeeding Learning Community that aims to improve breastfeeding initiation and duration rates by collaborating across programs to continue coordinating activities such as breastfeeding web presence, worksite wellness breastfeeding support effort, maternity care practices in hospitals, impact of marijuana on infant health, promote National Breastfeeding Week and promote Surgeon General's Call to Action to Support Breastfeeding.

Integration with WIC will target lactation accommodation in the workplace, improving breastfeeding environments in early care & education system, promoting access to breast milk by collaborating with the NW Mother's Milk Bank and engaging in dialogue with Coordinated Care Organization (CCO) partners. Dialogue with MAP (Medicaid agency) and CCOs about coverage for lactation care and services will continue.

Partnership with the Chronic Disease program will continue to implement strategies and actions for the 1305 CDC-funded grant, including focus on lactation accommodation and discharge planning from hospital to community. In-depth evaluation of workplace accommodation strategy will continue. Outreach and technical assistance to Healthy Community grantees will continue.

Title V and WIC will continue to partner with the Oregon Public Health Institute's Right from the Start coalition, Breastfeeding Coalition of Oregon and serve on advisory councils addressing breastfeeding as identified. Education about breastfeeding policy and systems change will continue to be provided to health professionals enrolled in lactation courses as well as to university students.

The WIC program will continue to provide personal and hospital-grade breast pumps while exploring opportunities to involve Medicaid and Coordinated Care Organizations in provision of pumps and lactation support under the ACA. The WIC BF Peer Counselor program will continue to be implemented in 10 local agencies in Oregon.

WIC will continue to provide education for WIC staff and community partners in breastfeeding management across the state for a three-day Breastfeeding Level 2 course, an on-line lactation course for advanced breastfeeding training and sponsorship of WIC staff to take the International Board of Lactation Consultants Exam.

Maternity Case Management and Babies First nurse home visiting programs will support public health nurse practice

guidelines for breastfeeding support at the population-based individual level of practice based on nursing standards.

Surveillance of breastfeeding data from NIS, PRAMS and WIC as well as new data sources (BRFSS surveillance of teachers and state employees) will continue.

Critical partnerships:

Public Health Division programs: WIC, Chronic Disease and Health Promotion

External: Right from the Start, Breastfeeding Coalition of Oregon, Medicaid, TANF, CCOs, ODE Child Nutrition Program

2014 Report: Hearing screening

National Performance Measure 12: Percentage of newborns who have been screened for hearing before hospital discharge.

Report on strategies and activities October 2013 – present:

The Early Hearing Detection and Intervention (EHDI) Program works to assure that all Oregon infants are screened for hearing loss by one month, infants who refer on newborn screening receive diagnostic evaluation by three months, and infants diagnosed with hearing loss enter early intervention (EI) by six months. EHDI tracks and monitors hearing screening, diagnosis and Early Intervention eligibility for Oregon births, provides technical assistance and support to newborn hearing screening programs, diagnostic centers and EI providers, educates families about the importance of hearing screening, mobilizes partnerships to address gaps in the EHDI system, develops policies and plans, and evaluates our effectiveness in assuring early identification and intervention for children with hearing loss.

During the reporting period, EHDI provided training and technical assistance for key system partners and stakeholders. Trainings included: presentation at Midwifery Alliance of North America (MANA) conference – 10/2013; presentations at MCH Nurse orientations – 01/2014, 10/2014; trainings to EI staff – 10/2013, 11/2013, 04/2014, 09/2014; trainings for midwife screeners – 08/2013, 12/2013, 04/2014; presentation at Naturopathic Midwives Conference – 04/2014; EHDI Information System Refresher – 12/2014. Site visits include: site visits to 6 hospitals in October, November 2013; 4 hospitals in July 2014.

Loaner hearing screening equipment is placed with 7 midwifery practices (6 of the 10 birth centers with the highest birth counts).

EHDI staff worked with colleagues from the Oregon Center for Children and Youth with Special Health Needs (OCCYSHN) to create an EHDI case study for regional public health nurse trainings around the state. The case study is composed of a series of vignettes that illustrate the multiple steps, challenges, barriers, supports and sometimes serendipity needed for many of our infants who refer on newborn hearing screening to receive a diagnosis. The case study was used with OCCYSHN nurses in 4 regional trainings.

The EHDI program completed Phase 1 and Phase 2 of the Clinical Document Architecture (CDA) Pilot to receive live data from a partner hospital using HL7 and the Hearing Plan of Care (HPoC).

A number of critical improvements to our information system were initiated or completed during the reporting window – more details are available upon request.

Oregon EHDI continues to develop our portfolio of performance monitoring tools including: completion and delivery of hospital performance reports in 10/2013, 12/2013, 07/2014 and 03/2015; creation of online, on-demand performance reports for hospital screening partners; and development of audit reports and a performance report for audiologists.

EHDI continues to improve our forms, letters, and brochures to promote plain speak and assure availability of information in Spanish as well as English language.

EHDI staff participated in special projects including the National Institute for Children's Health Quality (NICHQ) Learning Collaborative and ongoing technical assistance, the Public Health Data Standards Consortium Clinical Document Architecture Pilot Project, the National Early Childhood Assessment Project, and the CDC Sentinel Surveillance Project. EHDI also completed the CDC Annual Survey.

Finally, Oregon EHDI staff participated in the National EHDI Meetings: oral presentation - April 2014, poster - March 2015.

Plan for upcoming work through September 2015:

EHDI will continue to advance efforts to assure that children with hearing loss are identified early and benefit from a robust, coordinated system of care. Key focus areas are set forth in our Centers for Disease Control and Prevention (CDC) and Health Resources and Services Administration (HRSA) grant work plans. Plans include:

EHDI will continue to explore innovative strategies to reduce loss to follow-up and improve the 1-3-6 milestones for infants; provide targeted training and technical assistance; mobilize stakeholders to advance best practices for children with hearing loss; improve parent and provider educational materials; create and disseminate quality assurance reports for our screening and diagnostic center partners for continuous performance improvement; improve and enhance the EHDI Information System to support care coordination, data exchange and communication across the EHDI system; pilot a targeted partnership with Multnomah County WIC; complete the expansion of the automated referral process with EI partners; initiate Phase 3 efforts; provide regular reports, updates, and findings from data analysis and program efforts to partners including the EHDI Advisory Committee, parent guides, public health nurses, EI providers, legislators, and others.

Critical partnerships:

Critical partners include members of the legislatively mandated Advisory Committee, birth facilities, audiologists, EI and Regional Program staff at the state and local levels, parents, public health nurses, and other programs within public health.

2014 Report: VLBW infants born in level 3 NICU

National Performance Measure 17: Percent of very low birth weight (VLBW) infants delivered at facilities for high-risk deliveries and neonates.

Report on strategies and activities October 2013 – present:

The MCH Section has taken a more active role in Oregon's Perinatal Collaborative, a group convened by the March of Dimes. The Collaborative, with clinical leaders from the major health systems in Oregon, originally came together to take on the issue of early elective deliveries. The group has now moved on to consider other issues of perinatal care and is an important connection to the clinical side of perinatal care in Oregon. As priorities for the group are developed there is an opportunity to put systems in place to ensure that high-risk infants deliver at the appropriate facilities.

Title V has continued to support strategies to promote early and comprehensive prenatal care for women including screening for risk of premature delivery. Oregon Mothers Care (OMC), the MCH toll-free hotline (211info), and Oregon's statewide home visiting system continue to be important strategies.

The Oregon Title V program supports the education for pregnant women to decrease their chances of delivering preterm but also to help them recognize the signs of early labor and know what to do if it occurs. One of the required

teaching topics for the Maternity Case Management Home Visiting program is prematurity and pre-term birth risks. The Prenatal and Newborn Resource Guide developed by the MCH Section includes information about the signs of early labor. The guide is distributed to local health departments and prenatal providers and is available on the web.

In collaboration with the state's Center for Health Statistics, the MCH Section tracks VLBW births by County and facility. However, there are a number of measurement challenges such as the need to capture births to State residents that occur in other states and the unknown accuracy of the classification of the level of hospital care.

Plan for upcoming work through September 2015:

Title V will continue participation in the Oregon Perinatal Collaborative steering committee and its workgroups.

Critical partnerships:

The Oregon Perinatal Collaborative and the March of Dimes are key partners in this work.

2014 Report: First trimester prenatal care

National Performance Measure 18: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

Report on strategies and activities October 2013 – present:

Since the beginning of the ACA's Open Enrollment on October 1st, the MCH Section has worked closely with Oregon's Medicaid Program, the Health Insurance Exchange, and Local Public Health Departments to ensure that pregnant women are easily enrolled into health insurance. Health insurance in Oregon is the gateway to prenatal care and in the last year has seen early prenatal care rates for Oregon MothersCare (OMC) clients range around 87 percent of clients.

Oregon MothersCare continues to provide patient navigation services to about 4500 women per year to ensure early access to prenatal care. OMC has worked closely with Oregon's Medicaid office and with Coordinated Care Organizations (CCOs), who share the goal of early prenatal care for pregnant women. CCOs and OMC sites work together in many cases to ensure pregnant women receive early access to care.

The 211Info MCH Specialist position was filled January, 2014. She is working on a 211info team to assist women, children and families to facilitate connections with health and social service programs. She participates on the 211Info Advisory Committee with State Public Health staff and MCH Section staff and provides information as to trends she observes from call requests.

The redesigned Home Visiting System will continue to enhance access to both clinical and home visiting services statewide. Title V will continue to support this work to knit together a comprehensive system of home visiting services that enhances pregnant women's access to early prenatal care.

MCH will continue to administer and analyze the PRAMS survey of post-partum women to collect information related to prenatal care access for surveillance and program planning.

As health care reform efforts continue to develop, the Public Health Division will look for opportunities to provide guidance and technical assistance to ensure that health care systems support women in entering early prenatal care.

Plan for upcoming work through September 2015:

The MCH Section will continue to work with the Medicaid program to get pregnant women access to health insurance and subsequent pregnant care. The Section has also been, and will continue, to work with the Medicaid Advisory Committee on pregnancy churn issues to ensure that pregnant women have continuity of care. Other prenatal care issues have included a focus on the need for undocumented Americans to obtain prenatal care, and

the barriers that they face in obtaining such care.

Critical partnerships:

We work closely with the local public health departments, who in turn have close relationships with prenatal care providers and refer many pregnant women for care. Our other partners include Oregon's Medicaid Program, specifically, around policies and practices around enrollment and eligibility for Medicaid, and ability to access prenatal care.

State Action Plan Table						
Child Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
Physical activity throughout the lifespan.	Create the context to promote physical activity among children.	By August 2015, align state MCH staffing; develop Title V priority teams. By September 2015 recruit local partners to Title V priority teams. By October 2015, launch Title V priority teams. By November 2015 develop potential strategies and ESMs. By January 2016 determine State Title V strategies, ESMs, and data collection plans. By February 2016 local implementing	Percent of children in excellent or very good health Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)	Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day		

State Action Plan Table						
Child Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
		partners select NPMs, strategies/ESMs to implement. By April 2016 begin implementing strategies and tracking of ESMs. April 2016 - September 2020, implement strategies; track ESMs and NPMs; revise objectives, strategies and ESMs as needed.				

Child Health

Child Health - Plan for the Application Year

2015/2016 Plan: Physical activity

Objective: Create the context to promote physical activity among children.

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

Strategy 1. By August 2015, align state MCH staffing with new Block Grant 3.0 priorities and develop Title V priority teams consisting of a lead/coordinator, research analyst, and additional subject matter experts for each national priority area/performance measure.

Strategy 2. By September 2015 recruit local partners to participate in Title V priority teams.

Strategy 3. By September 30, 2015, launch Title V priority teams to guide development and implementation of Title V's work on physical activity (including strategies, evidence-based/informed strategy measures (ESMs), and grant-required detail sheets).

Strategy 4. By October 1, 2015 develop a background brief on children's physical activity in Oregon, including

potential strategies and ESMs. Include results of the following 4 activities:

- Activity 1. Summarize information about barriers and contributing factors to children's physical activity.
- Activity 2.Analyze and summarize available data (Oregon and/or national) on child physical activity including demographics and characteristics of populations at risk.
- Activity 3. Conduct a review of evidence-based/informed strategies and measures related to child physical activity, their cost, effectiveness for different populations, etc. (Build on MCHB evidence briefs).
- Activity 4. Conduct a survey of Oregon Title V implementing partners and stakeholders to solicit information about the strategies that they or their community partners are using, or would like to see Title V use to promote child physical activity.

Strategy 5. By January 1, 2016 Title V priority team and Title V leadership identify one or more strategies, associated measures (ESMs), and a data collection/tracking plan for Title V's work on child physical activity in Oregon.

- Activity 1. Determine target populations.
- Activity 2. Gather additional community input related to potential strategies/ESMs and their appropriateness, acceptability and viability - particularly from communities at highest risk.
- Activity 3. Priority team integrates community input and hones the list of recommended strategies to no more than 4 – including both state and local level.
- Activity 4. Priority team presents strategy/ESM recommendations to December 2015 stakeholder meeting (invitees tbd).
- Activity 5. State Title V leadership and priority teams make final determination of strategies and ESMs to be implemented.

Strategy 6. By February 1, 2016 local implementing partners select which 2-4 Title V national performance measures and associated strategies they will implement using Title V funds.

- Activity 1. State and local Title V partners establish parameters for strategy selection, implementation, and ESM tracking/reporting.
- Activity 2. Local implementing partners incorporate their chosen NPMs and ESMs into their Title V MCH report/plan due to the state by March 1.

Strategy 7. By March 30, 2016 state and local level implementation of evidence-informed strategies and tracking of ESMs begins.

- Activity 1. By January 30, simple template for LHD and tribal Title V annual report and plan developed.
- Activity 2. During February and March state and local implementing partners identify TA, workforce development and other needs related to implementation.
- Activity 2. During February and March State and locals Title V partners establish and test systems for collecting ESMs.

Strategy 8. April 1, 2016 through September 30, 2016 implement state and local level strategies and collect/track outcomes through monitoring of ESMs and NPMs. Revise objectives, strategies and ESMs as needed.

Child Health - Annual Report

NPM 8 - Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day

Annual Objectives

	2016	2017	2018	2019	2020
Annual Objective	34.2	34.7	35.2	35.7	36.2

2014 Report: Parent resources and support

State Performance Measure 5: Using benchmarks develop a Public Health Action Plan for improving parenting skills and education within the Maternal and Child health policies, programs and outcomes

Report on strategies and activities October 2013 – present:

1. Inventory parenting skills and resources for the MCH section: A primary focus has been on participating and engaging with parenting stakeholder groups that are working on parenting supports, programs and policies. This participation has helped to shape the knowledge, skills and resources that public health can use to determine the goals and outcomes for the Public Health Parenting Action Plan.

2. Identify a family strengthening framework that guides our work: This activity was completed prior to 2013, using the Center for Study on Social Policy (CSSP) Family Strengthening Approach.

3. Build partnerships with the professional community of parenting agencies and foster collaboration: This process is ongoing, see below for a list of the strongest partners.

4. Select parenting skills, knowledge and resources that are feasible for action by public health and Title V agencies: This goal has been exceptionally challenging because there is not currently one universal effort that is identifying skills, knowledge and resources to guide a collective strategic effort. However the one parenting skill that federal, state and local projects have identified as a shared interest is how to engage parents and support parent leadership skill development. There is expressed interest to support these skills through many public health and early learning programs and systems.

5. Align parenting outcomes/goals, indicators, outcomes that align with home visiting, the early learning division, parenting education partners, healthcare transformation and other indicators as appropriate. The parenting/family goal that is a shared goal between the early learning division and the public health division is for children to have safe, nurturing relationships and environments and live in stable and attached families. Unfortunately there is not currently a shared indicator on how to measure this. This should emerge in the next two years.

6. Develop the Public Health Action Plan for improving parenting skills and education. This activity is ongoing.

Plan for upcoming work through September 2015:

The Title V staff continues to work with 211info.org, the Early Learning Division, The Oregon Parenting Education Collaborative, the Children's Trust Fund and other external partners, as well as internal partners from the Public Health Division to provide parents with support and information about parent engagement; parent leadership; child growth/development; child safety and injury prevention; and basic needs.

The Title V staff will also review parent engagement data from the parent cafes, the final evaluation report from Project Linking Actions for Unmet Needs in Children's Health (LAUNCH) and parenting data from the Maternal Infant and Early Childhood Home Visiting (MIECHV) grant in order to help guide decisions about the public health action plan for parenting skills and resources. Although there is a significant amount of data that the Maternal and Child Health Section (within the Public Health Division) is collecting, other agencies across Oregon are also collecting child, family and parenting data as part of their strategic initiatives.

In order to try to address the many efforts that are working on parenting engagement, education and leadership the Title V staff is co-convening a group of parenting program staff from across the state so that the many partners can

learn from each other and align their shared goals and outcomes.

The biggest challenge that the parenting skills Title V staff are struggling with is developing common standard for knowledge and skills that are feasible to focus on as part of the goals and outcomes of this activity and how to measure them. One measurement that many projects are concerned with is parental stress and how some are measuring it.

The MIECHV grantees and the mental health specialist in the Deschutes County Project LAUNCH collected data on parent stress with the parenting stress index, short form. However, this instrument requires significant training and is not a population measure. The National Survey on Children's Health also measured parental stress in a broader population survey, but again this survey does not reach large populations. Both of these measures have found that many parents are experiencing stress with parenting.

Parents who experience high levels of stress and/or trauma may need additional supports for parenting skills in order to provide safe, nurturing relationships and environments for their children. This is important because children experience better health outcomes when they live in safe, nurturing relationships and environments.

In addition to current high levels of stress, parents that experienced many adverse childhood experiences (ACEs) as a child may have impaired executive function and therefore need extra parenting resources and skill development to support their children's health outcomes.

Critical partnerships:

- The State Maternal Infant Early Childhood Home Visiting (MIECHV) Program Staff
- The Oregon Parenting Education/Program Consortium is working on defining parenting terms and identifying new and emerging parenting education and resources across the state.
- The Oregon Parenting Education Collaborative funds and supports evidence-based parenting education to communities across the state
- The Teen Parent Family Resources Consortium Meeting meets quarterly to identify the needs and resources for teen parents.
- The Early Learning Division recognizes parenting skills and education as a critical component to achieving their goal of ensuring that children live in stable and attached families.
- The 211 Information and Referral System supports parents and families by connecting them to available resources
- The Children's Trust Fund of Oregon

2014 Report: Immunization

National Performance Measure #7: Percent of 19-35 month olds received full schedule of age appropriate immunization for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B (4:3:1:3:3)

Report on strategies and activities October 2013 – present:

To inform strategic planning, the Oregon Immunization Program (OIP) calculates child immunization up-to-date series rates using data from the ALERT Immunization Information System (IIS). This information, along with state and national rates produced by the National Immunization Survey, is disseminated to local health departments and other partners through the following webpage:

https://public.health.oregon.gov/PreventionWellness/VaccinesImmunization/Pages/researchchild.aspx.

Based on ALERT IIS data, the 4:3:1:3:3 series rate increased in Oregon from 2008-2013 (see Figure 1 below). The drop in 2009 can be attributed to a shortage of the Haemophilus influenza B vaccine. Calculation of the 2014 rate (due in June 2015) will help determine whether the lower 2013 rate is an isolated instance or part of a downward

trend. Despite the increase over time, Oregon's childhood immunization rates are below the Healthy People 2020 objective of 90% for individual antigens.

Oregon also uses the ALERT IIS to examine child immunization rates among WIC clients. Rates are consistently higher among WIC clients than non-clients (see Figure 2) suggesting that the Oregon WIC program does a very good job of screening clients for needed vaccinations. Oregon has found, like other states, that child rates have decreased among educated, upper-income Whites.

Oregon has undertaken key activities to increase its child immunization rates. In 2013, a law was passed that required parents or guardians who wanted to claim a non-medical exemption for school-required vaccinations to show proof that they had either talked to a healthcare provider or had watched an online module produced by OIP about childhood immunizations. Before the law was implemented, Oregon had the highest non-medical exemption rate in the nation (7%). One school year after its implementation, Oregon's rate dropped by 17% to 5.8%. OIP also reinstated monthly reminder-recalls for two-year olds. These had been stopped while ALERT IIS underwent an upgrade. OIP's Providers Services Team (PST) continues to provide technical support to child immunization healthcare providers in the form of statewide Vaccines for Children (VFC) site visits and it lead the Billables project, which trained local health departments on how to seek reimbursements for vaccinations for insured clients. OIP experienced significant cuts to its budget as a result of a dramatic increase in cost allocation charges. As a result, many educational opportunities (i.e., roundtables, conferences) for immunization providers were curtailed. The ALERT IIS team and OIP public health nurses, however, were able to continue giving trainings to healthcare providers.

Plan for upcoming work through September 2015:

Increasing child immunizations is a priority in Oregon's five-year State Health Improvement Plan. To that end, OIP will continue the activities listed below through 2015:

- Produce 2014 child immunization rates and make these available at the state, county and census-tract levels to partners
- Determine whether a performance measure around child immunizations should be put into the annual agreement between OIP and LHDs
- Work with school-based health centers on increasing the number of immunizations given at those locations.
- Produce vaccine standing orders for LHDs
- Provide vaccine administration education and hands-on training to allied health professionals
- Provide technical assistance to Oregon's VFC immunizers
- Train partners on the use of ALERT IIS
- Conduct an evaluation on the impact of the temporary stoppage of reminder-recalls on Oregon's child immunization rates
- Support providers, parents, schools and universities on the use of the vaccine educational module

Critical partnerships:

OIP recognizes that many healthcare and non-healthcare partners are needed to maintain or increase immunization rates. OIP obtains input and guidance from its critical partners through the following groups:

- Immunization Policy Advisory Team (IPAT)
- Immunize Oregon, the statewide immunization coalition
- ALERT IIS Advisory Council

- Immunization School/Facility/College Law Advisory Committee

2014 Report: Child deaths

National Performance Measure 10: The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.

Strategies and activities October 2013 – present

The Children's Injury Prevention Program/Safe Kids Oregon (CIPP/SKO) is housed in the Injury & Violence Prevention (IVPP) Section and funded by Title V Block Grant. Motor vehicle injuries are also a top injury priority with the IVPP Section, and funded through the CDC Violence and Injury Prevention Program Core grant. CIPP/SKO focuses on identifying evidence-based programs and policies to support the motor vehicle traffic priority. For motor vehicle traffic, between 2010 and 2013, 35 Oregon children ages 14 years and younger died, and 320 were hospitalized from motor vehicle traffic injuries. To decrease death and hospitalization due to motor vehicle occupant injuries, children need to be correctly restrained in car seats, booster seats or safety belts. To reduce motor vehicle/pedestrian and motor vehicle/pedal cyclist injuries, policy, system change and public education strategies need to be implemented.

Occupant Protection Efforts: CIPP/SKO and local Safe Kids coalitions held103 car seat checkup events between 10/13 and 3/15 with more than 6,700 car seats checked, 1,214 new car seats distributed and over 17,000 parents, caregivers, children and Child Passenger seat (CPS) technicians participating. Statewide, all Oregon Safe Kids coalitions promoted National Child Passenger Safety (CPS) Week by hosting car seat check-up events. CIPP/SKO promoted CPS week and other child passenger safety issues throughout the year by utilizing the Safe Kids Oregon website (www.safekidsoregon.org), and the quarterly Safe Kids Oregon newsletter, to nearly 700 subscribers. Some of the communication efforts discussed keeping an infant rear facing to age 2, managing children who escape from child restraints, and the importance of car seats and booster seats for children over 40 pounds. Throughout the year, car seat checkup events were also used to share educational materials regarding heatstroke prevention (Never Leave Your Child Alone in the Car), the Oregon law against smoking in vehicles with children, and toddler driveway safety (Spot the Tot).

CIPP/SKO sponsored several continuing education opportunities for CPS Technicians statewide including the Safe Kids Worldwide/State Farm Oregon Child Passenger Safety Technician Update on 3/6/15 to more than 50 CPS technicians; and two webinars on the role of Senior Checkers at car seat checkup events on 12/12/14 and 2/4/15. CIPP/SKO shared material on child passenger safety at the MIECHV Orientations in March, June and September 2014, the MCH Orientation on 10/28/14, the Oregon Association for the Education of Young Children conference on 10/11/14 and the Parent Cooperative Preschools of Oregon conference on 3/7/15.

Pedestrian and Bicycle Safety Efforts: CIPP/SKO promoted International Walk to School Day and Halloween Safety in 10/14 and Bike to School Day and the Walk & Bike Challenge Month in May 2014 and 2015 through the newsletter and website as well as hosting an event in Yamhill County. Through events, local Safe Kids coalitions provided safety information, distributed bike helmets and provided education to motorists, pedestrians and bicyclists on sharing the road.

CIPP/SKO co-coordinates the IVPP Pedestrian Safety Policy Work Group. This group produced the Oregon Pedestrian Safety Policy and Systems Change Strategies 2012-2015 report in 2012. Strategies that impact the health and safety children/youth as pedestrians and new drivers are being monitored. Seven meetings were held during this time period. In January 2014, IVPP was awarded a Pedestrian Injury Prevention Action Team grant from Safe States Alliance to implement Pedestrian Safety Action Plans through training and mini-grants. CIPP/SKO is the lead for the Oregon Action Team and grants were awarded and training provided to Eugene on 4/16/15, APANO in Portland on 3/17/15 and Lincoln City on 4/8/15. Each grantee is implementing strategies to impact local pedestrian safety.

Plan for upcoming work through September 2015:

CIPP/SKO will present on child passenger safety at the MIECHV workshop in September, 2015. Information on occupant, pedestrian and bike safety issues will be posted on the Safe Kids Oregon webpage monthly and in the summer newsletter edition. CIPP/SKO will attend the Safe Kids Worldwide Prevention Conference in Washington DC 7/29 – 8/2. The IVPP Pedestrian Safety Policy Work Group will meet 8/12 to work on pedestrian policies and strategies for 2016-2019. The mini-grants funded by the Pedestrian Injury Prevention Action Team will be completed by 8/31/15. Grantees and the Action Team will participate in the project evaluation through 12/31/15.

Critical partnerships:

- MIECHV
- Healthy Families Oregon
- Maternal and Child Health
- Emergency Medical Services for Children
- Oregon Department Of Transportation (ODOT) – Transportation Safety Division
- Randall Children's Hospital, Child Passenger Safety and Safety Store
- Doernbecher Children's Hospital, Tom Sargent Safety Store
- Safe Kids Coalitions in Central Oregon, Columbia County, Columbia Gorge, North Coast, Northeast Oregon, Portland Metro and Washington County

2014 Report: Uninsured children

National Performance Measure 13: Percent of children without health insurance.

Report on strategies and activities October 2013 – present:

October 2013 began the roll out of Oregon's Health Insurance Exchange called Cover Oregon (CO) and efforts to insure the 17% of Oregonians that were then uninsured. The MCH Section participated with CO to support enrollment throughout the State. The MCH role has been to communicate with local public health departments and support them in providing enrollment services to Oregonians. The MCH Section has also provided technical assistance to health departments regarding planning for priorities as Oregon citizens became insured under the 2014 Affordable Care Act requirements.

Oregon has been a Medicaid expansion state and our rates of uninsured Oregonians dropped from 17 percent to 5 percent with the implementation of the Affordable Care Act. In September, 2013 there were approximately 432,000 Oregonians on Medicaid, most of whom were women and children. By February 2015, that number had increased by 69 percent to 1,058,414 (http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/oregon.html).

The MCH Section has worked with both Cover Oregon and the State's Medicaid Office to ensure that pregnant women and children were able to be easily and quickly enrolled in both private "Qualified Health Plans" (QHPs), and the Medicaid Program, the Oregon Health Plan (OHP). The section worked with CO Community Partners, the CO Consumer Advisory Council, the Oregon Health Authority Ombudsperson, Statewide Provider Associations (such as Oregon Primary Care Association), and CO staff regarding access issues and barriers to enrollment.

In Oregon, Title V funds a program called Oregon MothersCare to ensure early access to prenatal care for pregnant women. Since the rollout of the ACA, and expansion of Medicaid in Oregon, a larger portion of the program has been focused on enrollment of those people who were uninsured. Public health departments have embraced their role as Medicaid enrollment assisters, providing guidance and support to their uninsured clients, both pregnant women and their children.

Local Title V funded maternal and child health programs and services will continue to assure that clients and families are informed about health insurance coverage options, and assist families with referrals and application assistance

as needed. With the closing of Cover Oregon, MCH programs in local counties have continued to work with community partners and stakeholders to assure awareness of the Medicaid enrollment process.

Plan for upcoming work through September 2015:

The MCH Section continues to liaison with Oregon's local public health departments and with Oregon's Medicaid Program to ensure comprehensive and easy enrollment into health insurance. The MCH Section follows the issues that arise with Oregon's Medicaid Advisory Committee and provides information from the field about issues such as the status of quickly enrolling pregnant women into Medicaid. The MCH Section is in the midst of working with the Medicaid Program to identify, address, and remove barriers for pregnant women and children in the enrollment process.

Currently, the Medicaid Program and MCH are in discussions about the lapse in time that occurs when families that are eligible for Medicaid enroll in the Federal Marketplace (FFM). Because it can take over two weeks for file transfers to occur from the Federal Marketplace to Oregon's Medicaid Program, this means that enrollment can be delayed for MCH populations. The MCH and Medicaid Program is partnering in developing alternatives for access to medical care during the application period and getting the word out to populations regarding enrollment delays into Medicaid for those who apply through the Federal Marketplace.

In 2016 the issue will be resolved when Oregon begins to use Kentucky's insurance enrollment system which will not require transfer of files, and allow for a "No Wrong Door" process. At that point, pregnant women and children will be enrolled in Oregon's Medicaid system in less than 24 hours.

Critical partnerships:

In order to ensure full insurance enrollment for pregnant women and children, our most critical partnership has been with Oregon's Medicaid Program, the Oregon Medical Assistance Program. We enjoy close relationships, meeting together often and attending each other's meetings to support our various populations and issues. In addition, we have worked closely with Oregon's Coordinated Care Organizations, again, with the shared focus of ensuring insurance coverage for pregnant women and children.

2014 Report: WIC children with BMI above 85%

National Performance Measure 14: Percent of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile

Report on strategies and activities October 2013 to present:

The focus of the FFY 2013-2014 Oregon WIC Program Nutrition Education Plan was to increase staff knowledge in breastfeeding, baby behavior and interpreting infant cues, in order to assist parents with infant feeding education that supports their children achieving and maintaining a healthy weight. Staff who counsel participants completed an on-line training module on Infant Cues/Baby Behaviors developed by Arizona WIC and available through the Department of Human Services (DHS) Learning Center.

WIC continued to partner with other USDA Food and Nutrition Services programs through the Supplemental Nutrition Assistance Program (SNAP) collaboration. WIC partnered with the Nutrition Council of Oregon's Family Meals initiative utilizing Oregon State Extension Program's Food Hero resources for WIC families and posters supporting the Family Meals messages were distributed to all 34 local WIC agencies.

WIC continued to work with the Child Health Collaborative Obesity Workgroup. A tool, Promoting Healthy Weight and Development in Early Childhood was created and shared with public health and local partners to engage in community-wide, public health strategies that support healthy behaviors throughout the life span.

Oregon WIC Breastfeeding Strategic Plan Activities were implemented. These included collaboration with the

CCO's, childcare and MCH programs to integrate breastfeeding promotion and communicate the impact on learning and health, including the impact of breastfeeding on the prevention of obesity. WIC staff was successful in strengthening language in MAP Guidance around provision of lactation services and breast pumps under the ACA.

The WIC Food Package final rule was implemented, which requires 1% or fat-free milk as the standard milk option for children 2-5 years old. Lower fat (2%) milk will only be available for underweight children 2-5 years old. The final rule also allowed WIC to support access to fresh fruits and vegetables with a new cash value fruit and veggie voucher for older infants that replaces half of the jarred fruits and vegetables in the WIC food package.

Two local WIC agencies began piloting screening questions to identify hunger and food insecurity in WIC families, with a goal to expand this to additional agencies as they are trained and ready.

Plan for upcoming work through September 2015:

WIC will continue to support ongoing nutrition education related to Family Meals and Baby Behaviors utilizing quality participant centered services. Staff will be trained on enhancing nutrition assessment so that appropriate and targeted nutrition education and referrals can be provided to support healthy weight and respond to appropriate hunger and feeding cues.

WIC will complete implementation of Year Three Activities from the Oregon WIC Breastfeeding Strategic Plan, with a continued focus on support for breastfeeding in the workplace and childcare settings, including revising and updating the PHD breastfeeding website with resources for parents, providers and partners in these key areas, with a goal of increasing duration and exclusivity of breastfeeding for Oregon mothers as a strategy to support healthy weight and prevention of future chronic conditions. WIC state staff will continue to work with MAP to encourage changes to update Oregon Administrative Rules (OARs) for breast pump specifications and issuance, but still faces challenges working with MAP to update OARs governing pumps.

With the help of an OHA VISTA member, WIC will expand hunger and food insecurity screening in selected local agencies in FY 2015-16 through community engagement, training and technical assistance, and identification of community resources to address hunger. Oregon continues to have high rates of hunger and food insecurity, and identifying families at risk and addressing hunger is a key strategy in prevention of childhood obesity. The challenge is to work with existing resources to address the root causes of hunger while the opportunity is to strengthen partnerships, community awareness and resources to work together to address hunger.

Critical Partnerships:

- OSU Extension SNAP-Ed program
- Oregon Child Development Coalition and Head Start Programs
- Childhood Hunger Coalition
- Breastfeeding Coalition of Oregon
- Nutrition Council of Oregon
- Partners for a Hunger-free Oregon

State Action Plan Table						
Adolescent Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**

State Action Plan Table						
Adolescent Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
High quality, confidential, preventive health services for adolescents	Increase the accessibility, quality and utilization of adolescent well visits.	By August 2015, align state MCH staffing; develop Title V priority teams. By September 2015 recruit local partners to Title V priority teams. By October 2015, launch Title V priority teams. By November 2015 develop potential strategies and ESMs. By January 2016 determine State Title V strategies, ESMs, and data collection plans. By February 2016 local implementing partners select NPMs, strategies/ESMs to implement. By April 2016 begin implementing strategies and tracking of	Adolescent mortality rate ages 10 through 19 per 100,000 Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000 Adolescent suicide rate, ages 15 through 19 per 100,000 Percent of children with a mental/behavioral condition who receive treatment or counseling Percent of children in excellent or very good health Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile) Percent of children 6 months through 17 years who are vaccinated annually against seasonal	Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.		

State Action Plan Table						
Adolescent Health						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
		ESMs. April 2016 - September 2020, implement strategies; track ESMs and NPMs; revise objectives, strategies and ESMs as needed.	influenza Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine			

Adolescent Health

Adolescent Health - Plan for the Application Year

2015/2016 Plan: NPM 10 – Adolescent well care

Objective: Increase the accessibility, quality and utilization of adolescent well visits.

Performance measure: Percent of adolescents with a preventive services visit in the last year.

Strategy 1. By August 2015, align state MCH staffing with new Block Grant 3.0 priorities and develop Title V priority teams consisting of a lead/coordinator, research analyst, and additional subject matter experts for each national priority area/performance measure.

Strategy 2. By September 2015 recruit local partners to participate in Title V priority teams.

Strategy 3. By September 30, 2015, launch Title V priority teams to guide development and implementation of Title

V's work on adolescent well visits (including strategies, evidence-based/informed strategy measures (ESMs), and grant-required detail sheets).

Strategy 4. By October 1, 2015 develop a background brief on adolescent well visits in Oregon, including potential strategies and ESMs. Include results of the following 4 activities:

- Activity 1. Summarize information about barriers and contributing factors to accessibility, quality and utilization of adolescent well visits.
- Activity 2.Analyze and summarize available data (Oregon and/or national) on adolescent well visits including demographics and characteristics of populations at risk.
- Activity 3. Conduct a review of evidence-based/informed strategies and measures related to adolescent well visits, their cost, effectiveness for different populations, etc. (Build on MCHB evidence briefs).
- Activity 4. Conduct a survey of Oregon Title V implementing partners and stakeholders to solicit information about the strategies that they or their community partners are using, or would like to see Title V use to promote child physical activity.

Strategy 5. By January 1, 2016 Title V priority team and Title V leadership identify one or more strategies, associated measures (ESMs), and a data collection/tracking plan for Title V's work on child physical activity in Oregon.

- Activity 1. Determine target populations.
- Activity 2. Gather additional community input related to potential strategies/ESMs and their appropriateness, acceptability and viability - particularly from communities at highest risk.
- Activity 3. Priority team integrates community input and hones the list of recommended strategies to no more than 4 – including both state and local level.
- Activity 4. Priority team presents strategy/ESM recommendations to December 2015 stakeholder meeting(invitees tbd).
- Activity 5. State Title V leadership and priority teams make final determination of strategies and ESMs to be implemented.

Strategy 6. By February 1, 2016 local implementing partners select which 2-4 Title V national performance measures and associated strategies they will implement using Title V funds.

- Activity 1. State and local Title V partners establish parameters for strategy selection, implementation, and ESM tracking/reporting.
- Activity 2. Local implementing partners incorporate their chosen NPMs and ESMs into their Title V MCH report/plan due to the state by March 1.

Strategy 7. By March 30, 2016 state and local level implementation of evidence-informed strategies and tracking of ESMs begins.

- Activity 1. By January 30, simple template for LHD and tribal Title V annual report and plan developed.
- Activity 2. During February and March state and local implementing partners identify TA, workforce development and other needs related to implementation.
- Activity 2. During February and March State and locals Title V partners establish and test systems for collecting ESMs.

Strategy 8. April 1, 2016 through September 30, 2016 implement state and local level strategies and collect/track outcomes through monitoring of ESMs and NPMs. Revise objectives, strategies and ESMs as needed.

Adolescent Health - Annual Report

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	74.2	78.4	79.6	80.8	81.9

2014 Report: Overweight and obesity

State Performance Measure 6: Percent of 8th grade students with a Body Mass Index (BMI) below the 85th percentile

Report on strategies and activities October 2013 - present:

- Collaborate with statewide nutrition and school health partners to leverage resources and promote shared messages around nutrition, physical activity, and obesity prevention.
- Published the Oregon Healthy Growth Survey Report, a statewide BMI survey of early-elementary school students.
- Created webpage, communication plan and distribution of Statewide Shared Meals Initiative: Eat Together. Cook Together. Talk Together. Make Meal time a shared time. A collaboration between the Oregon WIC, SNAP-Ed, Child Nutrition Programs, Public Health Division, Head Start and Oregon Dairy Council.
- Worked with and supported Health Promotion Chronic Disease Prevention (HPCDP) program and external partners in reaching out to 15 key school districts to provide technical assistance and professional development to help improve the school nutrition and physical activity environment for students and staff. Collaborate with partner organizations and local Healthy Communities funded counties in their work with schools and districts to improve nutrition and physical activity for students and staff and implement school wellness policies.
- Strong nutrition and school health partnerships are a contributing factor to the accomplishments we have made in Oregon around this performance measure.
- The Title V work around this performance measure has been extremely limited in the past year (since June 2014) due to the loss of the only Title V funded position working on nutrition, physical activity, and obesity prevention for this specific population (school age – through adolescence).

Plan for upcoming work through September 2015:

Use School Health Profiles data to support HPCDP and external partners in reaching out to 15 key school districts to provide technical assistance and professional development to help improve the school nutrition and physical activity environment for students and staff. Collaborate with partner organizations and local Healthy Communities funded counties in their work with schools and districts to improve nutrition and physical activity for students and staff and implement school wellness policies.

Critical partnerships:

- OHA-PHD Health Promotion and Chronic Disease Prevention section
- Oregon Department of Education Child Nutrition Programs

- DHS SNAP Program
- OSU Extension SNAP-Ed Program
- Oregon Dairy Council Fuel Up to Play 60 Program
- Oregon School Board Association
- OEA Choice Trust

2014 Report: Adolescent well-visit

State Performance Measure 7: Percent of 8th grade students who went to a doctor or nurse practitioner for a check-up or physical exam when they were not sick or injured during the past 12 months.

Report on strategies and activities October 2013 – present:

Title V staff in Adolescent and School Health (ASH) continued to facilitate a cross-Oregon Health Authority (OHA) group to assess the impact of confidentiality in health services. Staff convened a multi-stakeholder meeting that included Oregon Insurance Division (OID) staff, the OHA Child Health Director and representatives from 6 private insurance carriers to better understand the rules and regulations dictating when insurance communication (such as an Explanation of Benefits (EOB)) must be sent to the policyholder. Staff provided comment on draft legislation (HB 2758) related to the provision of confidential services. The original bill was amended to a "confidential communication request" and is currently in the Senate. Title V ASH Staff drafted and administered a health care provider survey to assess provider attitudes, awareness and behaviors related to providing confidential care.

The Youth Participatory Action Research (YPAR) curriculum was finalized, printed, and released online and in hard-copy to community partners and all certified school-based health centers (SBHCs) in Oregon. Funding was leveraged from the Addictions and Mental Health Division (AMHD) to support YPAR projects in four youth-serving organizations and eight SBHCs across the state. A contract was established with the Institute for Community Research (ICR) - who developed the curriculum in which the Oregon version is based – to provide a two-day facilitator training, technical assistance for project period (January-June 2015) and evaluation.

The "Adolescent Health Project" co-funded by the AMHD, is a performance improvement project directed toward adolescent primary care providers to increase utilization of Screening, Brief Intervention, and Referral to Treatment (SBIRT) and depression screening within the context of an adolescent well visit. The training is conducted through the Oregon Pediatric Society's Screening Tools and Referral Training (START) Program, with the Oregon Pediatric Improvement Partnership (OPIP) providing technical assistance related to QI, implementation and evaluation. The first cohort of clinics included four pediatric practices across the state and five SBHCs. Each clinic participated in a regional day-long training covering best practices in delivering adolescent well visits, use and scoring of screening tools, brief intervention techniques, implementation strategies and time with representatives from addictions and mental health providers in the community. An Office Report Tool was developed to assess changes in clinic practices and policies as it relates to the well visit, screening for substance use and depression, and follow up. Baseline data showed that few sites had standardized, universal screening procedures. Preliminary follow up data indicate that all sites have made improvements, but concerns around patient confidentiality and a lack of standardized procedures for tracking referrals continue to be challenges. Evaluation of the first cohort will end June 2015. Modifications to the project for the second cohort include: selection of fewer sites to be able to more fully support implementation; enhanced focus on client confidentiality; and referral tracking and follow up. See the fall 2014 Northwest Bulletin for more information.

Administrative rules on criteria for eligibility of SBHC funding, certification, and grant awards were drafted, approved by an advisory committee, and codified in April 2014. SBHC Incentive Funds allocated by HB 2445 (2013) were released to SBHC/Coordinated Care Organization (CCO) partnerships to: (A) Increase the number of school-based health centers certified as patient centered primary care homes; (B) Improve coordination of care of between coordinated care organizations and school-based health centers; and (C) Improve the effectiveness of the delivery of

health services through school-based health centers to children who qualify for medical assistance. Final grant reports and evaluations will be submitted to the SBHC State Program Office (SPO) June 2015. It is expected that by the end of June 2015 there will be 76 certified SBHCs in Oregon.

Plan for upcoming work through September 2015:

Analyze results of provider confidentiality survey and report to stakeholders across the state. Finalize and administer a CCO/health plan policy assessment survey. Track status of HB 2758 to determine public health role, if passed. Work with OHA and OID stakeholders to determine strategic next steps for this work within the context of the adolescent well visit priority measure for the 2015-2020 Block Grant.

Use ICR evaluation to assess effectiveness of YPAR curriculum for youth-serving entities. Include YPAR as a potential strategy for engaging youth in future Title V or other grant funded work. Continue to seek additional funding to support YPAR in Oregon.

Complete training and evaluation of Adolescent Health Project in fall 2015. Use project evaluation findings to work with partners in AMH, OPS, and OPIP to determine best next steps to carry work forward.

Evaluate outcomes of SBHC Innovation Grants. Complete a HB 2445 update report and continue to monitor and provide technical assistance to SBHCs in aligning and connecting with health system transformation efforts.

Critical partnerships:

Addictions and Mental Health Division, Oregon Pediatric Society, Oregon Pediatric Improvement Partnership, Institute for Community Research

2014 Report: Teen births

National Performance Measure 08: The rate of birth (per 1,000) for teenagers aged 15 through 17 years.

Report on strategies and activities October 2013 – present:

Oregon has had great success with this measure. The Teen Birth Rate for 15 – 17 year old declined 28% from 12.5/1,000 to 9.0/1,000 from 2010 to 2013.

Despite staffing changes and reduced Title V funding for this measure, the Youth Sexual Health (YSH) team continues to provide support and technical assistance in implementation of the Oregon Youth Sexual Health Plan.

Through the Personal Responsibility and Education Program (PREP), ¡Cuidate!, a Latino-specific Human Immunodeficiency Virus (HIV) and teen pregnancy prevention program, continued to be implemented in six counties. The YSH Team provided technical assistance, collected and analyzed program data to determine program effectiveness, and provided training for new facilitators. 957 youth were served between October 2013 and April 2014.

In spring 2014, a graduate student intern joined the YSH team to complete a youth sexual health assessment of county health departments. Outcomes of that assessment were shared with state and local partners in June 2014 and used for planning future teen pregnancy prevention grant applications. From this assessment, Eastern Oregon was identified as a high-priority area for teen pregnancy prevention work.

Public Health Division staff served on the planning committee for the Adolescent Sexuality Conference and provided two presentations at the Oregon Adolescent Sexuality Conference in April 2014.

- The Positive Youth Development Framework and Its Potential for Positive Sexual Health Outcomes among Latino Youth in Oregon
- What Every Teen Should Know about Contraceptive Access under Obamacare
- How Youth Make Sense of Unwanted Sex Involving Alcohol

The 2015 Adolescent Sexuality Conference was cancelled. This presented a challenge for Oregon as it was the only statewide professional development opportunity for people working in the area of youth sexual health.

The Rational Enquirer, Oregon's Youth-Focused Sexual Health magazine was released in April 2014 and April 2015. The Rational Enquirer includes pregnancy and Sexually Transmitted Infections (STI) prevention and healthy relationship information and is used by youth-serving organizations, youth-friendly clinics and high-school classrooms.

A CD Summary "Teen Pregnancy in Oregon: The Good News" was published in December 2014. The CD Summary is a bi-weekly publication of the Oregon Public Health Division sent to all clinical providers in Oregon,

The YSH Team presented at the Oregon Public Health Association Conference (October 2014) and during National Public Health Week (April 2015) on Adolescent Brain Development and the implications with evidence-based teen pregnancy prevention programming.

In April 2015, the Oregon Youth Sexual Health Plan 5 Year Update was released. This update shows Oregon is making progress in four of the five goals, including reducing the teen pregnancy rate, of the Youth Sexual Health Plan.

Plan for upcoming work through September 2015:

A CD Summary on Long Acting Reversible Contraceptives (LARC's) for 15-24 year olds is scheduled to be published in May 2015.

The Youth Sexual Health Coordinator and Oregon Department of Education Sexuality Education Specialist will meet with public health and education partners in Eastern Oregon in June.

The YSH Team will continue to offer technical assistance and support on the Oregon Youth Sexual Health Plan and in implementation of ¡Cuídate!. The team will continue to monitor and report out on teen pregnancy and teen birth rates.

With loss of Title V funding for this priority measure, the Public Health Division will seek other means to continue to support teen pregnancy prevention efforts. The Youth Sexual Health program applied for Capacity Building to Support Replication of Evidence-Based Teen Pregnancy Prevention Programs (Tier 1A) from the Office of Adolescent Health. If this grant is received, the YSH Team will be able to focus efforts on in Eastern Oregon.

Oregon has had success in reducing teen pregnancy rates due to strong partnerships. The YSH Team will continue to work with private and public partners through the statewide Oregon Youth Sexual Health Partnership (OYSHP). The YSH Coordinator serves as co-chair of OYSHP.

The YSH Team will work with partners to determine the needs for professional development opportunities in all areas of youth sexual health.

Critical Partners:

- Department of Education
- Department of Human Services
- Oregon Youth Sexual Health Partnership
- Oregon Teen Pregnancy Task Force
- Planned Parenthood of the Columbia Willamette
- Planned Parenthood of Southern Oregon
- Local Public Health Departments
- Cascade AIDS Project
- Sexual Assault Task Force
- Oregon Coalition Against Domestic and Sexual Violence

2014 Report: NPM 16 - Youth suicide

National Performance Measure 16: The rate (per 100,000) of suicide deaths among youths 15-19

Report on strategies and activities October 2013 – present:

The Youth Suicide Prevention Program in the Injury & Violence Prevention Section (IVPP) of the Oregon Public Health Division received a 5-year Garrett Lee Smith grant for youth suicide prevention that began on September 30, 2014. The grant provides $736,000 per year to help fund 7 Oregon counties to increase identification of suicide risk in youth by youth-serving professionals, increase mental and behavioral health clinicians' ability to assess, manage, and treat youth with suicidal behaviors, and increase integration among primary care, health, mental, and behavioral healthcare, hospital, and Emergency Department (ED) systems in their counties. The counties also will work to increase follow-up for youth who have been seen in hospital EDs and psychiatric units and increase continuity of care among service providers, including crisis response. One county (Washington) has adopted Zero Suicide as an aspirational goal to comprehensively implement Goals 8 and 9 of the National Strategies for Suicide Prevention. We also will work to increase counseling for families on limiting access to lethal means by providers. We have contracted with the Regional Research Institute (RRI) at Portland State University to evaluate project activities and outcomes.

The YSPC helped facilitate a workshop presentation on Connecting the Dots: An Overview of the Links among Multiple forms of Violence with CDC researchers at the April 2015 American Association of Suicidology conference.

The Oregon legislature mandated the state update the youth suicide prevention and intervention plan for youth through ages 24. The Addictions & Mental Health Division funded a new youth suicide intervention coordinator to help coordinate the planning process. At the direction of PHD, the plan uses select goals and objectives from the 2012 National Strategy for Suicide Prevention: Goals & Objectives for Action for Oregon's plan for the next 5 years. We established a charter agreement between PHD and AMH and are collaborating on plan development.

The YSPC continues to work with counties, offer technical assistance, the YSP Network listserv, the Applied Suicide Intervention Skills Training (ASIST) trainer listserv, program collaboration, share resources, and provide training support with data, brochures, Continuing Education Units (CEUs), and other resources. ASIST and Question, Persuade, and Refer (QPR) trainings are ongoing, as are the school-based RESPONSE program, and collaborative youth suicide prevention.

The National Violent Death Reporting System (NVDRS) epidemiologist published Suicide Among Oregon Veterans 2008-2012 in May, 2014.

The Oregon Violent Death Reporting System (ORVDRS), in existence since 2003 received new grant funding through the CDC. The ORDVRS epidemiologist will continue to provide meaningful data and reports to inform suicide prevention work and respond to the frequent requests for data from Oregon cities and counties.

We continue to promote upstream prevention for YSP and multiple other risks by protecting youth and families from numerous high risk factors such as child maltreatment, family violence, onset of depression, disruptive school behaviors, alcohol and drug use, and others. A CDC injury prevention grant supports work on child maltreatment; the Adolescent Health program engages in work on positive youth development; and the MCH program has a large grant to implement the Nurse Family Partnership program. These efforts present a life course approach to preventing youth suicide.

Plan for upcoming work through September 2015:

Work with the 7 counties funded through our GLS grant to improve youth suicide prevention efforts within healthcare systems and increase continuity of care across systems will continue.

The YSP plan will be completed by PHD and AMH and prepared for submission to the 2 agency leaders in preparation for the 2016 legislative session.

The ORVDRS epidemiologist will publish a report on Trends and Risk Factors in Suicide Prevention through 2013. The report is complete and awaits internal approval.

The YSP program will continue to work with county prevention specialists, GLS grant counties and individual high schools to implement RESPONSE and the Kognito At-Risk for High School Educators and Step In, Speak Up! programs.

Critical Partnerships:

We worked with MCH and used Title V Technical Assistance funds to develop a foundation for increasing work to create an environment of Safe and Nurturing Environments for all children.

The YSPC sits on the state's Child Fatality Review Team with MCH representatives, the state medical examiner, the district attorney's office, Addictions & Mental Health, Dept. of Justice, other IVPP program representatives and others.

CDC Injury Prevention funding includes suicide prevention as a priority.

County sub-grantees are critical partners for implementing the GLS youth suicide prevention grant, as is Regional Research Institute at PSU and the Association of County Mental Health Programs.

Addiction & Mental Health Division is working with us to create a 5-year state plan for youth suicide prevention.

State Action Plan Table						
Children with Special Health Care Needs						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
High quality, family-centered, coordinated systems of care for children and youth with special health care needs.	1.1 By 06/2020, increase percent of families of CYSHCN receiving care in a well-functioning system. 1.2 By 09/2020, increase the number of CYSHCN receiving care in a MH/PCPCH by 20%. 1.3 By 06/2020, develop a	1.1.1 Engage with the MCH WDC. 1.1.2 Build comprehensive understanding of care coordination within local system of care for CYSHCN. 1.1.3 Collaborate with the SOS Project to develop and implement a state plan.	Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system Percent of children in excellent or very good health Percent of children ages 19 through 35 months, who	Percent of children with and without special health care needs having a medical home		

State Action Plan Table						
Children with Special Health Care Needs						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
	measure of cross-systems, family-centered, actionable shared care plans for CYSHCN. 1.4 By 06/2020, increase the percent of CYSHCN who have a cross-systems, family-centered, actionable shared care plan. 1.5 By 06/2020, increase the percent of CYSHCN reporting they have community-based access to pediatric specialty care and other ancillary care needed.	1.2.1 Partner with OPIP to increase number of PCPCHs in Oregon. 1.2.2 Partner with ORF2FHIC to train families about Family Centered Care and MH Concepts. 1.2.3 Align community-based program standards to Standards for Systems of Care for CYSHCN. 1.3.1 Participate in ongoing discussions with stakeholders such as the CCO metrics and scoring committee. 1.4.1 Develop and implement annual regional workshops on actionable shared care plans for PCPCHs, community based partners, and families.	have received the 4:3:1:3(4):3:1:4 series of routine vaccinations Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine			

State Action Plan Table						
Children with Special Health Care Needs						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
		1.4.2 Promote the implementation of Community Health Teams. 1.5.1 Collaborate with OHSU to support increased use of telemedicine to enhance access to pediatric specialty services for CYSHCN throughout rural Oregon. 1.5.2 Conduct Action Learning Collaborative among community-based pilot projects.				
High quality, family-centered, coordinated systems of care for children and youth with special health care needs.	2.1 By 2020, increase percent of YSHCN receiving services necessary to transition from pediatric to adult medical care by	2.1.1 Assemble State Title V CYSHCN transition team. 2.1.2 Link State transition team with SOS Project.	Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system	Percent of adolescents with and without special health care needs who received services necessary to make transitions		

State Action Plan Table						
Children with Special Health Care Needs						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
	5%. 2.2 By 2018, increase number YSHCN receiving assistance from PCPs in transition planning, making positive choices about health, and gaining skills to manage health. 2.3 By 2020, create a comprehensive, regionally-based shared resource directory of transition services for YSHCN.	2.1.3 Align community-based program contracts with Standards for Systems of Care. 2.2.1 Promote pediatric and family practice providers applying “Got Transition” toolkit. 2.2.2 Train families of YSHCN in transition concepts. 2.3.1 Identify key tools and resources for families of YSHCN. 2.3.2 Integrate identified tools and resources into state Shared Resource.	Percent of children in excellent or very good health	to adult health care		
High quality, family-centered, coordinated systems of care for children and	3.1 By 06/2016, conduct additional needs assessment activities	3.1.1 Identify demographic and other pertinent information.				

State Action Plan Table						
Children with Special Health Care Needs						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
youth with special health care needs.	specific to non-white and non-English speaking CYSHCN and their families. 3.2 By 06/2020, 80% of providers participating in culturally and linguistically responsive services (CLRS) training report implementation of CLRS strategies. 3.3 By 08/2020, Diversify family network by partnering with three culturally diverse groups.	3.1.2 Identify gaps in service delivery to non-white CYSHCN and their families. 3.2.1 Conduct trainings with medical practices addressing culturally and linguistically responsive care for CYSHCN and families. 3.2.2 Modify community-based program standards and contracts to reflect CLRS strategies. 3.3.1 Increase contractual partnerships with organizations serving culturally diverse populations.				

Children with Special Health Care Needs

Children with Special Health Care Needs - Plan for the Application Year

2015/2016 Plan: Medical Home

Objective: Increase percentage of CYSHCN who report receiving care in a well-functioning system of care.

Performance measure: Percent of children with and without special health care needs having a medical home.

OCCYSHN staff work assignments will be aligned with Block Grant 3.0 priorities. Lead staff members with support of A&E staff and needed subject matter expertise will be assigned to the Medical Home (MH) priority area. Input from community-based partners will shape strategy development and implementation plans for MH including increased and more effective coordinated care.

OCCYSHN's community-based program contracts will be revised to align with the implementation plans for MH, the AMCHP Standards for Systems of Care, MH Domain, and standards associated with Care Coordination.

Evidenced based/informed strategies and associated evidenced based/informed measures (ESMs) impacting MH will be studied to include consideration of family engagement, provider training and TA, and measurement development and implementation of actionable shared care plans.

The Title V CYSHCN priority team and Title V CYSHCN leadership will identify 1 or more strategies, associated ESMs, and a data collection/tracking plan for OCCYSHN's MH work. Strategies for consideration include training delivered over sequential years to increase effective connections and working relationships among partners, resulting in an increase in coordinated care. Efforts will coordinate with the SOS Project to increase cross systems care coordination through assessment and analysis of systems connections at a local level. OCCYSHN will consider an Action Learning Collaborative for rural partners on distant access to specialty care in coordination with the MH.

Evidenced-based/informed family and youth involvement strategies will be researched for implementation in partnership with the ORF2FHIC. Access to quality MH and transition information for families, youth, and health care providers will be addressed. Strategies to increase health literacy will be explored to increase family/youth access to MH information.

MH strategies and ESMs will begin Spring 2016 and shape contracts with local partners extending 2016 through 2020.

2015/2016 Plan: Youth Transition

Objective: Increase the number of children who receive services necessary to transition from pediatric to adult medical care.

Performance measure: Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care.

OCCYSHN will align its program to Block Grant priorities 3.0. Lead staff members with support of A&E staff and needed subject matter expertise will be assigned to the Transition to Adult Health Care (TAHC) priority area. Community-based partners' input will shape strategy development and implementation plans for THAC.

Community partners’ contracts will be aligned with THAC implementation plan, AMCHP Standards for Systems of Care, Transition domain, and standards associated with transition to an adult health care both within pediatric and adult health care context.

Evidenced based/informed strategies and associated evidenced based/informed measures (ESMs) impacting TAHC will be studied, to include consideration of family engagement, provider training and TA. The priority team and Title V CYSHCN leadership will identify 1 or more strategies, associated ESMs, and a data collection/tracking plan.

A state transition team will advance initiatives with pediatric, family medicine, adult providers, and OCCYSHN community-based programs and families and YSHCN. Families and YSHCN will partner with the State Title V YSHCN Transition Team, to assure efforts are consistent with their priorities and needs. OCCYSHN will draw upon the expertise of the Center for Health Care Transition to assist the Transition Team, drawing on its Got Transition! resources, to identify strategies to increase the number of YSHCN and their families experiencing effective transition planning. Through workforce development, OCCYSHN will increase the capacity of providers to care for transitioning

YSHCN.

ORF2FHIC, in partnership with OCCYSHN, will inform Oregon families and YSHCN of transition concepts and with the SOS Grant, OCCYSHN will convene a work group to develop a shared resource for providers and families of YSHCN to include transition resources.

TAHC strategies and ESMs will begin 2016 and shape contracts with local partners extending 2016 through 2020.

Children with Special Health Care Needs - Annual Report

NPM 11 - Percent of children with and without special health care needs having a medical home

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	45.8	49	51	53	55

NPM 12 - Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	35.6	38	40	42	44

2014 Report: Newborn Screening
National Performance Measure 1: Percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.

Report on strategies and activities October 2013- present:
Last year, the Newborn Screening (NBS) program added SCID to the screening panel. Newborn screening administrative rules were updated to reflect the addition of SCID and to increase screening fees from $54 per double kit to $64.

Systems continue to be in place to provide pediatric specialty consultation to primary care providers; to offer public health nurse care coordination; to process WIC vouchers and dispense medical formula to WIC eligible children; and to provide information to health care providers, families, and the public through the NBS website.

The NBS panel will continue to include 30 core conditions recommended by the American College of Medical Genetics and the Secretary of HHS.

The NBS program will continue to adapt algorithms and materials for follow up with the newly assigned pediatric hematology/oncology consultants since adding SCID to the screening panel.
The NBS Program continues to investigate implementing second tier, mutation analysis for CF screening; continue to update the Neometrics data system to an HL7 format; continue to provide hospitals and physicians with secure, web-based access to NBS results.

NBS information for the public, parents, and health care providers will continue to be maintained on the OSPHL NBS Program website at https://public.health.oregon.gov/LaboratoryServices/NewbornScreening/Pages/index.aspx.

The NBS Program, OFH, and OCCYSHN/CDRC staff members will continue to participate in the Western States Genetic Services Collaborative, and other regional and national work groups and committees. OSPHL and CDRC staff will participate in multiple regional and national NBS-related work groups, including those on emergency preparedness and short- and long-term NBS follow-up.

The NBS program will streamline the dissemination of NBS reports to be electronically exchanged to large medical facilities' electronic medical records. The diet monitoring of patients with PKU will also be electronically disseminated to the OHSU Metabolic Program to streamline the process.

NBS quality assurance will continue with monitoring of specific collection and handling processes of all first screen submitters to include the transit time and satisfactory specimen submission. Monthly reports will be sent to all first time submitters to include facilities and individual providers.

Children with metabolic conditions continue to be offered visits to the OHSU/CDRC Metabolic Clinic. The clinic continues to offer assistance and follow-up to primary care providers of all children with metabolic conditions requiring treatment or monitoring. In addition, PCPs of infants with hemoglobinopathies, endocrinopathies, cystic fibrosis and severe combined immune deficiency detected by NBS will continue to be offered assistance and follow-up through the OHSU's pediatric hematology, endocrinology, pulmonology and hematology/oncology programs. New information on the children seen in the clinic, detected by tandem mass spectrometry, will be added to the Long-Term Newborn Screening Follow-up Database.

The CaCoon program will continue to offer community-based care coordination and follow-up for children with conditions detected by NBS. CaCoon public health nurses will enter data for children served into the Oregon Community Health Integrated Data System (ORCHIDS).

2014 Report: Family Involvement
National Performance Measure 2: Percent children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive.

Report on strategies and activities October 2013 – present:
One of the primary purposes of OCCYSHN's Family Involvement Network (FIN) is to help families of CYSHCN feel empowered in their decision making and be satisfied with the services their children need and receive.

FIN projects include parent professional partnerships on CCN teams, ASD Identification Teams (AITs) and partnering with professionals in training through the LEND program. In addition, FIN's partnership with the Oregon Family to Family Health Information Center (ORF2FHIC) provides OCCYSHN opportunities to train, support, and empower parents of CYSHCN directly.

Over the last 12 months, FIN has been able to work with the hospitalist program at OHSU in a QI program that includes the patient/parent voice in decision making and reporting during rounds. FIN worked with OPIP to develop QI processes that always include the family/patient voice, and to incorporate parents of CYSHCN on QI teams. Through LEND, the next generation of clinicians have been directly trained in partnering with parents/patients in decision making. The FIN coordinator sits on the Oregon state MIECHV steering committee to share the parent voice in decision making. The work with MIECHV includes participating on parent training committees and attending Parent Leadership Training Institute (PLTI) facilitation training.

FIN's successes have been in recruiting and retaining parents of CYSHCN to work on CDRC child development teams and for the ORF2FHIC. FIN has added 10 Family Liaisons (FLs). Increasing to 20 FLs has required increased time and effort in training. All new FLs receive on-boarding, hands-on training on working on teams, and monthly continuing educational webinars that includes information on disease specific issues, insurance, mental health, working with culturally diverse populations, disaster preparedness for CYSHCN, and others.

FIN and ORF2FHIC partner in an annual gathering of all FLs for a 2-day spring training session. In 2014, FIN joined an OCCYSHN conference on ASD. In 2015, FIN and ORF2FHIC partnered on insurance issues that continue to plague CYSHCN and their families. Oregon's change in Medicaid providers and the complexity of understanding

both private and state funded plans requires constant training.

All FLs are caring for their own CYSHCN, and their ability to work can be challenged by their children's needs. FIN addresses this by always having 2 FLs per team.

OCCYSHN requires parent and professionals partner on the ACCESS project's AIT. Some professionals have struggled with including non-professionals on AITs. As with any change process, it requires careful selection, enhanced training and continued support to gain the confidence, and confirm the importance, of the parent voice. On the AITs, the FLs serve as Parent Partners. Their presence enables parents of CYSHCN to be more empowered in decision making.

FIN continues to partner with the LEND program; the FIN coordinator leads the Family Mentor Program in which 15-20 families of CYSHCN mentor LEND trainees about the family experience. This year FIN recruited 2 young adults with disabilities to mentor students who are interested in transition and life course for people with disabilities. Additionally, FIN recruited and trained a family trainee through LEND who is bicultural and bilingual.

Due to the partnership with ORF2FHIC, FIN has been able to reach out to rural and frontier parts of the state and provide family support through ORF2FHIC's website, toll-free line, publications, and regional trainings and listening sessions. Since last year, ORF2FHIC has held 37 listening sessions where information about local resources, advocacy and health care reform were presented to parents of CYSHCN. In addition, ORF2FHIC was able to compile key points from these listening sessions with parents to report on for the 2015 needs assessment. Connecting with other family groups keeps FIN/ORF2FHIC's network of families informed and more able to make health care decisions for their CYSHCN.

2014 Report NPM 3: Medical Home
National Performance Measure 3: Percent of children with special health care needs age 0-18 who receive coordinated, ongoing, comprehensive care within a medical home.

Report on strategies and activities October 2013 – present:
OCCYSHN ensures that CYSHCN served through its community-based programs are linked to a medical home. OCCYSHN strengthens the medical home for CYSHCN by building capacity for care coordination, disseminating information and resources, delivering workforce development, building and supporting local AITs for the evaluation of ASD in young children, and informing practice and policy change.

ORF2FHIC, in partnership with OCCYSHN, supports the development of medical homes for CYSHCN by training families. Since few Oregon families are familiar with the term "medical home," ORF2FHIC introduces the term and concept using an interactive curriculum. ORF2FHIC also presents information about the medical home to non-medical CYSHCN-serving professionals. In FY2014, more than 20 presentations were made around the state. Since 2013, ORF2FHIC has included information and resources specific to Oregon's PCPCHs in all of its resource fairs and Regional Family Gatherings.

AITs are comprised of primary care, mental health, Parent Partners, and EI/ECSE community partners. Three new AITs began services this year, and an 8th team will begin functioning in the coming year. Teams in Marion and Jackson counties are working at capacity, and OCCYSHN is actively addressing this through on-going training of new team members.

OCCYSHN continues to support practice facilitation for implementation of medical home improvement. In the previous year, OCCYSHN collaborated with OPIP and OPS to improve care coordination through the ECHO (Enhancing Child Health in Oregon) Project. This year OCCYSHN collaborated with OPIP and ORPRN to support practice facilitation to enhance the medical homes for children with ASD/developmental delays (DD). A focus on practice facilitation will continue next year with 6 practices. The ACCESS project will develop education opportunities to address care coordination.

OCCYSHN disseminates resources to support medical home activities including care coordination for CYSHCN. In the current year, OCCYSHN populated a learning management system with information, tools, and resources for

other programs, to support medical home delivery for children with ASD/DD. Work will continue next year as OCCYSHN works toward building the capacity of communities to provide integrated team-based health care. An ongoing challenge of the system is ensuring that community partners are actively engaged with the information and that it is relevant to their needs.

OCCYSHN delivers professional development opportunities to support the medical home workforce. OCCYSHN continues to deliver monthly "Coffee Time Consultation" webinars for primary care providers, care coordinators, and CaCoon nurses that address specific clinical issues and provide resources and QI strategies.

OCCYSHN brought together its partners to a statewide spring conference last year. Content focused on condition-specific information, as well as strategies for strengthening the medical home. The 2nd day of the conference focused on supporting local AITs to evaluate and manage ASD in young children.

OCCYSHN is promoting the use of the shared care plan. In the current year, CCN promoted team QI efforts around the use of shared care plans, including strengthening care plan linkages to the medical home. One challenge pertaining to use of shared care plans is focused on EHR and the lack of interoperability. In the current year and moving forward, CaCoon is implementing regional trainings for CaCoon and its partners. Professional development is focused on working across systems in teams.

ORF2FHIC, in partnership with OCCYSHN, will continue to present workshops throughout the year in English and Spanish, utilizing the Family Voices-inspired interactive curriculum and Family-Centered Care Assessment Tool. Input from families will guide continued refinement of the curriculum. ORF2FHIC's key partnerships in this work are Oregon's 7 family networks, members of the statewide Family Training/Outreach Collaborative, CaCoon, other public health and education settings, and pediatric clinics around the state.

2014 Report: Healthcare Finance
National Performance Measure 4: Percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need.

Report on strategies and activities October 2013 – present:
OCCYSHN tracked and disseminated information about national and state health reform efforts, legislation, and policy concepts as they relate to CYSHCN. OCCYSHN participates in the Child & Family Well-being Measurement Workgroup, which recommends cross-sector measures to improve coordinated care across systems. This work could contribute to potentially lowering costs for families and the health care system overall. OCCYSHN participates in the Oregon HERC hearings when issues of interest to CYSHCN families are on the agenda (e.g. coverage of ABA, coverage of genetic testing). OCCYSHN's genetics consultant, in collaboration with the OHA Oregon Genetics Program, continues to identify health insurer contacts to provide education regarding coverage of genetic services. OCCYSHN staff participates on projects to improve coverage of genetic services in collaboration with the Western States Regional Genetics Consortium. OCCYSHN participates on a work group with OHSU government relations and other genetic counselors to support licensure legislation.

OCCYSHN staff participate in the Medicaid Ombudsman Advisory Committee to track trends in OHP transformation and to bring the CYSHCN voice to policy makers at the table. Three FLs serve on their local CCO Community Advisory Committees (CACs) representing the voice of CYSHCN. OCCYSHN staff also attend local CCO CACs. OCCYSHN attended the Oregon's Insurance Division's bi-weekly bill tracking and input meetings during the 2015 Legislative Session to monitor key legislation that affects pediatric populations.

OCCYSHN supported 50 hours of training to 20 FLs statewide on health insurance advocacy, marketplace navigation, systems integration, and appeals rights. Those FLs are responsible for informing and training families in their communities on those topics. OCCYSHN contracted to provide coaching and support to families of children with ASD to utilize their insurance policies to pay for behavioral training.

ORF2FHIC continuously disseminates information on the ACA through newsletters, tip sheets, website and Facebook posts, family gatherings, staff meetings, and at community resource fairs. ORF2FHIC provides information on CCOs, provider clinics, social service systems, free preventive services, how to comparison shop for

policies when a child has complex needs, managing medical debt, avoiding "chairside denials" of services, etc. A toll free line is available to families and professionals to help with identifying solutions to complex financing issues.

OCCYSHN is exploring sustainability of the ACCESS project, which makes available local identification of young children with ASD thus avoiding the long waits for evaluation at a tertiary care center. The Project Medical Consultant is in conversations with CCOs about how to build a payment model for these locally provided services.

OCCYSHN contributed to a Learning Collaborative, hosted by WIC state leadership, to define appropriate use of oral nutrition supplements for children age 1 to 5 years, assuring access to special formulas for CYSHCN. OHA is revising rules for enteral nutrition therapy addressing an omission of metabolic formulas and medical foods for treatment of inborn errors of metabolism identified by newborn screening; OCCYSHN's nutrition consultant is providing TA. The nutrition consultant is also participating in the regional training sessions focused on cross system collaboration for CaCoon home-visiting nurses and community partners.

Critical Partnerships include the Oregon Insurance Divisions' Consumer and Business Services program, and the Benefits Advisor from the Seattle office of the US Department of Labor. Both agencies regularly provide TA to OCCYSHN and ORF2FHIC on private health care rights and navigation support. The Catalyst Center provides TA on public and private financing. DMAP, in particular the OHP Care Coordination Program, is a key partner. OHA provides TA related to Oregon's Marketplace.

2014 Report: Community-based Service Systems are Organized/Easy to Use
National Performance Measure 5: Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily.

Report on strategies and activities October 2013 – present:
OCCYSHN continues to provide level funding to the 35 Oregon counties offering **CaCoon** public health nurse (PHN) home visiting services. A new CaCoon standard, speaking to development of shared care plans, was implemented in 2014. This new standard is responsive to the AMCHP Standards for Systems of Care for CYSHCN. Workforce development activities were put in place to support this new CaCoon standard.

The CaCoon Program Consultant led a series of visits to the OHSU campus, including CDRC and Shriners, for CaCoon nurses. The goal was to help CaCoon PHNs provide anticipatory guidance to the many families of CYSHCN visiting the large and often confusing campus.

A new and interactive "Introduction to CaCoon" curriculum for CaCoon PHNs has been developed this year. It includes learning about shared care planning, working with partner agencies, as well as family engagement. Learning about community-based care coordination strategies has been a focus at regional workshops for CaCoon PHNs. The agenda for the 2014 CaCoon Regional Meetings included learning about care coordination in nursing practice, with a focus on client/family activation and teaming effectively with PCPCH and other partners.

CaCoon home visits are currently primarily funded through Targeted Case Management via Medicaid. As health care reform evolves in Oregon, TCM funding will be integrated into the CCO model. OCCYSHN staff is actively advocating for the needs of the CYSHCN population in this process.

Beginning Spring 2015, the CaCoon Regional Meetings' audience was expanded to include community partners such as local CCN team members, care coordinators with primary care practices as well as representatives from the education community and payers such as Coordinated Care Organizations (CCOs). The agenda also expanded to include discussion of the challenges of working together across systems, and experiential learning around shared care planning. A particular focus is partnership with families. This alignment of effort by OCCYSHN's community-based programs is providing depth as well as breadth to OCCYSHN's workforce development activities. A challenge for bringing together this expanded audience is that the present economic climate in Oregon tends to emphasize productivity, thus the opportunity costs associated with workshop attendance can be a barrier.

OCCYSHN continued level funding to **Community Connections Network (CCN)** in 9 communities. CCN teams have met monthly to provide community-based team care coordination for 105 CYSHCN and their families. Teams

reviewed 287 shared care plans to ensure linkage to community-based resources and services. CCN teams are involved in QI activities including activities focused on strengthening the shared care planning process and alignment with the AMCHP Standards for Systems of Care for CYSHCN. Program planning includes strengthening the orientation to the development and implementation of community-based team care. OCCYSHN provided a CCN in-service on Executive Functioning.

OCCYSHN is partnering with 4 county public health departments, in a 3-month **Action Learning Collaborative (ALC)**, to promote effective care coordination for CYSHCN through development of shared care planning processes. Topics of focus are EHR: elements specific to CYSHCN, telehealth, team building across community based services: autism-specific and adolescent transition.

2014 Report: Youth Transition
National Performance Measure 6: Percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work and independence.

Report on strategies and activities October 2013 – present:
Families of YSHCN are challenged at the time of transition by often being unprepared, leading to stressful decision making and uncoordinated efforts. Families are isolated during the transition process, lacking mentors or guides. Health care providers and professionals seldom initiate the process.

The 2014-2015 Needs Assessment assessed the current needs of CYSHCN, including YSHCN and their families, as well as strengths and challenges in the systems serving YSHCN.

The CaCoon for Youth (C4Y) project ended successfully in August 2014. Key issues important to sustainability of the project were considered during an end of project meeting. The final report outlined lessons learned, challenges, and successes in the grant. Accomplishments include contributing to YSHCN and their families receiving coordinated care, development of community partnerships, community members' valuing C4Y, increase in referrals for services, increased collaboration within health departments, and bringing needed expertise to the community. Youth Transition was a topic at the statewide 2014 CaCoon Regional Meetings. A barrier to CaCoon support of effective transition is that many counties lack capacity to respond to all referrals and often must prioritize younger children with a new diagnosis.

OCCYSHN continues to partner with IDD/CDRC in the development of a consistent approach to health care transition as well as ensuring CDRC clinics to community-based services linkages for transitioning YSHCN. Challenges to transition to community-based services include lack of adult-oriented health care providers available to care for YSHCN.

OCCYSHN informs clinical QI activities related to transition, including activities of the pediatric neurology clinic and pediatric hemophilia clinic.

OCCYSHN continues to serve YSHCN and their families through CCN and CaCoon. However, the Lincoln County CCN team did not take on a targeted transition initiative due to local contract changes and a change in the health team structure. OCCYSHN provided consultation to CCN teams related to transition services for YSHCN.

OCCYSHN continues to inform local policy and systems development related to coordinated care for CYSHCN, including transition for YSHCN. OCCYSHN has supported and informed coalitions and initiatives in Wasco-Hood River and Marion-Polk counties.

OCCYSHN disseminates transition-related information to providers through its "Coffee Time Consultations" webinars.

YSHCN and their families served through CCN and CaCoon are linked to ORF2FHIC for transition information and resources. ORF2FHIC communicates with families about transition planning via resource fairs, regional family gatherings, and 1-to-1 mentorship. This brings awareness to families and providers about transition concepts for YSHCN with and without intellectual disabilities.

OCCYSHN communicated with the "Got Transition! 2.0" to begin a plan toward a State YSHCN Transition Committee with an emphasis on engaging a few pediatricians and family providers in exploring implementation of transition activities. OCCYSHN met with the Title V MCH program Adolescent Health Program to learn their approach to adolescent transition and opportunities for coordinated or collaborative efforts.

Beginning in 2014, the ORF2FHIC worked with 4 families to create sample "Oregon Transition Stories." These can be used to mentor families of transition-aged youth. These stories are shared during regional family gatherings. "Got Transition 2.0" materials are foundational to this work.

The ORF2FHIC's future work will include increasing the number of transition stories to mentor families. The stories will feature families of youth with a variety of conditions, including those with/without IDD, varying levels of medical complexity, and geographical/cultural diversity. ORF2FHIC will explore strategies for the development of a shared resource for adult providers who accept YSHCN into their practice.

2014 Report: Access to Mental Health Services
State Performance Measure 8: Increase linkages to mental health services for children and youth with special health needs.

Report on strategies and activities October 2013 – present:
OCCYSHN supports community based health care teams. It provides ongoing infrastructure building of the 9 CCN teams and 7 AITs in rural and semi-rural communities across the state. The CCN teams' coordination of community-based services includes mental health services. AITs provide evaluation and diagnosis of CYSHCN who may experience a dual diagnosis of health and mental health concerns. Mental health providers actively participate on these teams, either in evaluation or consultation roles.

OCCYSHN collaborated with the Swindells Center to provide a day-long presentation and resource fair on the topic of dual-diagnosis in Salem. It sponsored a family mental health advocate to provide training to FLs, which focused on legislative efforts to coordinate care for mentally ill youth who are at risk for suicide following hospitalization. OCCYSHN has tracked 3 bills related to pediatric mental health in the 2015 legislative session.

OCCYSHN's "Coffee Time Consultation" webinars include topics pertaining to mental health. OCCYSHN staff participate on the state's Emergency Medical Systems for Children Advisory Group, and successfully advocated for a mental health practitioner to serve on its board since mental health emergencies have not been a focus prior to 2014. OCCYSHN launched the SOS for Oregon CYSHCN grant, primarily focusing on the improvement of the coordination and integration of systems serving CYSHCN, inclusive of health and mental health programs.

In partnership with OCCYSHN, ORF2FHIC has held more than 62 Regional Family Gatherings throughout Oregon, during which families learn about a variety of mental health resources including programs for medication management (OPAL K), behavior management (Collaborative Problem Solving), emotional support (multiple support groups), the family experience of mental illness (NAMI Basics), early-onset psychosis (EASA program), and many others. Through the Regional Family Gatherings, parents with mental health concerns often request and receive referral information for themselves as well as their children.

OCCYSHN staff actively participate in the Family Leaders Group, the Statewide Outreach and Training Group, and the Sustaining Families Group, all of which include representation from the mental health community. FLs were introduced to their counterparts at the OFSN via a webinar, whereby each group was better informed about one another's services.

OCCYSHN is educating families about systems of care, being present at and initiating cross-systems activities and policy conversations inclusive of the mental health system. OCCYSHN supports increased capacity in the arena of mental health through a collaborative partnership with the CDRC to support the efforts of Dr. Arlene Hagen, an expert in pediatric dual diagnosis and provides training and TA to community team members.

OCCYSHN will continue cross-systems conversations at both the state systems and policy level, with families and

providers through its SOS grant, its community-based programs and in partnership with the ORF2FHIC. Critical partners in this work are the Department of Addictions and Mental Health, DMAP, the Oregon Pediatric Society's OPAL-K program, (a real-time pediatric psychiatric consultation program for primary care providers) the OFSN, the OHSU Pediatric Psychiatry Department and Collaborative Problem Solving Initiative.

2014 Report: Access to Specialized Services
State Performance Measure 9: Increase access to specialized health and related services for underserved populations of children and youth with special health care needs.

Report on strategies and activities October 2013 – present:
CCN and AITs address specialized health and related services in the shared care planning processes. Families are supported by Parent Partners in accessing these services.

The 16 Oregon CCO's were surveyed to better understand how these Medicaid payment plans viewed nutrition services, what their population priorities were, i.e., CYSHCN, and who they identified as providers of those services. These findings were shared in May 2015, at the annual meeting of the Oregon Academy of Nutrition and Dietetics; steps for becoming a nutrition services provider were outlined. Additional opportunities to work with CCOs to assure that CYSHCN have access to local services were explored, including telemedicine and collaborations with local health departments and WIC staff. The LEND and MCH trainees worked with the OCCYSHN nutrition consultant to deliver a presentation for their fellow trainees on the nutrition needs of CYSHCN. The nutrition consultant is providing technical assistance to the Oregon Health Authority to assure that special formulas and medical foods are available for children and youth with metabolic disorders identified by newborn screening. Efforts to build a network of clinical dietitians who can provide services to CYSHCN in their local communities, gauging their interests and training needs continue through 2015.

OCCYSHN continues to partner with the ORF2FHIC to provide information to CYSHCN and their families on how to access specialized health and related services, especially in rural/frontier areas. OCCYSHN will work with the ORF2FHIC to identify ongoing needs of families regarding access to specialty care and therapies as evidenced through ORF2FHIC data and the Title V CYSHCN 5-year needs assessment. OCCYSHN supported the ORF2FHIC's efforts to reach monolingual Russian and Spanish-speaking families to inform them of rights and resources in their health communities as well as partnering in support of ORF2FHIC's "Resources and More" curriculum and handout. This curriculum informs parents and professionals about specialty resources around the state, including tele-speech therapy and behavior therapy.

OCCYSHN disseminated information to PCPs and families about specialized services available at OHSU/CDRC through one of its sponsored "Coffee Time Consultations" held in June 2015.

OCCYSHN continues to partner with the genetic counselors work group and OHSU Government Relations in preparation for a genetic counselor licensure bill in the next legislative session. OCCYSHN genetics staff are identifying potential sponsors in the House and Senate, stakeholders (such as parent support groups, physician geneticists, primary care providers), and current partnerships, to educate legislators and stakeholders. The climate for adding genetic counselors as a professional group to the agency looks promising.

OCCYSHN sustains a strong partnership with the CDRC to assure family centered care delivered within a multi-disciplinary tertiary center. OCCYSHN draws on the CDRC expertise to outreach to community providers in an ongoing effort of workforce development.

2014 Report: Family Support
State Performance Measure 10: Increase access to family support services among families of children and youth with special health needs.

Report on strategies and activities October 2013 – present:
OCCYSHN FIN created a work plan with 4 Benchmarks: (1) Inventory of family support needs across the state; (2) establishing a statewide network of family-driven organizations; (3) identify and develop strategies to increase family support especially in rural areas and (4) creating an action plan for increasing access. These were the principle

drivers of the work this year.

Within the prior year, FIN/ORF2FHIC met the first 2 benchmarks. Therefore, it focused on increasing outreach this year by further networking with new and established family support networks. In addition, FIN/ORF2FHIC increased staffing in rural areas, mental health resources, and on AITs.

ORF2FHIC's website acts as a repository for family support resources and listservs of family driven organizations, family liaisons, navigators, individual families, professionals, and agencies for information sharing and linking activities.

ORF2FHIC FLs each have specific areas of expertise, such as understanding particular conditions and diagnoses, rural communities, specific systems, and/or languages. When possible, families calling into the F2FHIC are matched to the FL per this expertise. Families access the FLs by calling the toll free line, encounters at community activities, and via email. The ORF2FHIC website and publications all contain contact information for the FLs, so families can easily reach a FL in their community. FIN/ORF2FHIC's improvement plan for 2015-16 includes in-depth training for FLs to be able to answer parent questions about complex issues with health care coverage as well as mental and behavioral health issues. The plan also includes improving communication and reliability with culturally diverse populations.

FIN and the ORF2FHIC added 10 more FLs to the shared family network. The workforce development effort was improved with a training curriculum to include a training manual, several specific webinar trainings, one-on-one training and an annual FL "family gathering" training.

FIN and ORF2FHIC linked with other family networks including the family networks supported by the Oregon Council on Developmental Disabilities, the PTI, the Oregon Family Support Network that works primarily with children with mental and behavior health challenges, the Autism society of Oregon and others. FIN/ORF2FHIC's team of family networks meet virtually, quarterly to talk about out-reach to the rural and frontier parts of the state.

The Sidney and Lillian Zetosch Fund of The Oregon Community Foundation, administered through OCCYSHN, provides educational equipment to CYSHCN from low-income families. In FY14, OCCYSHN used these funds to purchase equipment for 70 CYSHCN in 18 Oregon counties. The most common purchases were tablets, computers, and software for children with communication needs and/or mobility impairments.

OCCYSHN provided 10 full scholarships in 2014 and 15 full scholarships in 2015, to Spanish-speaking families to attend a multi-disability "All Born-in" conference.

OCCYSHN provided funding for 2 "Family Matters" discussion groups for parents of CYSHCN. "Family Matters" is a discussion group, that occurs over a 5-week period. It is facilitated in Spanish by a family member of a CYSHCN to introduce concepts of healthy eating, physical exercise, and the reduction of screen time. Two "Family Matters" classes were offered in Hood River and Salem, and a third will be offered prior to September 2015 in a location to be determined.

State Action Plan Table						
Cross-Cutting/Life Course						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
Improved oral health for pregnant women	Increase the percent of pregnant women	By August 2015, align state MCH staffing; develop	Percent of children ages 1 through 17 who	A) Percent of women who had a dental visit		

State Action Plan Table						
Cross-Cutting/Life Course						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
and children.	and children who receive preventive oral health services.	Title V priority teams. By September 2015 recruit local partners to Title V priority teams. By October 2015, launch Title V priority teams. By November 2015 develop potential strategies and ESMs. By January 2016 determine State Title V strategies, ESMs, and data collection plans. By February 2016 local implementing partners select NPMs, strategies/ESMs to implement. By April 2016 begin implementing strategies and tracking of ESMs. April 2016 - September	have decayed teeth or cavities in the past 12 months Percent of children in excellent or very good health	during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year		

State Action Plan Table						
Cross-Cutting/Life Course						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
		2020, implement strategies; track ESMs and NPMs; revise objectives, strategies and ESMs as needed.				
Reduced tobacco use and exposure among pregnant women and children.	Reduce Smoking during pregnancy and household tobacco exposure for children.	By August 2015, align state MCH staffing; develop Title V priority teams. By September 2015 recruit local partners to Title V priority teams. By October 2015, launch Title V priority teams. By November 2015 develop potential strategies and ESMs. By January 2016 determine State Title V strategies, ESMs, and data collection plans. By February	Rate of severe maternal morbidity per 10,000 delivery hospitalizations Maternal mortality rate per 100,000 live births Percent of low birth weight deliveries (<2,500 grams) Percent of very low birth weight deliveries (<1,500 grams) Percent of moderately low birth weight deliveries (1,500-2,499 grams) Percent of preterm births (<37 weeks)	A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes		

State Action Plan Table						
Cross-Cutting/Life Course						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
		2016 local implementing partners select NPMs, strategies/ESMs to implement. By April 2016 begin implementing strategies and tracking of ESMs. April 2016 - September 2020, implement strategies; track ESMs and NPMs; revise objectives, strategies and ESMs as needed.	Percent of early preterm births (<34 weeks) Percent of late preterm births (34-36 weeks) Percent of early term births (37, 38 weeks) Perinatal mortality rate per 1,000 live births plus fetal deaths Infant mortality rate per 1,000 live births Neonatal mortality rate per 1,000 live births Post neonatal mortality rate per 1,000 live births Preterm-related mortality rate per 100,000 live births Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births Percent of children in			

State Action Plan Table						
Cross-Cutting/Life Course						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
			excellent or very good health			
Safe and nurturing relationships; and stable, attached families.	Develop a State Performance Measure (SPM) in the area of trauma and toxic stress.	By October 2015, align state MCH staffing and develop a state performance measure work group. By December 2015, recruit local partners to state performance measure work group. By January 2016, launch state performance measure work group. By March 2016 develop a set of potential performance measures By April 2016 select a state a state performance measure for toxic stress and trauma. June –				

State Action Plan Table						
Cross-Cutting/Life Course						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
		September 2016, develop a strategic plan for impacting the state performance measure By October 2016 begin implementation of strategies to move the dial on our state performance measure.				
Improved health equity and reduced MCH disparities.	Develop a state performance measure in the area of culturally and linguistically responsive MCH services.	By October 2015, align state MCH staffing and develop a state performance measure work group. By December 2015, recruit local partners to state performance measure work group. By January 2016, launch state performance measure work group. By March 2016				

State Action Plan Table						
Cross-Cutting/Life Course						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
		develop potential performance measures By April 2016 select a state a state performance measure for culturally and linguistically responsive MCH services. June – September 2016, develop a strategic plan for impacting the state performance measure By October 2016 begin implementation of strategies to move the dial on our state performance measure.				
Improved maternal, infant, child, adolescent and family nutrition.	Develop a state performance measure in the area of food insecurity.	By October 2015, align state MCH staffing and develop a state performance measure work group.				

State Action Plan Table						
Cross-Cutting/Life Course						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
		By December 2015, recruit local partners to state performance measure work group. By January 2016, launch state performance measure work group. By March 2016 develop a set of potential performance measures. By April 2016 select a state a state performance measure for food insecurity. June – September 2016, develop a strategic plan for impacting the state performance measure By October 2016 begin implementation of strategies to move the dial on our state				

State Action Plan Table						
Cross-Cutting/Life Course						
State Priority Needs	**Objectives**	**Strategies**	**National Outcome Measures**	**National Performance Measures**	**ESMs**	**SPMs**
		performance measure.				

Cross-Cutting/Life Course

Cross-Cutting/Life Course - Plan for the Application Year

2015/2016 Plan: NPM 13 – Oral health

Objective: Increase the percent of pregnant women and children who receive preventive oral health services.

Performance measures: A) Percent of women who had a dental visit during pregnancy; B) Percent of children ages 1 to 6 years who had a preventive dental visit in the last year.

Strategy 1. By August 2015, align state MCH staffing with new Block Grant 3.0 priorities and develop Title V priority teams consisting of a lead/coordinator, research analyst, and additional subject matter experts for each national priority area/performance measure.

Strategy 2. By September 2015 recruit local partners to participate in Title V priority teams.

Strategy 3. By September 30, 2015, launch Title V priority teams to guide development and implementation of Title V's work on preventive oral health visits (including strategies, evidence-based/informed strategy measures (ESMs), and grant-required detail sheets).

Strategy 4. By October 1, 2015 develop a background brief on preventive oral health for pregnant women and children in Oregon, including potential strategies and ESMs. Include results of the following 4 activities:

- Activity 1. Summarize information about barriers and contributing factors to utilization of dental services among pregnant women and preventive dental visits among children.
- Activity 2.Analyze and summarize available data (Oregon and/or national) on preventive dental services including demographics and characteristics of populations at risk.
- Activity 3. Conduct a review of evidence-based/informed strategies and measures related to preventive dental services, their cost, effectiveness for different populations, etc. (Build on MCHB evidence briefs).
- Activity 4. Conduct a survey of Oregon Title V implementing partners and stakeholders to solicit information about the strategies that they or their community partners are using, or would like to see Title V use to promote child physical activity.

Strategy 5. By January 1, 2016 Title V priority team and Title V leadership identify one or more strategies, associated measures (ESMs), and a data collection/tracking plan for Title V's work on oral health in Oregon.

- Activity 1. Determine target populations.
- Activity 2. Gather additional community input related to potential strategies/ESMs and their appropriateness, acceptability and viability - particularly from communities at highest risk.
- Activity 3. Priority team integrates community input and hones the list of recommended strategies to no more than 4 – including both state and local level.

- Activity 4. Priority team presents strategy/ESM recommendations to December 2015 stakeholder meeting(invitees tbd).
- Activity 5. State Title V leadership and priority teams make final determination of strategies and ESMs to be implemented.

Strategy 6. By February 1, 2016 local implementing partners select which 2-4 Title V national performance measures and associated strategies they will implement using Title V funds.

- Activity 1. State and local Title V partners establish parameters for strategy selection, implementation, and ESM tracking/reporting.
- Activity 2. Local implementing partners incorporate their chosen NPMs and ESMs into their Title V MCH report/plan due to the state by March 1.

Strategy 7. By March 30, 2016 state and local level implementation of evidence-informed strategies and tracking of ESMs begins.

- Activity 1. By January 30, simple template for LHD and tribal Title V annual report and plan developed.
- Activity 2. During February and March state and local implementing partners identify TA, workforce development and other needs related to implementation.
- Activity 2. During February and March State and locals Title V partners establish and test systems for collecting ESMs.

Strategy 8. April 1, 2016 through September 30, 2016 implement state and local level strategies and collect/track outcomes through monitoring of ESMs and NPMs. Revise objectives, strategies and ESMs as needed.

2015/2016 Plan: NPM 14 - Smoking

Objective: Reduce smoking during pregnancy and household tobacco exposure for children.

Performance measures: A) Percent of women who smoke during pregnancy; B) Percent of children who live in households where someone smokes.

Strategy 1. By August 2015, align state MCH staffing with new Block Grant 3.0 priorities and develop Title V priority teams consisting of a lead/coordinator, research analyst, and additional subject matter experts for each national priority area/performance measure.

Strategy 2. By September 2015 recruit local partners to participate in Title V priority teams.

Strategy 3. By September 30, 2015, launch Title V priority teams to guide development and implementation of Title V's work on smoking (including strategies, evidence-based/informed strategy measures (ESMs), and grant-required detail sheets).

Strategy 4. By October 1, 2015 develop a background brief on smoking among pregnant women and household exposure of children, including potential strategies and ESMs. Include results of the following 4 activities:

- Activity 1. Summarize information about barriers and contributing factors to smoking among pregnant women and household exposure of children.
- Activity 2.Analyze and summarize available data (Oregon and/or national) on smoking among pregnant women and household exposure of children, including demographics and characteristics of populations at risk.
- Activity 3. Conduct a review of evidence-based/informed strategies and measures related to smoking among pregnant women and household exposure of children, their cost, effectiveness for different populations, etc. (Build on MCHB evidence briefs).
- Activity 4. Conduct a survey of Oregon Title V implementing partners and stakeholders to solicit information about the strategies that they or their community partners are using, or would like to see Title V use to reduce

smoking among pregnant women and children's household exposure.

Strategy 5. By January 1, 2016 Title V priority team and Title V leadership identify one or more strategies, associated measures (ESMs), and a data collection/tracking plan for Title V's work on smoking in Oregon.

- Activity 1. Determine target populations.
- Activity 2. Gather additional community input related to potential strategies/ESMs and their appropriateness, acceptability and viability - particularly from communities at highest risk.
- Activity 3. Priority team integrates community input and hones the list of recommended strategies to no more than 4 – including both state and local level.
- Activity 4. Priority team presents strategy/ESM recommendations to December 2015 stakeholder meeting(invitees tbd).
- Activity 5. State Title V leadership and priority teams make final determination of strategies and ESMs to be implemented.

Strategy 6. By February 1, 2016 local implementing partners select which 2-4 Title V national performance measures and associated strategies they will implement using Title V funds.

- Activity 1. State and local Title V partners establish parameters for strategy selection, implementation, and ESM tracking/reporting.
- Activity 2. Local implementing partners incorporate their chosen NPMs and ESMs into their Title V MCH report/plan due to the state by March 1.

Strategy 7. By March 30, 2016 state and local level implementation of evidence-informed strategies and tracking of ESMs begins.

- Activity 1. By January 30, simple template for LHD and tribal Title V annual report and plan developed.
- Activity 2. During February and March state and local implementing partners identify TA, workforce development and other needs related to implementation.
- Activity 2. During February and March State and locals Title V partners establish and test systems for collecting ESMs.

Strategy 8. April 1, 2016 through September 30, 2016 implement state and local level strategies and collect/track outcomes through monitoring of ESMs and NPMs. Revise objectives, strategies and ESMs as needed.

2015/2016 Plan – State performance measure (SPM) development

Objective: Develop state performance measures in the areas of: 1) food insecurity; 2) trauma, toxic stress and ACEs; and 3) culturally and linguistically responsive MCH services to address Oregon's priority needs #2 (improve maternal, infant and child nutrition), # 8 (increase safe and nurturing relationships and stable, attached families), and #9 (improve health equity and reduce maternal, child and adolescent health disparities).

Strategy 1. By October 2015, align state MCH staffing with new Block Grant 3.0 priorities and develop a state performance measure work group consisting of a lead/coordinator for each of the 3 priority areas, research analyst, and additional subject matter experts.

Strategy 2. By December 2015 recruit local partners to participate in State Performance measure work group(s).

Strategy 3. By January 2016 Launch state performance measure work group to guide development of the state performance measures and related strategic plans.

Strategy 4. By March 2016, develop a background brief on each state priority area, including recommended performance measure(s), partnerships, and strategies. Include results of the following activities:

- Activity 1. Research and summarize information about the priority areas including available data (Oregon

and/or national) and potential performance measures as well as demographics of populations at risk, key strategic partners and potential strategies.
- Activity 2. Explore strategic partnerships and opportunities for Title V in each state priority area.

Strategy 5. During March 2016, hone potential performance measures and strategies using community and stakeholder input.

Strategy 6. By April, 2016 select one state performance measure each for food insecurity, toxic stress/trauma and ACEs, and culturally and linguistically responsive services.

Strategy 7. During June – September 2016, engage stakeholders and communities to develop a strategic plan for Title V's work in each state priority area.

Strategy 8. Begin implementation of strategic plan for each SPM by October 2016.

Cross-Cutting/Life Course - Annual Report

NPM-13 A) Percent of women who had a dental visit during pregnancy

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	56.7	57.5	58.4	59.2	60.1

NPM-13 B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	77.0	78.3	78.7	79.2	79.6

NPM-14 A) Percent of women who smoke during pregnancy

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	9.9	9.6	9.4	9.1	8.8

NPM-14 B) Percent of children who live in households where someone smokes

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	20.9	20.4	19.9	19.4	18.9

2014 Report - Oral health preventive visit

State Performance Measure 4: Percent of children less than 4 years of age on Medicaid who received preventive dental services from a dental provider in the year.

Report on strategies and activities October 2013 – present:

The First Tooth project was transitioned to the Oregon Oral Health Coalition (OrOHC) in late 2012. The Oral Health Program continues to provide technical assistance and support to OrOHC regarding the evaluation plan and data collection and analysis.

The Oral Health Program continues to promote First Tooth as a model for clinical providers to provide dental services to its members. To help integrate First Tooth into Oregon's Medicaid system, the Oral Health Program applied for a four-year federal HRSA grant in February 2015 - Perinatal and Infant Oral Health Quality Improvement Expansion Grant Program. The goal of the grants is to develop a sustainable, comprehensive system of care for Oregon's Medicaid population that fully integrates oral health policies and evidence-based practices for pregnant women and infants. The integration model is based on three key focus areas:

1. Collaborate with Coordinated Care Organizations (CCOs) to establish organizational policies that promote and support provision of dental services to infants during well-child visits; risk assessment and provision of oral health information to pregnant women during prenatal care visits; and provision of dental services, both preventive and restorative, for pregnant women.

2. Provide First Tooth training for medical and dental providers to implement evidence-based oral health practices for pregnant women and infants.

3. Collaborate with programs such as the Oregon WIC program, Home Visiting programs, and Oregon MothersCare to create continuity of oral health care from pregnancy, into infancy, and on into adulthood.

Plan for upcoming work through September 2015:

The Oral Health Program will continue to provide technical assistance and support to the Oregon Oral Health Coalition (OrOHC) regarding the evaluation plan and data collection and analysis. The Oral Health Program will also collaborate with Coordinated Care Organizations (CCOs) to integrate First Tooth into their systems of care. If the HRSA grant application is approved, grant activities will begin in August 2015. The program will also work with the newly hired OHA Dental Director to develop and implement the new Title V ESMs related to preventive oral health.

Critical partnerships:

In 2014, a broad group of oral health advocates and stakeholders in Oregon including the Oregon Health Authority's Oral Health Program, the Oregon Oral Health Coalition, and the Oregon Oral Health Funders Collaborative published the Strategic Plan for Oral Health in Oregon: 2014-2020. The Strategic Plan is comprised of three priority areas where action-oriented objectives and strategies have been defined:

- Priority Area 1: Infrastructure
- Priority Area 2: Prevention and Systems of Care
- Priority Area 3: Workforce Capacity

Several of the main strategies in priority area 2 address expanding First Tooth and ensuring that pregnant women and young children receive oral health services. The Oral Health Program will continue to collaborate with advocates and stakeholders to integrate First Tooth into a variety of settings.

2014 Report: Dental sealants

National Performance Measure 09: Percent of third grade children who have received protective sealants on at

least one permanent molar tooth.

Report on strategies and activities October 2013 – present:

The Oral Health Program's statewide School-based Dental Sealant Program served 159 schools during the 2013-14 school year. Local sealant programs served 227 schools. Together, 77.7% of the eligible schools were served in Oregon - schools where at least 50% of the students are eligible for the federal Free-and-Reduced Lunch (FRL) Program.

During the current 2014-15 school year, the Oral Health Program's statewide School-based Dental Sealant Program is serving 152 schools and local sealant programs are serving 248 schools. Together, 80% of the eligible schools are being served in Oregon.

During 2014, we saw an increase in the number of local community-based programs currently providing or interested in providing dental sealants in a school-based setting. The Oregon Metrics and Scoring Committee - the entity responsible for determining the data indicators and metrics that will be utilized by Coordinated Care Organizations (CCOs) to measure performance in Oregon's Medicaid system - finalized only one dental health metric as an incentive measure beginning in 2015: Children ages 6-9 & 10-14 who received a sealant on a permanent molar tooth, regardless of whether the sealant was provided by a dentist or non-dentist. This was in response to the Oral Health Program's 2012 Smile Survey that indicated that 52% of 6- to 9-year-olds in Oregon had already had a cavity.

Historically, there has been no avenue to ensure consistent, high-quality services are being provided to schools and children. As part of a federal HRSA workforce grant that ends in August 2015, the Oral Health Program has piloted a voluntary certification program where local programs can be certified after receiving training and signing a Memorandum of Understanding (MOU). Certification provides schools with assurance that a minimum set of standards will be met while delivering services. It also:

- Ensures evidence-based practices are being followed;
- Increases coordination of services and data collection at a statewide level; and
- Increases the opportunity to leverage resources within a community.

As of May 2015, two certification trainings have been provided and at least two local dental sealant programs have been certified.

The Oral Health Program continues to accomplish activities outlined in the HRSA workforce grant. We are still piloting the use of Expanded Practice Dental Hygienists (EPDHs) providing additional preventive services in schools. An evaluation project comparing 10 control schools, 10 regular dental sealant program schools, and 10 expanded services schools is in its second and final year. We are piloting collecting data electronically on iPads in the field - five hygienists and 68 schools are being served on an iPad. We are also conducting an incentives project that is measuring the effectiveness of various incentives to increase parent permission return rates.

Plan for upcoming work through September 2015:

The Oral Health Program will be promoting the voluntary certification program for local dental sealant programs. We will also be working to change the statewide School-based Dental Sealant Program for the 2015-16 school year in response to the dental sealant metric:

- Expand the program to include schools where 40% of the students are eligible for the FRL Program.
- Transition more schools to local sealant programs.
- Provide sealants on second permanent molars to children in middle schools (6th and 7th grades).

With these changes, the Oral Health Program will be able to serve the same number of schools it has been serving.

The Oral Health Program will finalize activities from the HRSA workforce grant. Reports will be developed that summarize the findings from the EPDH expanded services evaluation and incentives project. In August 2015, the calibration training for the statewide program will include instruction on the iPad. All of our hygienists will be using iPads for electronic data collection during the 2015-16 school year.

Critical partnerships:

In 2014, a broad group of oral health advocates and stakeholders in Oregon including the Oregon Health Authority's Oral Health Program, the Oregon Oral Health Coalition, and the Oregon Oral Health Funders Collaborative published the Strategic Plan for Oral Health in Oregon: 2014-2020. The Strategic Plan is comprised of three priority areas where action-oriented objectives and strategies have been defined:

- Priority Area 1: Infrastructure
- Priority Area 2: Prevention & Systems of Care
- Priority Area 3: Workforce Capacity

Several of the main strategies in priority area 2 address expanding dental sealant programs and evidence-based, best practice oral health programs in schools. The Oral Health Program will continue to collaborate with stakeholders and local school-based dental sealant programs to increase the number of children that have dental sealants.

2014 Report: Smoking in pregnancy

National Performance Measure 15: Percent of women who smoke in the last three months of pregnancy.

Report on strategies and activities October 2013 – present:

Cessation screening and counseling continue to be offered through local public health programs including: family planning; home visiting; Oregon Mothers Care (OMC); and WIC. All public health programs receive training and technical assistance in delivering tobacco education and quitting support to pregnant women. This spring, Oregon's tobacco program offered 5As training in combination with training on motivational interviewing.

Tobacco messages for women, including print and electronic media, continue to be included in OMC and WIC materials, the Oregon Prenatal and Newborn Resource Guide as well as through promotion of Text4baby. Oregon's tobacco program has launched a recent media campaign that targeted Spanish speakers, American Indian/Alaska Native (AI/AN) populations and pregnant women. For January and February 2015, participants calling the Spanish quitline or accessing the Spanish quitline website increased 150% compared to January and February 2014. For the same reporting period, increases were also seen among AI/AN populations (61% increase). However, Quitline activity among pregnant women has not increased or decreased from the previous year suggesting a different strategy is necessary for this population.

Surveillance of perinatal tobacco use and cessation continued through PRAMS surveys. Monitoring and evaluation of client data from the statewide data system (ORCHIDS) was used by nurse home visiting programs for quality improvement initiatives and program planning activities.

The MCH Section is working to collaborate and build partnerships with Oregon's Tobacco Prevention and Education Program (TPEP). Oregon TPEP has formed a Tobacco Use and Pregnant Women Work Group that is promoting collaboration with maternal and child health programs at the local level. Oregon's Quitline has recently started to offer more intensive services for pregnant and postpartum callers. In addition, the Public Health Division has identified tobacco cessation as a priority in its most recent strategic plan. The MCH section is participating in a division-wide group charged with developing and implementing an action plan.

The Oregon Collaborative Improvement & Innovation Network (CoIIN) to Reduce Infant Mortality chose tobacco cessation as one of its strategies to improve birth outcomes. The Oregon team has identified 2 tribal health clinics

for pilot sites where quality improvement science will be used to support referral to evidenced based smoking cessation programs and delivering culturally-specific cessation messages.

Plan for upcoming work through September 2015:

The Oregon CoIIN team will continue to participate in collaborative learning sessions and develop activities aimed at tobacco cessation among pregnant and postpartum women receiving care at tribal health clinics.

Public health programs including family planning, home visiting, OMC and WIC will continue to receive training and technical assistance in delivering tobacco education and quitting support to pregnant women.

Critical partnerships:

Partnerships with the state's tobacco program, local health departments, the Oregon CoIIN team and tribal clinics are essential for this work.

Other Programmatic Activities

In addition to investments in Title V priorities outlined above, Oregon's Title V program also invests in infrastructure activities including MCAH data infrastructure (epidemiology, assessment, evaluation, and informatics), communications, equity and workforce development, and partnerships to develop MCH policy and coordinated systems - which go beyond any one priority or domain. This work is essential to carrying out the core public health functions of Title V in support of Oregon's MCAH populations as outlined below. The work, housed within the Center for Prevention & Health Promotion (CP&HP) under the Title V MCH Director, and the Oregon Center for Children and Youth with special Health Needs (OCCYSHN) under the CYSHCN Director, is described below.

Policy and system development

- **MCH** - The Title V program's work in policy and system development includes support for adolescent health staff working on coordinated school health, confidentiality of adolescent health services across systems, and providing adolescent health expertise to cross-agency and community policy and systems initiatives. Title V MCH policy staff work with multiple agency and health system partners to improve quality, coordination and accessibility of a broad range of MCH services and policy initiatives that impact health and development of the population. Positions supported include the Title V Director, and the MCH Policy Lead/Title V coordinator, as well as staff working on intimate partner violence, ACEs, perinatal access and quality of care, and a range of child health policy initiative.
- **CYSHCN** - OCCYSHN works in system and policy development in support of genetic licensure, nutrition services payment and a coordinated and integrated system of care. OCCYSHN staff in the position of Systems & Policy Specialist (TBD) is assigned the responsibility to coordinate systems development initiatives within these specific areas and the general responsibility for tracking and reporting on legislative activity of interest to CYSHCN. Also, OCCYSHN is highly involved with the Oregon Commission on Autism Spectrum Disorder (OCASD) and efforts to improve services and systems of care for individuals with Autism Spectrum Disorders. OCCYSHN's medical consultant serves on the OCASD. OCCYSHN participates on the Oregon Home Visiting Steering Committee to provide input and advice to the MIECHV home visiting grant in relation to the needs of CYSHCN.

Communications, outreach and community engagement

- **MCH** - Title V supports a state level health education and communications specialist who works on dissemination of MCH data and educational messaging, as well as cultural and linguistic accessibility of MCH

materials, and communications consultation to Local Public Health Authorities. Title V also supports two MCH specialists at Oregon's 211info line to provide MCH warm-line information and referrals, as well as enhanced anticipatory guidance and linkage to services for MCH clients.

- **CYSHCN** - Title V supports a Communication Coordinator who works on dissemination of CYSHCN data and information as well as cultural and linguistic accessibility of CYSHCN materials. OCCYSHN supports FTE of the ORF2FHIC Project Coordinator to outreach to families around the state on behalf of Title V.

Epidemiology, assessment, evaluation and informatics

- **MCH** - Title V supports the MCH epidemiologist, research analysts, data management and informatics staff who conduct research, surveillance and epidemiology (including PRAMS, PRAMS2, BRFSS, Oregon Healthy Teens surveys), needs assessment, evaluation and data collection/management and MCH data dissemination functions across MCH populations and programs.

- **CYSHCN** - OCCYSHN has successfully initiated a strong programmatic unit specializing in assessment and evaluation. This has greatly increased OCCYSHN's capacity for program evaluation, research, data management, and quality improvement. OCCYSHN supports a Coordinator, Research Associate, Data Analyst and several interns. Title V CYSHCN also supports opportunities for engaging a summer GSEP (Graduate Student of Epidemiology Program) intern to conduct research project utilizing PRAMS and PRAMS 2 data. The GSEP intern assisted in the analysis of preliminary needs assessment data and drafting a summary of the results. The activities performed by the GSEP were incorporated into OCCYSHN's final needs assessment.

Health equity and workforce development

- **MCH** - Title V is integrating a health equity focus into all its MCH work across population domains and functions. This includes creating MCH infrastructure to support health equity through policies and guidelines, workforce development, community engagement, communications, data collection and dissemination, and culturally and linguistically responsive services.

- **CYSHCN** - OCCYSHN has a community consultant with a trained specialty in cultural competency who will spearhead planning and development of health equity efforts in the new Block Grant priority areas. OCCYSHN maintains a strong partnership with the OHSU Leadership Education in Neurodevelopmental and Related Disabilities (LEND) program. The FIN Coordinator works with the LEND Family Mentoring Program to match students with Parent Mentors and as Family Faculty. LEND Family Faculty helps to identify and mentor a Family Trainee to participate in the 10 month training program and provides family perspectives in LEND activities. OCCYSHN partners with the Pediatric Residency Training program at OHSU Doernbecher Children's Hospital to educate pediatric residents about the CaCoon program and community health as part of their Child Advocacy and Community Health (CACH) rotation.

Infrastructure and finance

- **MCH** - Title V provides infrastructure support for management, as well as fiscal, communications and clerical staff that support both the grants management functions and clerical support needs of the Title V Director and

other Title V staff.

- **CYSHCN** - OCCYSHN provides infrastructure support for management, as well as fiscal and clerical staff that support both the grants management functions and clerical support needs of the Title V CYSHCN Director and other Title V CYSHCN staff.

Partnerships with other MCHB-supported programs

- **MCH** - Title V works partnership with a variety of other MCHB-supported programs, including in many cases sharing offices and organizational infrastructure. Section II.B.2.c. describes these partnerships and collaborations.

- **CYSHCN** - Title V CYSHCN also invests in infrastructure that goes beyond any one priority or domain. This work is essential to successful implementation of the core public health functions of Title V CYSHCN in impacting the CYSHCN population.

II.F.2 MCH Workforce Development and Capacity

II.F.2. MCH Workforce Development and Capacity

Workforce strengths, capacity/development needs of MCH Staff

Oregon's MCH workforce strengths include an experienced and dedicated workforce that continually demonstrates creativity and flexibility in the face of changing systems and funding. On the local level, MCH staff and programs are both deeply connected to community needs and integrated into local systems of health care and education, making them a vital voice for MCH population health in many policy and planning processes. Needs assessment section II.B.2.ii. further describes the strengths and needs of Oregon's MCH workforce on both the state and local levels.

Despite its many strengths, Oregon's Title V program is also experiencing significant challenges related to MCH workforce capacity at both the state and local levels. During FY 13, state level MCH staffing capacity was reduced by 40%, and local MCH grants from the state were reduced by 30% due to reduced flexible state public health funding for MCH. In addition, state level MCH capacity has been further reduced during the past year by new state agency approval processes which require all hiring to be approved by the OHA Director's office. Currently, when staff retire, resign or are promoted, their positions have not been approved to fill. In addition, renewal of temporary and limited duration positions now require exception approval from the OHA Director's Office. These new processes are having a negative impact on State level Title V workforce capacity which is unrelated to funding. No vacancies have been approved to fill since February 2015 and MCH currently has 7 vacant positions, with additional vacancies anticipated in the coming months. Finally, agency-wide layoffs of management classification employees have just been implemented, resulting in the loss of two additional Title V positions – the MCH epidemiologist and the MCH operations and finance coordinator.

Local Health Departments each have unique circumstances and workforce challenges. However, high numbers of retirements among long-term MCH and Public Health nurses, combined with budget constraints and limited recruitment pools are a common concern around the State.

Actions to build MCH workforce capacity

MCH workforce development needs are addressed through a variety of mechanisms on both the state and local levels. Workforce capacity-building efforts, which reflect the changing MCH landscape in Oregon, have been a central focus of workforce development efforts over the past year including: health system transformation, equity cultural/linguistic responsiveness, and early childhood/home visiting.

- State MCH staff have individual employee development plans and attend conferences, trainings, university courses, or other development opportunities to meet the goals of those plans. State staff have the opportunity to participate in a state government leadership academy, as well as the Northwest Center for Public Health Leadership Institute's year-long fellowship program.

- Title V sponsors or supports a variety of workforce development activities throughout the year which are available to both state and local MCH staff. This year, Title V and WIC co-sponsored a two-day Bridges out of Poverty training attended by 200 state and local staff from a wide range of MCH. Title V also co-sponsors a series of lectures each year with OHSU's Center for Women's Health. This year's theme was Fertility, Reproduction and Sexuality, and included lectures on the affordable care act and reproductive health; challenges facing adolescent girls; adoption and reproductive technology, and sexuality and gender. Title V is also disseminating and sponsoring discussion of the Raising of America series.

- The state MCH program is also active in mentoring MCH students through internships, as well as participating as a training site for maternal and child health epidemiologists from around the country. The program has hosted five 2-year MCH epidemiology fellows through the Council of State and Territorial Epidemiologists (CSTE) in recent years. In addition, four of CDC's Epidemic Intelligence Service (EIS) fellows have done major projects with the Oregon MCH program since 2010. During 2014, Master's and undergraduate students from Oregon Health and Sciences University and Portland State University completed internships with the state MCH program.

- Local MCH programs receive ongoing technical assistance and training through state MCH nurse consultants, program, policy, and research staff, and nutrition consultants. A critical area of consultation for the past year has been the development of relationships and contracts between local public health and the CCOs for delivery of MCH services. State MCH has worked closely with local MCH leadership to develop both the tools and skills necessary to manage those transitions.

- The home visiting program has an active workforce development component which includes: building a set of core competencies (including cultural and linguistic competencies) for home visitors, developing an Infant Mental Health Endorsement (IMH-E) for Oregon, providing regional home visitor trainings, and partnering to offer home visiting workforce development as a part of other conferences and trainings. In support of the IMH-E the program provided 40 scholarships for home visitors to attend the Spring and Summer sessions of the Introduction to Infant Mental Health course at Portland State University. Regional trainings are being provided quarterly to Early Learning Hub districts through a partnership with Trauma-Informed Oregon at PSU. Staff have developed and delivered a home visiting track at several training venues including the Parent Education Institute and the Association for Education of the Young Child (AEYC) Conference planned for October. Intensive training in Motivational Interviewing (MI), and training for working with parents who may demonstrate developmental delays are being developed. A partnership with the Transformation Center's Child Well Being

unit will coordinate the Training of Trainers (ToTs) to include home visitors for delivery of the ASQ developmental screening (part of the ECCS grant).

- Another critical and ongoing consultation/workforce development activity has been the training of new MCH supervisors and staff as they are hired to replace retiring staff in local health departments around the state. This training is conducted through a combination of state public health orientation trainings and individualized consultation delivered on site or by phone.

- The Oregon MothersCare program provides quarterly training and ongoing technical assistance to staff in local health departments across the state to facilitate enrollment in Oregon Health Plan (OHP) and other forms of health insurance, and access to prenatal services.

- Local level MCH programs also serve as critical training sites for the emerging MCH workforce in Oregon. Local MCH programs serve as field placement sites for nursing students as well as high school, undergraduate and graduate students – providing critical exposure to public health career opportunities.

OCCYSHN Workforce Development and capacity

OCCYSHN experienced staff turnover during 2014-15. Two administrative staff accepted new positions at other institutions. The Senior Nurse Consultant, focusing on systems and policy issues and program development, retired. OCCYSHN hired 3 new staff: an Administrative Assistant, a part-time Data Entry Student Worker, and a new Community Consultant out-stationed in Medford. Assessment & Evaluation (A&E) hired a PhD student on an as-needed basis, to enter and analyze data from OCCYSHN's needs assessment. All OCCYSHN staff develop annual goals for professional development and participate in annual performance reviews.

OCCYSHN partners with the OHSU/Institute on Developmental Disabilities (IDD) Child Development & Rehabilitation Center (CDRC) to further policy, systems of care, provider and parent preparation in the care of CYSHCN. The partnership prioritizes care coordination, behavioral health, medical consultation, feeding and nutrition, genetics, and high-risk infant care and follow-up. This partnership allows OCCYSHN to draw on the clinical expertise of the CDRC and thus strengthen the overall capacity of OCCYSHN's efforts.

CYSHCN and their families come to the CDRC from all counties in Oregon. CDRC serves CYSHCN and their families to assure a family-centered, team based, interdisciplinary care model involving many health specialists evaluating a child on the same day, and developing a holistic integrated diagnostic summary and recommendations for families. CDRC's approach assists families in "pulling all of the pieces together" for their CYSHCN, many who have complex needs. CDRC maintains a patient and family centered interdisciplinary care model due in large part to the ongoing partnership with Oregon's Title V program for CYSHCN. A major emphasis of the CDRC model of tertiary care center practice is on care coordination, including the development of care plans incorporating community systems and services and direct communications to community based health specialists, including public health (CaCoon) nurses and primary health care providers.

OCCYSHN's co-location and coordination with the University Centers for Excellence in Developmental Disabilities (UCEDD), LEND and Oregon's Office for Citizens with Developmental Disabilities (OCDD) programs strengthens its capacity to address the workforce related needs of CYSHCN, including children with disabilities and their families through partnership in the education of pre-service students as well as community providers.

OCCYSHN has determined there is a strong need for training of care coordinators as well as healthcare providers and community-based services providers in the use of shared care planning for CYSHCN. CYSHCN receiving services across multiple systems benefit from a shared care plan that includes the family as the center of the plan and incorporates all of the members of the child/youth's care team.

II.F.3. Family Consumer Partnership

II.F.3. Family/Consumer Partnership

Oregon's MCH program is committed to building the capacity of women, children and youth, including those with special health care needs to partner in decision making for the Title V program. Special efforts are made at each juncture of assessment, planning, policy development, and program implementation to include representatives of communities experiencing disparities – and to engage families and consumers in ways that are culturally and linguistically accessible. State and local efforts to build and strengthen family/consumer partnerships include:

- The Title V Needs Assessment engaged families and consumers through a variety of mechanisms. Fifty-three community assessments conducted in Oregon over the past 3 years were analyzed to ensure that the voices and concerns of families across Oregon were reflected in the needs assessments. Although funding/staffing constraints precluded conducting family focus groups, listening sessions were held with parenting educators working in rural and minority communities, Tribal representatives, as well as Regional Equity Coalition members, to engage them in defining the needs of their MCH communities. Participants in each of those groups included family members as well paraprofessional and professional staff.
- The Title V program, in partnership with the MIECHV and LAUNCH programs have made parent engagement a priority through the Title V parenting support priority, the LAUNCH grant implementation, and the home visiting system development work.
    - Project LAUNCH (a SAMHSA funded federal grant) used parent cafés, meaningful dialogues led by parent hosts, as a methodology to promote parent engagement and parent leadership, in several communities across Oregon. The goals of the parent cafés were to listen to and learn from the parents that participated in the parent cafés, promote protective factors in the participating parents, and develop leadership skills in the parents who were trained to facilitate these parent cafés as parent hosts.
    - The analysis of the parent cafés were resoundingly positive from both the parents that participated in the cafes, and the organizations that sponsored the cafés. Three of the parent hosts shared their experiences about hosting parent cafes at a statewide Parenting Educator's Conference.
    - One of the sites that implemented parent cafés found the process to be so successful in authentically

engaging parents and developing parent leadership that they are developing a parent train the trainer approach to expanding parent cafés in their community.
    - A parent survey is being fielded to all participating parents in MIECHV programs to ask them about their interest in parent engagement and leadership.
    - The MIECHV systems contractors have the opportunity to apply for additional resources ($5000) in the form of a contract amendment for implementation of parent engagement strategies. Contractors will be required to demonstrate how they intend to promote parent engagement and leadership strategies that align with local initiatives and organizational efforts, such as parent cafes, parents anonymous, Oregon Family Support Network (OFSN), etc.
- Oregon Early Hearing Detection and Intervention program (EHDI) engages families of infants with hearing loss in all phases of the program:
    - EDHI assures that families of infants newly diagnosed with hearing loss are offered ongoing informational and emotional support through our staff Family Support Coordinator and EHDI-contracted, trained parent guides.
    - EHDI actively recruits parents to participate on the legislatively mandated EHDI Advisory Committee, where they provide their valued guidance and perspective on program and policy decisions.
    - EHDI performed an extensive survey of parents of infants diagnosed with hearing loss in 2013 to learn about their experiences, system successes and opportunities for improvement.
    - EHDI has performed a comprehensive review of all communications to parents and families, including letters, brochures, resource guides, and our website, for improved literacy level and translation to Spanish language.
- The Center for Prevention and Health Promotion has multiple advisory groups which rely on community and consumer representatives to develop policies and programs. These include: the WIC Advisory Committee, Oregon Partners to Immunize Children, Immunization Advisory Committee, Genetics Advisory Committee, Teen Pregnancy Prevention Task Force, the Youth Sexual Health Task Force.
- Local Title V programs are administered through local health departments and tribes in each county in Oregon, and all have unique approaches to family/consumer partnership that meet the specific needs of their communities. Consumers are engaged in needs assessment, program development and quality assurance in local Title V programs through community meetings, advisory boards, surveys, etc.
- Family and consumer engagement will be a cornerstone of Oregon's work to develop NPM strategies and our three state-specific performance measures to address Oregon's identified MCH needs over the coming year. Engagement of communities experiencing disparities will be especially important in developing effective strategies to address the health equity and culturally/linguistically responsive services' needs.
- The Adolescent Health Program has a focus on engaging youth in the development and implementation of their policies and programs.
    - Adolescent and School Health (AHS) Programs developed a Youth Participatory Action Research (YPAR) Curriculum for use in youth-serving organizations, schools, or local public health departments. ASH has provided small grant funding to pilot the YPAR curriculum to a small number of youth serving organizations and school based health centers, with a focus on mental health. The ASH is partnering with the Institute for Community Research to evaluate the effectiveness of the YPAR Curriculum to inform future use.
    - SBHC mental health expansion funding supports the development of SBHC youth advisory councils (YACs) across the state.

OCCYSHN

OCCYSHN ensures family partnership in all OCCYSHN activities. It partners with 19 Family Liaisons (FLs), parents

of CYSHCN, as members of the CCN and ASD teams.

All FLs serve on **non-profit and government agency committees and boards**. Most notably, 3 FLs, in their private capacity, serve on local CCO Consumer Advisory Councils to advocate for CYSHCN. OCCYSHN family staff serves on advisory committees for the Oregon Home Visiting System redesign, OPIP, Emergency Medical Services for Children, the Medicaid Ombuds Advisory Committee, and OCDD. The SOS grant's 2 state advisory committees include parents to ensure a family perspective.

The OCCYSHN FIN Coordinator participated on the 2015 OCCYSHN **strategic planning team** and development of the OCCYSHN Block Grant state plan.

Three FLs are on **clinical quality improvement (QI) teams.** FLs bring the family perspective and peer-to-peer support to families served by each clinical team. ORF2FHIC and OCCYSHN link FLs to activities and groups that work to improve the systems of care for CYSHCN and their families.

FIN and ORF2FHIC educate families of CYSHCN on how to **effectively partner with professionals** in policy and program development and QI. FIN collaborates with CDRC programs, including LEND, to ensure family participation in decision-making, family-centered and culturally competent services and systems of care. The FIN Coordinator is also the LEND Family Discipline Director. To increase collaboration between family groups, ORF2FHIC and FIN coordinate a quarterly meeting of family groups to provide training and outreach information to families.

OCCYSHN received input from family staff in the development of its **2015 needs assessment.** Family staff provided guidance in language for the parent and youth survey, and was integral to disseminating the surveys to families across the state. The FIN Coordinator participates as a member of the **block grant development and review team.**

The ORF2FHIC Project Coordinator, in partnership with OCCYSHN, **develops family tip sheets and other materials.** The cultural broker, also a parent, translates materials into Spanish which is then reviewed by another native Spanish-speaking FL prior to publication. Translation of selected materials into Russian will begin in 2015.

Advocating for CYSHCN and their families is woven into all aspects OCCYSHN FIN and ORF2FHIC. FLs on CCN and ASD teams advocate for the families. The FIN Coordinator as LEND Family Faculty, requires all LEND trainees to be trained in and complete an advocacy plan. ORF2FHIC provides training for parents on advocating for their child's special health needs.

II.F.4. Health Reform

II.F.4. Health Reform

Overview of Health Reform in Oregon

Oregon's health system transformation, guided by the triple aim: better health, better care, and lower costs, has been underway since 2011. The Oregon Health Authority, within which the Title V program is housed, is the key agency tasked with responsibility for implementing Federal health reform as well as Oregon's health system transformation. Title V is a partner in supporting key elements of Health Reform in Oregon including: Medicaid expansion, rollout of Oregon's Coordinated Care Organizations and Transformation Center; the Maternal, Infant and Early Childhood

Home visiting program (MIECHV), coordination of services for children and youth with special health care needs, as well as enrollment in coverage through the health insurance exchange (formerly Cover Oregon).

Oregon's Medicaid Expansion and Demonstration

Oregon was one of 27 states to accept federal funding, expanding access to the Oregon Health Plan (OHP), the state's Medicaid program. Oregon also received a waiver from the Centers for Medicare and Medicaid Services (CMS) that allowed for "fast-track" enrollment, through which OHA pre-screened and recruited Medicaid-qualified participants of the Supplemental Nutrition Assistance Program (SNAP) and parents of children enrolled in the OHP. Fast-track enrollment complemented other outreach efforts, and by the second quarter of 2014 OHP enrollment had increased by approximately 360,000 individuals compared to enrollment a year earlier. In 2012, CMS approved Oregon's 1115 Medicaid Demonstration for transformation of the Oregon Health Plan. Through the Demonstration, Oregon is accountable for bending the cost curve for Medicaid by 2% in the first 2 years, while improving access and quality of care for Medicaid clients. Title V's work to ensure access and coordinate systems of care for MCH populations on Medicaid includes linking women to prenatal care (Oregon MothersCare, 211info, etc); anticipatory guidance and referrals for women and children through home visiting, childcare and schools; and policy and system development work on both the state and local levels.

Coordinated Care model

Coordinated Care Organizations (CCOs) are at the center of Oregon's health system transformation. Sixteen Coordinated Care Organizations (CCOs) have been established since 2012. The CCOs coordinate physical, mental, and dental health care for Medicaid clients with a focus on prevention and management of chronic disease, as well as increased health equity. The CCO model is designed to provide person-centered and coordinated care. CCOs are accountable for improving the health of their entire population, and have a global budget that grows at a fixed rate. Quarterly progress towards defined benchmarks, including 17 incentive metrics is being measured and shared publicly. In addition, each CCO has a community advisory council, a transformation plan, and a community improvement plan. Local Title V agencies are active partners with their CCOs in assessment, community prevention, and MCH service delivery.

The Oregon Health Authority's Transformation Center supports CCOs, and the adoption of the coordinated care model throughout the health care system. The Center also serves as a backbone structure for transformation efforts across health and early learning so all Oregon children are healthy and ready to learn. The Center administers the $45 million State Innovation Model (SIM) grant to test innovative approaches to improving health and lowering costs. One component of the grant funds local health department-CCO collaboration to improve community health. Title V partners with the MCH grantees of the SIM grant, as well as the Transformation Center to provide technical assistance, data, and consultation for MCH prevention and health promotion.

Health Insurance Exchange (formerly Cover Oregon)

One notable stumbling block in ACA implementation has been the failure of Oregon's state-run health insurance exchange, Cover Oregon. Oregon has now switched to using the healthcare.gov portal for enrollment in both Medicaid and QHPs. Title V has taken an active role in advocating for MCH populations, particularly pregnant women in the Medicaid enrollment process. System barriers and processing delays have caused significant barriers to both eligibility and access for pregnant women, and efforts to resolve these continue.

Home visiting system

Health reform has spurred transformation of Oregon's home visiting system, both through the expanded services and systems supported by the MIECHV grants, and the transformed Medicaid funding mechanisms associated with the implementation of the CCO model. Oregon has received 7 MIECHV grants including the formula, development, expansion and competitive grants, which are administered jointly with Title V through the MCH section. Together, MIECHV and Title V collaborate to strengthen the home visiting system in Oregon, develop the home visiting workforce, and expand evidence-based home visiting services. Oregon's traditional public health home visiting programs – Maternity Case Management, Babies First!, and CaCoon continue to provide services to families and communities not covered by MIECHV. The ability for LHDs to bill Medicaid for these services is changing however and in the future LHDs will need to contract with their local CCOs for reimbursement of home visiting services, rather than billing OHP directly. This is a major change for local MCH programs, and Title V is very actively involved in negotiating and supporting the transition together with the Conference of Local Health Officials and the office of Medicaid Assistance Programs (MAP).

Children, youth and families with special health needs

OCCYSHN, in partnership with the ORF2FHIC, provides training and updates on topics related to both public and private insurance to its FLs, including protections, appeals and navigation. Prior to the launch of Oregon's health insurance marketplace, FLs were trained in how the marketplace worked, how to access it, and how to answer families' questions and concerns about the health insurance marketplace. Since most families are insured, FLs focus on helping families utilize it to promote their children's health, with emphasis on the 25 Preventative Health Services for Children. In helping families navigate insurance, FLs utilize the ORF2FHIC's collection of resources and information, such as family tip sheets, appeals and grievances tool-kits, and web-based materials from the Oregon Insurance Division Consumer and Business Services. As part of quality improvement, FLs were asked to complete a competency activity related to the ACA and Oregon-specific health care policies. In addition, three FLs serve on local Coordinated Care Organization (CCO) Consumer Advisory Councils.

OCCYSHN is collaborating and consulting with several CCOs in relation to systems and services development on behalf of CYSHCN, focused on community-based health teams and ASD identification teams.

II.F.5. Emerging Issues

II.F.5. Emerging Issues

In addition to examining Oregon's MCH needs related to current state Title V priorities and the new National Priority/Performance Measures, Oregon's Title V Needs Assessment explored emerging MCH needs. Seven issues that were most commonly identified across needs assessment data sources (including a scan of 53 community assessments and health improvement plans, partner and provider surveys, community stakeholder listening sessions, expert panel and webinars, key informant interviews, demographic and health data, and state/national policy forums) were further explored as emerging issues for Oregon. These included: mental health for CYSHCN; adolescent mental health, depression and suicide; drug abuse and misuse; food insecurity; toxic stress and trauma, culturally and linguistically responsive services; and systems coordination and integration. Three of these issues: toxic stress and trauma, culturally and linguistically responsive services, and food insecurity will become the focus of Oregon's state performance measure development over the next year.

Mental health services for CYSHCN

Accessing mental health services is a significant issue for CYSHCN and their families in Oregon. Nationally, the most commonly reported service that was needed for CYSHCN but not received was mental health care or counseling. A study found that 38% of families of CYSHCN that were enrolled in Medicaid had a child with a mental health problem in need of treatment (Agency for Healthcare Research and Quality, 2009). Slightly more than one-quarter of Oregon's CYSHCN ages 2 to 17 years needed mental health care in the 12 months prior to the survey (NS-CSHCN, 2009-10). The National Standards for the Systems of Care for CYSHCN, Access to Care Standard, asserts that the system have the capacity to ensure CYSHCN geographical and timely access to appropriate primary and specialty services, including mental health services. Oregon has a shortage of mental and behavioral providers for CYSHCN, especially in rural/frontier communities. This shortage causes long wait times for children to be screened for ASD. In addition, insurance often will not reimburse for the mental health services. The majority of parents who responded to OCCYSHN's needs assessment reported that autism-specific therapies and mental and behavioral health care were difficult to access.

Adolescent mental health, depression and suicide

In Oregon, suicide is the second leading cause of death for 10-19 year-olds, and 15% of adolescents report having considered suicide in the past 12 months. One third of girls and one fifth of boys report being depressed in the past year, and LGBTW youth are more likely both to report depression and to contemplate suicide. Mental health was one of the most frequently mentioned unmet MCH needs in both the scan of community assessments and the partner and provider survey. Key Title V partners including the Oregon legislature, Public Health Division, Addictions and Mental Health, community agencies and CCOs all share a commitment to work together to improve adolescent mental health.

Drug misuse/abuse

Drug misuse/abuse was among the most frequently mentioned unmet MCH need among the community assessments and MCH partner survey respondents. Marijuana is legal in Oregon as of July 1st, and little is known about the health impacts of marijuana on MCH populations. Never-the-less, public health will have a role in providing guidance on use in pregnancy/postpartum, protection of children from unintentional poisoning, and prevention of youth initiation. Oregon also has a high rate of non-medical opioid use and parental drug/alcohol use is a factor in nearly half of child abuse cases and cases of children entering foster care.

Food insecurity

Access to adequate and nutritious food is critical to perinatal and child development, and influences health throughout the life course. However, over one quarter (27%) of Oregon children are food insecure. Rural communities, communities of color and single-parent families have higher rates of food insecurity. Food insecurity is recognized as a key driver of poor MCH health, and was among the most frequently mentioned topics that needs assessment participants thought should be added to the Oregon's Title V priorities.

Toxic Stress, trauma and ACEs

Toxic stress and trauma in pregnancy and childhood have lifelong impact on health across multiple domains. The risk

for inter-generational exposure and impact is significant. Furthermore, exposure to adverse childhood experiences (ACEs) is common, and risk for poor health outcomes increases with multiple ACEs. This topic ranked first for impact on health and most common unmet MCH need in the Title V needs assessment. A public health approach to toxic stress and trauma includes strategies for prevention, promoting resilience, and providing effective care and treatment for people who have experienced toxic stress and trauma.

Culturally and linguistically responsive service

Elimination of health inequities is at the foundation of improving the health of MCH population. Culturally and linguistically responsive services and systems are a key component to address health equity. Oregon's increasing diversity highlights the need to address culturally and linguistically responsive MCH/CYSHCN services. Language access and/or culturally relevant services were among the top 3 issues raised in each of the systems and forces of change sessions of the Needs Assessment, and will need to be a focus of both Title V and health systems transformation work if improvements in MCH population health are to be realized.

Cross-system coordination

Cross-system coordination (including care coordination) is recognized as key to providing comprehensive, community-based, family-centered care to all MCH/CYSHCN populations. Oregon's health and early learning systems transformation creates new opportunities/changes the landscape for MCH Title V service coordination across systems. Coordination and integration of services was the most frequently mentioned challenge in discussions about systems and forces of change. Continued work to ensure cross-system coordination will be needed across Title V and health systems as transformation progresses in the coming years.

II.F.6. Public Input

II.F.6 Public Input

The MCH Center for Prevention and Health Promotion (CP&HP) and Oregon Center for Children and Youth with Special Health Needs (OCCYSHN) involve communities, stakeholders, and program participants, including family consultants, in policy and program decision-making at many levels. MCH assessment data, priorities, strategies and performance measure trends and outcomes, are regularly presented and reviewed by stakeholders and Title V implementing partners across Oregon. Title V engages and solicits input from local public health, tribal health, community-based organizations, primary care, and safety-net providers and consumers in both the 5-year needs assessment and ongoing strategy development and implementation throughout the Block Grant cycle. Mechanisms through which input is solicited include: websites (PHD and OCCYSHN), surveys, community listening sessions, webinars, online discussion forums, sessions held at conferences and partner meetings, advisory groups, and inter-agency committees and task forces. An overview of the strategies used by both branches of Title V to solicit stakeholder and public input during the needs assessment and grant development process are described below.

Center for Prevention & Health Promotion (CP&HP) Title V MCH Public Input Process

The process of developing and conducting the 5 year MCH Needs Assessment, and subsequently developing the 2016-2020 Title V priorities for Oregon involved an extensive process of public input and stakeholder engagement which spanned 18 months.

- **Needs Assessment Planning:**

Representatives of all implementing partners (state, local, and tribal) were engaged through an advisory group to guide development of the needs assessment and prioritization process over an 18 month period. Each was responsible for gathering input from and communicating with their constituencies, and for being their voice at the planning table.

- **Needs Assessment implementation:**
  The needs assessment was designed to maximize engagement of wide array of MCH stakeholder voices with scarce resources. Over 1,600 people participated directly including 743 in the Oregon Center for Children and Youth with Special Health Needs' assessment and 857 in the MCH Section's assessment. Pre-existing community assessment results were used to further broaden input from diverse stakeholders. Needs assessment public input was solicited through the following methods:
  - A scan was conducted of results from 53 recent community assessments across Oregon, to identify MCAH needs that communities had already identified.
  - Surveys of 750 MCAH and 554 CYSHCN Providers and Partners assessed needs related to proposed, existing, and emerging priorities; as well as MCH workforce and other capacity issues. Survey respondents (healthcare, public health, early care and education, social service providers, community advocates, etc.) addressed importance, potential for MCH impact, potential to address equity, and alignment with partners in each priority area. (See Attachment 3 for demographics of survey respondents)
  - Stakeholder and community input on issues related to infrastructure, partnerships, systems, and Oregon's changing MCH landscape was solicited through: an online discussion forum, stakeholder listening sessions, key informant interviews, a webinar, and a CYSHCN stakeholder panel. Over 140 community partners, stakeholders and family representatives took part in these sessions.

- **Selection of Title V priorities:**
  Two half-day Stakeholder meetings were held to develop recommendations for Title V Block Grant priorities. (Day 1 – national priorities; Day 2 – current and emerging state priorities). Stakeholders were invited to participate representing key constituencies including: local public health, Oregon tribes, adolescent health, maternal and child health, children with special health needs, mental health, early education, and Medicaid. Needs Assessment findings were presented; data tools, selection parameters and criteria were provided; and stakeholder input was used to develop recommendations for prioritizing Oregon's Title V work in the coming grant cycle.

- **Dissemination of Needs Assessment findings and Title V priorities**
  - CP&HP has a website for resources and public comment on the Block Grant and the Five-Year Needs Assessment priorities. The website and public comment can be found at http://public.health.oregon.gov/HealthyPeopleFamilies/DataReports/MCHTitleV/Pages/index.aspx
  - Title V leadership and staff have been presenting the new Block Grant 3.0 priorities, and soliciting input on the priorities as well as on strategic measure development at partner and community meetings since March. Presentations and community engagement will continue as we move into strategic development and throughout the grant cycle.

- **Engagement and input for strategy and strategic measure development**
  - Community and partner engagement, and broader solicitations of public input will continue as the Title V

program moves into the strategy and ESM/SPM development, and implementation over the next year. Anticipated engagement and input opportunities will be through community and partner meetings, web postings, surveys and focus groups, and development of an advisory group and priority teams that include state and local partners as well as family representatives.

- Additional information about family and consumer engagement strategies is provided in section II.F.3.

A graphic presentation summarizing all phases of stakeholder engagement and input in the Needs Assessment process is available at: http://prezi.com/zy_sf3dogqtb/?utm_campaign=share&utm_medium=copy&rc=ex0share

Oregon Center for Children and Youth with Special Health Needs (OCCYSHN) Public Input Process

OCCYSHN engaged partners and key stakeholders to provide input to OCCYSHN's five-year needs assessment. OCCYSHN conducted group discussions and shared preliminary needs assessment results with CaCoon public health nurses and nurse supervisors during CaCoon's regional development meetings during fall 2014. Around 70 CaCoon staff attended. The purpose of these discussions were to understand the types of needs families of CYSHCN working with CaCoon staff, experiences in coordinating care for CYSHCN in their communities, and perceptions of what "coordinated care for CYSHCN" should look like. In addition to discussions with CaCoon nurses, OCCYSHN held a Key Stakeholder Panel to facilitate a discussion focused on the needs of CYSHCN and the capacity of Oregon's system of services to address those needs. Needs assessment results were also shared with participants. Eighteen professionals participated and represented a variety of organizations including allied health care, coordinated care organizations, education, mental health, parents, primary health care, and tertiary care. Participants also recommended priority areas of focus for OCCYSHN for the next 5 years.

In April 2015, a two-day family gathering/leadership training was convened for OCCYSHN family staff at which input into the Title V Block Grant and OCCYSHN's needs assessment, was received. Twenty-one family staff attended. OCCYSHN presented needs assessment results and discussed with family staff best methods for disseminating the results to stakeholders around the state in a meaningful manner. The input process also provided opportunities for discussion of issues facing Oregon families of CYSHCN including adequacy of insurance, health care financing, adequacy of screening and diagnostic services, specialty care, and other unmet needs. The information collected will inform program planning and evaluation efforts over the next fiscal year.

The ORF2FHIC, administered from within OCCYSHN, conducts family listening sessions around the state to collect information about family experiences with health services, delivery, gaps, and access. In 2014, 17 family listening sessions were conducted in 5 rural communities and 10 urban/suburban communities. Input from these sessions was included in the OHA Maternal and Child Health Section's environmental scan of assessments, which was conducted to better understand the status of maternal and child health care needs in Oregon as part of the Title V needs assessment. In addition, input is shared with OCCYSHN and Family Voices.

A summary of Block Grant activities, written for the general audience, is posted on OCCYSHN's website: http://www.ohsu.edu/xd/outreach/occyshn/publications/index.cfm. The website also provides a link by which ongoing feedback, about how OCCYSHN can best serve Oregon CYSHCN, can be received.

II.F.7. Technical Assistance

II.F.7. Technical Assistance

Care Coordination (CC) for CYSHCN – Learning Community Development Consultation Background: Medical Home is 1 of 2 national priorities selected for OCCYSHN. Effective CC within an integrated and coordinated system of care is best practice to assure CYSHCN receive the services they need. OCCYSHN seeks to develop a statewide **Oregon CYSHCN CC Learning Community** to meet the professional development needs of an emerging workforce of care coordinators. "Care Coordinators" serving CYSHCN are being hired by Primary Care Physicians, Coordinated Care Organizations (CCOs), tertiary care centers, and public health. We aim to ensure a prepared and supported emerging workforce. Expert consultation will support this effort.

Purpose: Consultation on development of a CC Learning Community to support Medical Home.

Performance Measure: Current NPM 3

Proposed TA source: Jeanne W. McAllister, MHA, Center for Medical Home Improvement

Estimated budget: $3000 for travel, lodging, consultation

Estimated dates: 10/2015 - 6/2016

Outcomes Measurement of Community Health Teams

Background: OCCYSHN seeks to adapt its CCN program to the transforming healthcare and education systems to better serve CYSHCN. For 20 years, Community Care Network (CCN) has provided a point of "wrap-around" for CYSHCN in rural areas with unresolved complex issues. CCN teams have become a community "CYSHCN team" to serve a population beyond children referred to CCN. Outcomes are challenging to measure. OCCYSHN seeks TA in developing an evaluation plan to measure outcomes of the model, and to support assessment of the communities' capacity to continue with and/or adapt the CCN model within the changing context of healthcare.

Purpose: Receive consultation on outcomes evaluation and sustainability of CCN model as CYSHCN Community Health Team

Performance Measure: Current NPM 4 & 5

Proposed TA source: Sara S. Bachman, Ph.D. Health & Disability Working Group, Boston Univ

Estimated budget: $3000

Estimated dates: 10/2015 – 06/2016

Systems Change: Systems of Services for CYSHCN – Long Term Planning Consultation

Background: Oregon is in the midst of a state initiated healthcare system transformation resulting in significant changes in healthcare delivery and organizational structures at the state and regional levels. Cross cutting systems transformation are occurring in education and public health. These transformations are happening simultaneously with changes occurring in healthcare and MCH at the federal level. This time presents opportunities and challenges to the systems of care that have been established over the past 20 years on behalf of CYSHCN. OCCYSHN seeks consultation on long term planning for responding to these changes at the highest policy and agency level within the state.

Purpose: Support OCCYSHN in long term planning and to systems level change

Performance Measure: New NPM 11 & 12

Proposed T.A. Source: Artemis Consulting, Portland Oregon

Estimated Budget: $5,000

Estimated Dates: 10/2015 – 6/2016

Parent and Consumer Engagement for ESM development

Parent and consumer engagement, particularly within communities experiencing disparities, will be critical to development of effective strategies and ESMs. The Title V program will contract with established leaders in target communities to engage families in the development of strategies and ESMs to reach Oregon's newly identified Title V performance measures.

Purpose: The purpose of this activity is to enhance the effectiveness of Title V strategies and ESMs by engaging MCH consumers and family members in their development.

Performance Measure*:* all

Proposed TA source, estimated budget and dates: TBD

Tribal Engagement

The MCH program would like to do a special engagement process with our tribal partners. As of 2009, Oregon Tribes are statutorily entitled to request Title V funds to serve the MCAH needs of their populations. Five of the 9 federally recognized tribes in Oregon currently participate as Title V grantees. Development of culturally specific strategies to address new Title V priorities will be critical for success in tribal communities. In order to do this, we will seek a contracted consultant with experience and expertise working with Oregon tribes to work with our new MCH Tribal liaison to develop tribal strategies and ESMs.

Purpose: 1) To strengthen the relationship between Oregon's Title V agency and Oregon Tribes in relation to MCH needs; and 2) to engage Tribal MCH stakeholders as partners in developing culturally appropriate strategies and ESMs.

Proposed TA source, estimated budget and dates: TBD

Culturally and linguistically responsive MCH services

Oregon's Title V program has identified health equity and improved access to culturally and linguistically responsive MCH services as one of our state specific priorities. Technical assistance is sought to assess the current status of culturally and linguistically responsive services in Oregon's MCH program, and identify potential strategies and an appropriate state performance measure. A contractor with expertise in developing standards and supports to enhance the cultural and linguistic responsiveness of MCH/CYSHCN systems and services will be sought.

Purpose: To enhance the cultural and linguistic responsiveness of Oregon's MCH/CYSHCN systems and services.

Proposed TA source, estimated budget and dates: TBD

III. Budget Narrative

	2012		2013	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$ 6,148,111	$ 6,092,903	$ 6,100,000	$ 5,878,363
Unobligated Balance	$ 0	$ 0	$ 0	$ 0
State Funds	$ 12,694,490	$ 35,862,151	$ 12,894,577	$ 20,035,607
Local Funds	$ 0	$ 0	$ 0	$ 0
Other Funds	$ 8,123,706	$ 2,801,110	$ 10,810,637	$ 6,228,865
Program Funds	$ 0	$ 0	$ 0	$ 0
SubTotal	$ 26,966,307	$ 44,756,164	$ 29,805,214	$ 32,142,835
Other Federal Funds	$ 65,973,783	$ 61,438,025	$ 66,858,842	$ 47,644,449
Total	$ 92,940,090	$ 106,194,189	$ 96,664,056	$ 79,787,284

	2014		2015	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$ 5,889,022	$ 6,122,592	$ 6,062,381	$
Unobligated Balance	$ 0	$ 0	$ 0	$
State Funds	$ 13,544,943	$ 8,922,561	$ 12,402,451	$
Local Funds	$ 0	$ 6,360,256	$ 0	$
Other Funds	$ 3,500,210	$ 5,655,785	$ 7,541,766	$
Program Funds	$ 0	$ 0	$ 0	$
SubTotal	$ 22,934,175	$ 27,061,194	$ 26,006,598	$
Other Federal Funds	$ 66,741,931		$ 68,190,634	$
Total	$ 89,676,106	$ 27,061,194	$ 94,197,232	$

Due to limitations in TVIS this year, States are not able to report their FY14 Other Federal Funds Expended on Form 2, Line 9. States are encouraged to provide this information in a field note on Form 2.

	2016	
	Budgeted	Expended
Federal Allocation	$ 6,122,592	$
Unobligated Balance	$ 0	$
State Funds	$ 8,272,612	$
Local Funds	$ 6,360,256	$
Other Funds	$ 5,583,777	$
Program Funds	$ 0	$
SubTotal	$ 26,339,237	$
Other Federal Funds	$ 33,903,443	$
Total	$ 60,242,680	$

III.A. Expenditures

Oregon's expenditure report represents the totals from both Title V Agencies -- Oregon Health Authority-Public Health Division-Center for Protection and Health Promotion (CP&HP) and the Oregon Center for Children and Youth with Special Health Needs (OCCYSHN) in the Institute for Developmental Disabilities (IDD) at Oregon Health and Sciences University (OHSU). The total State Funds and Other Funds expenditures include expenditures identified as benefitting the health of the maternal, child and adolescent populations. These expenditures are funded by the state general fund and other non-Federal organizations. The expenditures are within CP&HP, though, not specifically under the organizational authority of the Title V director. Other Funds also includes the Newborn Metabolic Screening Program conducted in the Public Health Lab of the Public Health Division. Though this program is not in CP&HP, it provides a critical public health service to the MCH population and is included to align with the National Performance Measures and Form 4. The Local Funds expenditures include expenditures at the County level that are funded by Patient Fees, Third Party Insurance and County General Fund. Funding from Medicaid is excluded because of potential matching at the local level. Notes about the sources for the expenditures and budget are included in the Forms.

The allocation for the pyramid level of services is distributed according to the use of funds at the state level or the county level. Funds that are provided to county health departments and other local agencies are considered to be Enabling Services. Funds that are used at the State level, in CP&HP, are considered to be Public Health Services and Systems. There are no Direct Services expenditures.

The Oregon Center for Children and Youth with Special Health Needs reports its expenditures and includes the 30% Federal funds transferred from CP&HP to OCCYSHN along with matching OHSU state general funds. OCCYSHN's

community-based programs (CaCoon, Community Connections) are allocated approximately 40% in Enabling services and the remainder in Public Health Services and Systems for the federal MCH block grant and 100% in enabling services for the non-federal MCH block grant.

The Oregon Title V expenditures represent actual expenditures at the time of the report preparation.

In order to comply with the new reporting format, we thoroughly reviewed all expenditures in CP&HP to determine Oregon's total investment in the health of the maternal, child and adolescent populations. This resulted in several significant variances from the prior year's reported expenditures. State Fund expenditures are significantly less since the County expenditures are now included as Local Funds. Previous reports had the expenditures included in State Funds and Local Funds were zero. Also, State Funds were increased by a new legislative allotment of funds to fund the expansion of the School Based Health Centers of $1.95 million annually. Other Funds increased due to the review and inclusion of expenditures that were previously not considered. The largest of these is the tobacco cessation program, for which a percentage was included based on the portion of program services provided to the Title V population.

III.B. Budget

Oregon's budget report represents the projected totals from both Title V Agencies -- Oregon Health Authority-Public Health Division-Center for Protection and Health Promotion (CP&HP) and the OHSU Oregon Center for Children and Youth with Special Health Needs (OCCYSHN). The total State Funds and Other Funds budgets include projected expenditures identified as benefitting the health of the maternal, child and adolescent populations. These expenditures are funded by the state general fund and other non-Federal sources. The expenditures are within CP&HP, though, not specifically under the organizational authority of the Title V director. The majority of Other Funds is from the Newborn Metabolic Screening Program conducted in the Public Health Lab of the Public Health Division. Though this program is not in CP&HP, it provides a critical public health service to the MCH population and is included to align with the National Performance Measures and Form 4. The Local Funds budget includes expenditures at the County level that are funded by Patient Fees, Third Party Insurance and County General Fund. Funding from Medicaid is excluded because of potential matching at the local level. Other Federal Funds include Federal grants awarded to CP&HP that benefit the Title V population. The primary sources of these funds include the USDA Nutrition Program for Women, Infants and Children (WIC), the HRSA Maternal, Infant and Childhood Home Visiting program, and the Medicaid Title XIX match.

Oregon's Title V Program meets its 30%-30% minimum requirement by transferring 30% of the Oregon MCH Block Grant appropriation to the OCCYSHN for serving the children and youth with special health care needs. No administrative or indirect is retained by CP&HP prior to transfer. The required Maintenance of Effort for Oregon is $3,950,427, which is achieved through funds generated at the state and local levels that benefit the maternal and child health population. Also, the OCCYSHN budget includes the required 3:4 Title V match from state general funds through a state budget line item for the OHSU Child Development and Rehabilitation Center. CP&HP considers the cost allocation of central support services to represent Administrative costs. The 10% of the total budget limit is maintained by transferring excess expenses to the State General Fund. The 3:4 Title V match is achieved in the budget with projections of revenue from the State General Funds, county local funds including patient fees, local general funds, and non-Medicaid 3rd-party payments and other funds, mainly the newborn screening fees. In order to comply with the new reporting format, we thoroughly reviewed all expenditures in CP&HP in order to project Oregon's total investment in the health of the maternal, child and adolescent populations. This resulted in several significant variances from the prior year's budget. The State Fund budget is significantly less since the County

expenditures are now included as Local Funds. Previous reports had the expenditures included in State Funds and Local Funds were zero. Also, State Funds were increased by a new legislative allotment of funds to fund the expansion of the School Based Health Centers of $1.95 million annually. Other Funds increased due to the review and inclusion of funding sources that were previously not considered. The largest of these is the tobacco cessation program, for which a percentage was included based on the portion of program services provided to the Title V population.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - State of OR - CDRC DMAP 139056 4-1-14.pdf

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - OCCYSHN Needs Assessment Final Report_2015.pdf

Supporting Document #02 - OCCYSHN Program Overview and Partnerships_2015_FINAL.pdf

Supporting Document #03 - MCH Needs Assessment Final Report_2015 .pdf

Supporting Document #04 - Title V Needs Assessment Data Tools.pdf

Supporting Document #05 - Title V three Organizational Charts.pdf

VI. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Oregon

	FY16 Application Budgeted	FY14 Annual Report Expended
1. FEDERAL ALLOCATION	$ 6,122,592	$ 6,122,592
(Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)		
A. Preventive and Primary Care for Children	$ 2,732,690	$ 2,456,164
B. Children with Special Health Care Needs	$ 1,836,778	$ 1,836,778
C. Title V Administrative Costs	$ 612,259	$ 612,259
2. UNOBLIGATED BALANCE	$ 0	$ 0
(Item 18b of SF-424)		
3. STATE MCH FUNDS	$ 8,272,612	$ 8,922,561
(Item 18c of SF-424)		
4. LOCAL MCH FUNDS	$ 6,360,256	$ 6,360,256
(Item 18d of SF-424)		
5. OTHER FUNDS	$ 5,583,777	$ 5,655,785
(Item 18e of SF-424)		
6. PROGRAM INCOME	$ 0	$ 0
(Item 18f of SF-424)		
7. TOTAL STATE MATCH	$ 20,216,645	$ 20,938,602
(Lines 3 through 6)		
A. Your State's FY 1989 Maintenance of Effort Amount	$ 3,950,427	
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL	$ 26,339,237	$ 27,061,194
(Same as item 18g of SF-424)		
9. OTHER FEDERAL FUNDS		
Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS	$ 33,903,443	
(Subtotal of all funds under item 9)		
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL	$ 60,242,680	$ 27,061,194
(Partnership Subtotal + Other Federal MCH Funds Subtotal)		

	FY14 Annual Report Budgeted
1. FEDERAL ALLOCATION	$ 5,889,022
A. Preventive and Primary Care for Children	$ 3,403,852
B. Children with Special Health Care Needs	$ 1,776,707
C. Title V Administrative Costs	$ 412,232
2. UNOBLIGATED BALANCE	$ 0
3. STATE MCH FUNDS	$ 13,544,943
4. LOCAL MCH FUNDS	$ 0
5. OTHER FUNDS	$ 3,500,210
6. PROGRAM INCOME	$ 0
7. TOTAL STATE MATCH	$ 17,045,153

	FY16 Application Budgeted
9. OTHER FEDERAL FUNDS	
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning;	$ 2,467,376
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > MIECHV;	$ 4,492,685
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > SSDI;	$ 105,521
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > UNHSI;	$ 249,332
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Oral Health;	$ 246,417
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > PRAMS;	$ 142,927
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > EHDI;	$ 156,483
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prev. Edu.;	$ 417,295
Department of Health and Human Services (DHHS) > Health Resources and Services	$ 608,413

Administration (HRSA) > PREP;	
US Department of Agriculture (USDA) > Food and Nutrition Services > WIC;	$ 23,730,145
Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Medicaid Title XIX;	$ 1,286,849

Form Notes For Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**1. FEDERAL ALLOCATION**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**
	Field Note: This is based on the FFY 14 Notice of Award (NOA).	
2.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**
	Field Note: Based on the BG 3.0 guidance and 2016-2020 priorities, the Title V funds allocated for direct family planning services in FFY 2014 will be redistributed to preventive and primary care for children population group in FFY 2016. This the reason for the greater than 10% increase.	
3.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**
	Field Note: Transfering 30% of the Oregon MCH Block Grant appropriation to the OCCYSHN for serving the children with special health care needs.	
4.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**
	Field Note: CP&HP considers the 10% cost allocation of central support services to represent Administrative costs.	
5.	**Field Name:**	**2. UNOBLIGATED BALANCE**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**
	Field Note: Do not anticipate any unobligated funds.	

6.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**
	Field Note: State MCH matching funds include budgets identified as benefitting the health of the maternal, child, and adolescent populations. - State general funds in the CP&HP.	
7.	**Field Name:**	**4. LOCAL MCH FUNDS**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**
	Field Note: The Local MCH Funds budget includes revenues at the County level that are funded by county general funds, patient fees, third party insurance for services in local Title V agencies (county health departments).	
8.	**Field Name:**	**5. OTHER FUNDS**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**
	Field Note: Other Funds include the Newborn Screening Program conducted in the Public Health Lab of the Public Health Division. Though this program is not in CP&HP, it provides a critical public health service to the MCH population and is included to align with the National Performance Measures and Form 4.	
9.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children:**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: Based on the BG 3.0 guidance and 2016-2020 priorities, the Title V funds allocated for direct family planning services in FFY 2014 will be redistributed to preventive and primary care for children population group in FFY 2016. This the reason for the greater than 10% increase.	
10.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs:**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: Transfering 30% of the Oregon MCH Block Grant appropriation to the OCCYSHN for serving the children with special health care needs.	
11.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2014**

	Column Name:	**Annual Report Expended**
	Field Note: CP&HP considers the 10% cost allocation of central support services to represent Administrative costs. The 10% of the total budget limit is maintained by transferring excess expenses to the State general funds.	
12.	**Field Name:**	**2. UNOBLIGATED BALANCE**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: Do not anticipate any unobligated funds.	
13.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: State MCH matching funds include expenditures identified as benefitting the health of the maternal, child, and adolescent populations. - State general funds in the CP&HP.	
14.	**Field Name:**	**4. LOCAL MCH FUNDS**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: The Local MCH Funds includes revenues at the County level that are funded by county general funds, patient fees, third party insurance for services in local Title V agencies (county health departments).	
15.	**Field Name:**	**5. OTHER FUNDS**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: Other Funds also includes the Newborn Screening Program conducted in the Public Health Lab of the Public Health Division. Though this program is not in CP&HP, it provides a critical public health service to the MCH population and is included to align with the National Performance Measures and Form 4.	
16.	**Field Name:**	**1.FEDERAL ALLOCATION**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: This is based on the FFY 14 Notice of Award (NOA).	

Data Alerts:

None

Form 3a
Budget and Expenditure Details by Types of Individuals Served

State: Oregon

	FY16 Application Budgeted	FY14 Annual Report Expended
I. TYPES OF INDIVIDUALS SERVED		
IA. Federal MCH Block Grant		
1. Pregnant Women	$ 305,405	$ 277,755
2. Infants < 1 year	$ 31,179	$ 88,890
3. Children 1-22 years	$ 2,732,690	$ 2,456,164
4. CSHCN	$ 1,836,778	$ 1,836,778
5. All Others	$ 604,282	$ 850,747
Federal Total of Individuals Served	$ 5,510,334	$ 5,510,334
IB. Non Federal MCH Block Grant		
1. Pregnant Women	$ 788,642	$ 788,642
2. Infants < 1 year	$ 5,761,558	$ 5,833,566
3. Children 1-22 years	$ 11,336,714	$ 11,466,704
4. CSHCN	$ 1,380,925	$ 1,380,925
5. All Others	$ 948,806	$ 1,468,765
Federal Total of Individuals Served	$ 20,216,645	$ 20,938,602
Federal State MCH Block Grant Partnership Total	$ 25,726,979	$ 26,448,936

Form Notes For Form 3a:

None

Field Level Notes for Form 3a:

1.	**Field Name:**	**IA. Federal MCH Block Grant, 1. Pregnant Women**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**
	Field Note: Budgets are based on the 2015 actual (9 months) and projected (3 months) expenditures at the time the 2016 Block Grant Application was prepared.	
2.	**Field Name:**	**IA. Federal MCH Block Grant, 2. Infant < 1 Year**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**
	Field Note: Budgets are based on the 2015 actual (9 months) and projected (3 months) expenditures at the time the 2016 Block Grant Application was prepared.	
3.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1-22 years**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**
	Field Note: Budgets are based on the 2015 actual (9 months) and projected (3 months) expenditures at the time the 2016 Block Grant Application was prepared.	
4.	**Field Name:**	**IA. Federal MCH Block Grant, 4. CSHCN**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**
	Field Note: The Oregon Center for Children with Special Health Care Needs budget includes the 30% Title V federal funds transferred from the Oregon Health Authority, Public Health Division, Center for Prevention & Health Promotion to OCCYSHN.	
5.	**Field Name:**	**IA. Federal MCH Block Grant, 5. All Others**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**
	Field Note: Budgets are based on the 2015 actual (9 months) and projected (3 months) expenditures at the time the 2016	

Block Grant Application was prepared.

6.	**Field Name:**	**IB. Non Federal MCH Block Grant, 1. Pregnant Women**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**

Field Note:
Budgets are based on the 2014 expenditures at the time the 2016 Block Grant Application was prepared. These budget amounts include state, local, and other funds. The Legislative Approved Budget limitations for the 2015-17 biennium is not available.

7.	**Field Name:**	**IB. Non Federal MCH Block Grant, 2. Infant < 1 Year**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**

Field Note:
Budgets are based on the 2014 expenditures at the time the 2016 Block Grant Application was prepared. These budget amounts include state, local, and other funds. The Legislative Approved Budget limitations for the 2015-17 biennium is not available.

8.	**Field Name:**	**IB. Non Federal MCH Block Grant, 3. Children 1-22 years**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**

Field Note:
Budgets are based on the 2014 expenditures at the time the 2016 Block Grant Application was prepared. These budget amounts include state, local, and other funds. The Legislative Approved Budget limitations for the 2015-17 biennium is not available.

9.	**Field Name:**	**IB. Non Federal MCH Block Grant, 4. CSHCN**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**

Field Note:
The Oregon Center for Children with Special Health Care Needs budget includes the OCCYSHN matching State General and Other funds.

10.	**Field Name:**	**IB. Non Federal MCH Block Grant, 5. All Others**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**

Field Note:
Budgets are based on the 2014 expenditures at the time the 2016 Block Grant Application was prepared. These budget amounts include state, local, and other funds. The Legislative Approved Budget limitations for the 2015-17 biennium is not available.

11.	**Field Name:**	**IA. Federal MCH Block Grant, 1. Pregnant Women**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: Expenditures are based on the actual expenditures at the time the 2016 Block Grant Application was prepared. Final expenditures may differ from budgeted amounts reported two years earlier due to variation of the actual NOA and necessary adjustments made at the closing of the grant budget period.	
12.	**Field Name:**	**IA. Federal MCH Block Grant, 2. Infant < 1 Year**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: Expenditures are based on the actual expenditures at the time the 2016 Block Grant Application was prepared. Final expenditures may differ from budgeted amounts reported two years earlier due to variation of the actual NOA and necessary adjustments made at the closing of the grant budget period.	
13.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1-22 years**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: Expenditures are based on the actual expenditures at the time the 2016 Block Grant Application was prepared. Final expenditures may differ from budgeted amounts reported two years earlier due to variation of the actual NOA and necessary adjustments made at the closing of the grant budget period.	
14.	**Field Name:**	**IA. Federal MCH Block Grant, 4. CSHCN**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: The Oregon Center for Children with Special Health Care Needs expenditures includes the 30% Title V federal funds transferred from the Oregon Health Authority, Public Health Division, Center for Prevention & Health Promotion to OCCYSHN.	
15.	**Field Name:**	**IA. Federal MCH Block Grant, 5. All Others**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: Expenditures are based on the actual expenditures at the time the 2016 Block Grant Application was prepared. Final expenditures may differ from budgeted amounts reported two years earlier due to variation of the actual NOA and necessary adjustments made at the closing of the grant budget period.	

16.	**Field Name:**	**IB. Non Federal MCH Block Grant, 1. Pregnant Women**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: Expenditures are based on the actual expenditures at the time the 2016 Block Grant Application was prepared. Final expenditures may differ from budgeted amounts reported two years earlier due to variation state, local, and other expenditures not anticipated in the original budget.	
17.	**Field Name:**	**IB. Non Federal MCH Block Grant, 2. Infant < 1 Year**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: Expenditures are based on the actual expenditures at the time the 2016 Block Grant Application was prepared. Final expenditures may differ from budgeted amounts reported two years earlier due to variation state, local, and other expenditures not anticipated in the original budget.	
18.	**Field Name:**	**IB. Non Federal MCH Block Grant, 3. Children 1-22 years**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: Expenditures are based on the actual expenditures at the time the 2016 Block Grant Application was prepared. Final expenditures may differ from budgeted amounts reported two years earlier due to variation state, local, and other expenditures not anticipated in the original budget.	
19.	**Field Name:**	**IB. Non Federal MCH Block Grant, 4. CSHCN**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: The Oregon Center for Children with Special Health Care Needs expenditures includes the OCCYSHN matching state General and Other funds.	
20.	**Field Name:**	**IB. Non Federal MCH Block Grant, 5. All Others**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: Expenditures are based on the actual expenditures at the time the 2016 Block Grant Application was prepared. Final expenditures may differ from budgeted amounts reported two years earlier due to variation state, local, and other expenditures not anticipated in the original budget.	

Data Alerts:

None

Form 3b
Budget and Expenditure Details by Types of Services

State: Oregon

	FY16 Application Budgeted	FY14 Annual Report Expended
I. TYPES OF SERVICES		
IIA. Federal MCH Block Grant		
1. Direct Services	$ 0	$ 0
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 0	$ 0
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 0	$ 0
2. Enabling Services	$ 2,389,973	$ 1,910,541
3. Public Health Services and Systems	$ 3,732,619	$ 4,212,051
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		
Physician/Office Services		
Hospital Charges (Includes Inpatient and Outpatient Services)		
Dental Care (Does Not Include Orthodontic Services)		
Durable Medical Equipment and Supplies		
Laboratory Services		
Direct Services Total		$ 0
Federal Total	$ 6,122,592	$ 6,122,592

IIB. Non-Federal MCH Block Grant

1. Direct Services	$ 0	$ 0
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 0	$ 0
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 0	$ 0
2. Enabling Services	$ 18,758,278	$ 19,480,235
3. Public Health Services and Systems	$ 1,458,367	$ 1,458,367
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		
Physician/Office Services		
Hospital Charges (Includes Inpatient and Outpatient Services)		
Dental Care (Does Not Include Orthodontic Services)		
Durable Medical Equipment and Supplies		
Laboratory Services		
Direct Services Total		$ 0
Non-Federal Total	$ 20,216,645	$ 20,938,602

Form Notes For Form 3b:

None

Field Level Notes for Form 3b:

1.	**Field Name:**	**IIA. - 1. Direct Services**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**
	Field Note: The allocation for the pyramid level of services is distributed according to the use of funds at the state level or the county level. Funds that are provided to county health departments and other local agencies are considered to be Enabling Services. Funds that are used at the State level, in CP&HP, are considered to be Public Health Services and Systems. There are no Direct Services budgets.	
2.	**Field Name:**	**IIA. - 1. A. Preventive and Primary Care Services for all Pregnant Women,Mothers, and Infants up to Age One**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**
	Field Note: There are no Direct Services budgets.	
3.	**Field Name:**	**IIA. - 1. B. Preventive and Primary Services for Children**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**
	Field Note: There are no Direct Services budgets.	
4.	**Field Name:**	**IIA. - 1. C. Services for CSHCN**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**
	Field Note: There are no Direct Services budgets.	
5.	**Field Name:**	**IIA. - 2. Enabling Services**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**
	Field Note: Funds that are provided to county health departments and other local agencies are considered to be Enabling Services.	

6.	**Field Name:**	**IIA. - 3. Public Health Services and Systems**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**
	Field Note: Funds that are used at the State level, in CP&HP, are considered to be Public Health Services and Systems. There are no Direct Services budgets.	
7.	**Field Name:**	**IIB. - 1. Direct Services**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**
	Field Note: The allocation for the pyramid level of services is distributed according to the use of funds at the state level or the county level. Funds that are provided to county health departments and other local agencies are considered to be Enabling Services. Funds that are used at the State level, in CP&HP, are considered to be Public Health Services and Systems. There are no Direct Services budgets.	
8.	**Field Name:**	**IIB. - 1. A. Preventive and Primary Care Services for all Pregnant Women,Mothers, and Infants up to Age One**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**
	Field Note: There are no Direct Services budgets.	
9.	**Field Name:**	**IIB. - 1. B. Preventive and Primary Services for Children**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**
	Field Note: There are no Direct Services budgets.	
10.	**Field Name:**	**IIB. - 1. C. Services for CSHCN**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**
	Field Note: There are no Direct Services budgets.	
11.	**Field Name:**	**IIB. - 2. Enabling Services**
	Fiscal Year:	**2016**
	Column Name:	**Application Budgeted**

	Field Note: Funds that are provided to county health departments and other local agencies are considered to be Enabling Services.	
12.	**Field Name:**	**IIA. - 1. Direct Services**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: The allocation for the pyramid level of services is distributed according to the use of funds at the state level or the county level. Funds that are provided to county health departments and other local agencies are considered to be Enabling Services. Funds that are used at the State level, in CP&HP, are considered to be Public Health Services and Systems. There are no Direct Services expenditures.	
13.	**Field Name:**	**IIA. - 1. A. Preventive and Primary Care Services for all Pregnant Women,Mothers, and Infants up to Age One**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: There are no Direct Services expenditures.	
14.	**Field Name:**	**IIA. - 1. B. Preventive and Primary Services for Children**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: There are no Direct Services expenditures.	
15.	**Field Name:**	**IIA. - 1. C. Services for CSHCN**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: There are no Direct Services expenditures.	
16.	**Field Name:**	**IIA. - 2. Enabling Services**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: Funds that are provided to county health departments and other local agencies are considered to be Enabling Services.	
17.	**Field Name:**	**IIA. - 3. Public Health Services and Systems**

	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: Funds that are used at the State level, in CP&HP, are considered to be Public Health Services and Systems.	
18.	**Field Name:**	**IIB. - 1. Direct Services**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: The allocation for the pyramid level of services is distributed according to the use of funds at the state level or the county level. Funds that are provided to county health departments and other local agencies are considered to be Enabling Services. Funds that are used at the State level, in CP&HP, are considered to be Public Health Services and Systems. There are no Direct Services expenditures.	
19.	**Field Name:**	**IIB. - 1. A. Preventive and Primary Care Services for all Pregnant Women,Mothers, and Infants up to Age One**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: There are no Direct Services expenditures.	
20.	**Field Name:**	**IIB. - 1. B. Preventive and Primary Services for Children**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: There are no Direct Services expenditures.	
21.	**Field Name:**	**IIB. - 1. C. Services for CSHCN**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: There are no Direct Services expenditures.	
22.	**Field Name:**	**IIB. - 2. Enabling Services**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: Funds that are provided to county health departments and other local agencies are considered to be Enabling	

Services.

23.	**Field Name:**	**IIB. - 3. Public Health Services and Systems**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**

Field Note:
Funds that are used at the State level, in CP&HP, are considered to be Public Health Services and Systems.

Form 4

Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: Oregon

Total Births by Occurrence 45,714

1a. Core RUSP Conditions

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Propionic acidemia	45,714 (100.0%)	0	0	0 (0%)
Methylmalonic acidemia (methylmalonyl-CoA mutase)	45,714 (100.0%)	13	1	1 (100.0%)
Methylmalonic acidemia (cobalamin disorders)	45,714 (100.0%)	0	0	0 (0%)
Isovaleric acidemia	45,714 (100.0%)	18	0	0 (0%)
3-Methylcrotonyl-CoA carboxylase deficiency	45,714 (100.0%)	10	0	0 (0%)
3-Hydroxy-3-methyglutaric aciduria	45,714 (100.0%)	0	0	0 (0%)
Holocarboxylase synthase deficiency	45,714 (100.0%)	0	0	0 (0%)
ß-Ketothiolase deficiency	45,714 (100.0%)	2	0	0 (0%)
Glutaric acidemia type I	45,714 (100.0%)	9	0	0 (0%)
Carnitine uptake defect/carnitine transport defect	45,714 (100.0%)	16	1	1 (100.0%)
Medium-chain acyl-CoA dehydrogenase deficiency	45,714 (100.0%)	5	1	1 (100.0%)
Very long-chain acyl-CoA dehydrogenase deficiency	45,714 (100.0%)	23	1	1 (100.0%)
Long-chain L-3 hydroxyacyl-CoA dehydrogenase deficiency	45,714 (100.0%)	4	0	0 (0%)

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Trifunctional protein deficiency	45,714 (100.0%)	0	0	0 (0%)
Argininosuccinic aciduria	45,714 (100.0%)	0	0	0 (0%)
Citrullinemia, type I	45,714 (100.0%)	3	0	0 (0%)
Maple syrup urine disease	45,714 (100.0%)	3	1	1 (100.0%)
Homocystinuria	45,714 (100.0%)	7	0	0 (0%)
Classic phenylketonuria	45,714 (100.0%)	10	4	4 (100.0%)
Tyrosinemia, type I	45,714 (100.0%)	13	1	1 (100.0%)
Primary congenital hypothyroidism	45,714 (100.0%)	461	22	22 (100.0%)
Congenital adrenal hyperplasia	45,714 (100.0%)	23	5	5 (100.0%)
S,S disease (Sickle cell anemia)	45,714 (100.0%)	432	1	1 (100.0%)
S, βeta-thalassemia	45,714 (100.0%)	0	0	0 (0%)
S,C disease	45,714 (100.0%)	0	0	0 (0%)
Biotinidase deficiency	45,714 (100.0%)	4	0	0 (0%)
Critical congenital heart disease	45,714 (100.0%)	0	0	0 (0%)
Cystic fibrosis	45,714 (100.0%)	206	14	14 (100.0%)
Severe combined immunodeficiences	45,714 (100.0%)	59	3	3 (100.0%)
Classic galactosemia	45,714 (100.0%)	21	0	0 (0%)

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment

1b. Secondary RUSP Conditions

2. Other Newborn Screening Tests

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Newborn Hearing	45,714 (100.0%)	0	0	0 (0%)
Short Chain Acyl-CoA Dehydrogenase Deficiency	45,714 (100.0%)	22	2	2 (100.0%)
Malonic Aciduria	45,714 (100.0%)	67	0	0 (0%)
Hyperphenylalanemia	45,714 (100.0%)	2	2	2 (100.0%)
Carnitine palmitoyl transferase	45,714 (100.0%)	29	2	2 (100.0%)

3. Screening Programs for Older Children & Women

4. Long-Term Follow-Up

Long term follow up is not recorded at the Newborn Screening office. Oregon Health and Sciences University Metabolic clinic maintains the long term follow up database and patient records for metabolic patients in Oregon. Once any case is confirmed by newborn screening with all other disorders we close to short term follow up and leave the primary care provider to care for child. Specialists such as pediatric endocrinology will have their own records for long term monitoring.

Form Notes For Form 4:

None

Field Level Notes for Form 4:

1.	**Field Name:**	**Propionic acidemia - Positive Screen**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: There were no presumptive positive screens	
2.	**Field Name:**	**Propionic acidemia - Confirmed Cases**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: There were no confirmed cases	
3.	**Field Name:**	**Propionic acidemia - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: Since there were no confirmed cases, no cases were referred for treatment	
4.	**Field Name:**	**Methylmalonic acidemia (methylmalonyl-CoA mutase) - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: All confirmed cases were referred for treatment	
5.	**Field Name:**	**Methylmalonic acidemia (cobalamin disorders) - Positive Screen**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: There were no presumptive positive screens	
6.	**Field Name:**	**Methylmalonic acidemia (cobalamin disorders) - Confirmed Cases**
	Fiscal Year:	**2014**

	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: There were no confirmed cases	
7.	**Field Name:**	**Methylmalonic acidemia (cobalamin disorders) - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: Since there were no confirmed cases, no cases were referred for treatment	
8.	**Field Name:**	**Isovaleric acidemia - Confirmed Cases**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: There were no confirmed cases	
9.	**Field Name:**	**Isovaleric acidemia - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: Since there were no confirmed cases, no cases were referred for treatment	
10.	**Field Name:**	**3-Methylcrotonyl-CoA carboxylase deficiency - Confirmed Cases**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: There were no confirmed cases	
11.	**Field Name:**	**3-Methylcrotonyl-CoA carboxylase deficiency - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: Since there were no confirmed cases, no cases were referred for treatment	
12.	**Field Name:**	**3-Hydroxy-3-methyglutaric aciduria - Positive Screen**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**

	Field Note:	
	There were no presumptive positive screens	
13.	**Field Name:**	**3-Hydroxy-3-methyglutaric aciduria - Confirmed Cases**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note:	
	There were no confirmed cases	
14.	**Field Name:**	**3-Hydroxy-3-methyglutaric aciduria - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note:	
	Since there were no confirmed cases, no cases were referred for treatment	
15.	**Field Name:**	**Holocarboxylase synthase deficiency - Positive Screen**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note:	
	There were no presumptive positive screens	
16.	**Field Name:**	**Holocarboxylase synthase deficiency - Confirmed Cases**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note:	
	There were no confirmed cases	
17.	**Field Name:**	**Holocarboxylase synthase deficiency - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note:	
	Since there were no confirmed cases, no cases were referred for treatment	
18.	**Field Name:**	**ß-Ketothiolase deficiency - Confirmed Cases**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note:	

	There were no confirmed cases	
19.	**Field Name:**	**ß-Ketothiolase deficiency - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: Since there were no confirmed cases, no cases were referred for treatment	
20.	**Field Name:**	**Glutaric acidemia type I - Confirmed Cases**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: There were no confirmed cases	
21.	**Field Name:**	**Glutaric acidemia type I - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: Since there were no confirmed cases, no cases were referred for treatment	
22.	**Field Name:**	**Carnitine uptake defect/carnitine transport defect - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: All confirmed cases were referred for treatment	
23.	**Field Name:**	**Medium-chain acyl-CoA dehydrogenase deficiency - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: All confirmed cases were referred for treatment	
24.	**Field Name:**	**Very long-chain acyl-CoA dehydrogenase deficiency - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**

	Field Note: All confirmed cases were referred for treatment	
25.	**Field Name:**	**Long-chain L-3 hydroxyacyl-CoA dehydrogenase deficiency - Confirmed Cases**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: There were no confirmed cases	
26.	**Field Name:**	**Long-chain L-3 hydroxyacyl-CoA dehydrogenase deficiency - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: Since there were no confirmed cases, no cases were referred for treatment	
27.	**Field Name:**	**Trifunctional protein deficiency - Positive Screen**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: There were no presumptive positive screens	
28.	**Field Name:**	**Trifunctional protein deficiency - Confirmed Cases**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: There were no confirmed cases	
29.	**Field Name:**	**Trifunctional protein deficiency - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: Since there were no confirmed cases, no cases were referred for treatment	
30.	**Field Name:**	**Argininosuccinic aciduria - Positive Screen**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**

	Field Note:	
	There were no presumptive positive screens	
31.	**Field Name:**	**Argininosuccinic aciduria - Confirmed Cases**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note:	
	There were no confirmed cases	
32.	**Field Name:**	**Argininosuccinic aciduria - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note:	
	Since there were no confirmed cases, no cases were referred for treatment	
33.	**Field Name:**	**Citrullinemia, type I - Confirmed Cases**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note:	
	There were no confirmed cases	
34.	**Field Name:**	**Citrullinemia, type I - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note:	
	Since there were no confirmed cases, no cases were referred for treatment	
35.	**Field Name:**	**Maple syrup urine disease - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note:	
	All confirmed cases were referred for treatment	
36.	**Field Name:**	**Homocystinuria - Confirmed Cases**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note:	
	There were no confirmed cases	

37.	**Field Name:**	**Homocystinuria - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: Since there were no confirmed cases, no cases were referred for treatment	
38.	**Field Name:**	**Classic phenylketonuria - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: All confirmed cases were referred for treatment	
39.	**Field Name:**	**Tyrosinemia, type I - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: All confirmed cases were referred for treatment	
40.	**Field Name:**	**Primary congenital hypothyroidism - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: All confirmed cases were referred for treatment	
41.	**Field Name:**	**Congenital adrenal hyperplasia - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: All confirmed cases were referred for treatment	
42.	**Field Name:**	**S,S disease (Sickle cell anemia) - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: All confirmed cases were referred for treatment	
43.	**Field Name:**	**S, βeta-thalassemia - Positive Screen**

	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note:	
	There were no presumptive positive screens	
44.	**Field Name:**	**S, βeta-thalassemia - Confirmed Cases**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note:	
	There were no confirmed cases	
45.	**Field Name:**	**S, βeta-thalassemia - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note:	
	Since there were no confirmed cases, no cases were referred for treatment	
46.	**Field Name:**	**S,C disease - Positive Screen**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note:	
	There were no presumptive positive screens	
47.	**Field Name:**	**S,C disease - Confirmed Cases**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note:	
	There were no confirmed cases	
48.	**Field Name:**	**S,C disease - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note:	
	Since there were no confirmed cases, no cases were referred for treatment	
49.	**Field Name:**	**Biotinidase deficiency - Confirmed Cases**
	Fiscal Year:	**2014**

	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: There were no confirmed cases	
50.	**Field Name:**	**Biotinidase deficiency - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: Since there were no confirmed cases, no cases were referred for treatment	
51.	**Field Name:**	**Critical congenital heart disease - Positive Screen**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: There were no presumptive positive screens	
52.	**Field Name:**	**Critical congenital heart disease - Confirmed Cases**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: There were no confirmed cases	
53.	**Field Name:**	**Critical congenital heart disease - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: Since there were no confirmed cases, no cases were referred for treatment	
54.	**Field Name:**	**Cystic fibrosis - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: All confirmed cases were referred for treatment	
55.	**Field Name:**	**Severe combined immunodeficiences - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**

	Field Note: All confirmed cases were referred for treatment	
56.	**Field Name:**	**Classic galactosemia - Confirmed Cases**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: There were no confirmed cases	
57.	**Field Name:**	**Classic galactosemia - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: Since there were no confirmed cases, no cases were referred for treatment	
58.	**Field Name:**	**Short Chain Acyl-CoA Dehydrogenase Deficiency - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Other Newborn**
	Field Note: All confirmed cases were referred for treatment	
59.	**Field Name:**	**Malonic Aciduria - Confirmed Cases**
	Fiscal Year:	**2014**
	Column Name:	**Other Newborn**
	Field Note: There were no confirmed cases	
60.	**Field Name:**	**Malonic Aciduria - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Other Newborn**
	Field Note: Since there were no confirmed cases, no cases were referred for treatment	
61.	**Field Name:**	**Hyperphenylalanemia - Confirmed Cases**
	Fiscal Year:	**2014**
	Column Name:	**Other Newborn**
	Field Note:	

The number of presumptive positive screens equals the number of confirmed cases.

62.	**Field Name:**	**Hyperphenylalanemia - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Other Newborn**

Field Note:
All confirmed cases were referred for treatment

63.	**Field Name:**	**Carnitine palmitoyl transferase - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Other Newborn**

Field Note:
All confirmed cases were referred for treatment

Form 5a
Unduplicated Count of Individuals Served under Title V

State: Oregon

Reporting Year 2014

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	7,307	27.6	0.0	19.5	38.8	14.1
2. Infants < 1 Year of Age	3,188	65.1	0.0	8.0	2.5	24.4
3. Children 1 to 22 Years of Age	52,320	36.7	1.9	19.7	27.5	14.2
4. Children with Special Health Care Needs	9,413	59.7	0.0	38.4	1.9	0.0
5. Others	46,338	23.7	0.0	18.4	50.8	7.1
Total	118,566					

Form Notes For Form 5a:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2014**
	Field Note: Individuals served by Maternity Case Management, Oregon Mother's Care, and injury prevention activities.	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2014**
	Field Note: Individuals served by Babies First and injury prevention activities.	
3.	**Field Name:**	**Children 1 to 22 Years of Age**
	Fiscal Year:	**2014**
	Field Note: Individuals served by School Based Health Centers, Babies First, Family Planning for children <22 years of age (males and females), and injury prevention activities.	
4.	**Field Name:**	**Children with Special Health Care Needs**
	Fiscal Year:	**2014**
	Field Note: Number of children with special health care needs (CYSHCN) served in FY14 through direct and enabling services: CaCoon program, Community Connections Network (CCN), Zetosch Charitable Gift Fund, and CDRC clinical programs. Sources: ORCHIDS (Oregon Child Health Information Data Systems), OCCYSHN CCN database, OCCYSHN Zetosch database, CDRC clinics. Percentage of “Sources of Coverage” is based on the following categories: Public Insurance Only, Private/Other Insurance, and Uninsured. This is taken from ORCHIDS, CCN, and CDRC. Zetosch does not track insurance coverage.	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2014**
	Field Note: Family planning for reproductive women (22 to 54 years of age).	

Form 5b
Total Recipient Count of Individuals Served by Title V

State: Oregon

Reporting Year 2014

Types Of Individuals Served	Total Served
1. Pregnant Women	44,681
2. Infants < 1 Year of Age	44,681
3. Children 1 to 22 Years of Age	1,075,547
4. Children with Special Health Care Needs	198,222
5. Others	865,976
Total	2,229,107

Form Notes For Form 5b:

None

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women**
	Fiscal Year:	**2014**
	Field Note: Number of individuals served by Maternity Case Management, Maternal, Infant, and Early Childhood Home Visiting, Oregon Mothers Care, injury prevention activities, and the Special Supplemental Nutrition Program for Women, Infants, and Children. Total unduplicated number served = 54,303. This exceeds population number, therefore population number reported instead.	
2.	**Field Name:**	**Infants Less Than One Year**
	Fiscal Year:	**2014**
	Field Note: Number of individuals served by Newborn Screening, Early Hearing Detection & Intervention, Babies First, Maternal, Infant, and Early Childhood Home Visiting, and injury prevention activities. Total unduplicated number served = 92,128. This exceeds population number, therefore population number reported instead.	
3.	**Field Name:**	**Children 1 to 22 Year of Age**
	Fiscal Year:	**2014**
	Field Note: Number of individuals served by family planning for children < 22 years of age, Maternal, Infant, and Early Childhood Home Visiting, injury prevention activities, and the Special Supplemental Nutrition Program for Women, Infants, and Children.	
4.	**Field Name:**	**Children With Special Health Care Needs**
	Fiscal Year:	**2014**
	Field Note: Number of "Title V Total Served" is from the most recent 2011/12 National Survey of Children's Health CSHCN prevalence available at http://www.childhealthdata.org/browse/survey/results?q=2546&r=39. Estimate was forecasted to the 2014 population estimate of children birth - 21 years old (instead of ages 0-17) using Oregon Population Report (PSU) estimate, to better align with the population estimates of "Children 1-22" immediately above. Note: NS-CSHCN has been phased out, and prevalence of CSHCN was estimated from the modified NSCH.	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2014**
	Field Note: Number of women of reproductive age (22 to 54 years), served by family planning.	

Form 6

Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Oregon

Reporting Year 2014

I. Unduplicated Count by Race

	(A) Total All Races	(B) White	(C) Black or African American	(D) American Indian or Native Alaskan	(E) Asian	(F) Native Hawaiian or Other Pacific Islander	(G) More than One Race Reported	(H) Other & Unknown
1. Total Deliveries in State	44,681	36,908	980	527	2,216	312	1,597	2,141
Title V Served	6,374	4,826	202	178	176	96	111	785
Eligible for Title XIX	20,031	15,945	601	366	539	209	881	1,490
2. Total Infants in State	44,681	36,908	980	527	2,216	312	1,597	2,141
Title V Served	3,893	3,004	213	168	139	57	211	101
Eligible for Title XIX	20,031	15,945	601	366	539	209	881	1,490

II. Unduplicated Count by Ethnicity

	(A) Total Not Hispanic or Latino	(B) Total Hispanic or Latino	(C) Ethnicity Not Reported	(D) Total All Ethnicities
1. Total Deliveries in State	36,349	8,332	0	44,681
Title V Served	4,098	1,839	437	6,374
Eligible for Title XIX	14,088	5,943	0	20,031
2. Total Infants in State	36,349	8,332	0	44,681
Title V Served	2,284	1,114	495	3,893
Eligible for Title XIX	14,088	5,943	0	20,031

Form Notes For Form 6:

None

Field Level Notes for Form 6:

None

Form 7

State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: Oregon

	Application Year 2016	Reporting Year 2014
A. State MCH Toll-Free Telephone Lines		
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 211-0000 x6	(800) 211-0000 x6
2. State MCH Toll-Free "Hotline" Name	Maternal and Child Health	Maternal and Child Health
3. Name of Contact Person for State MCH "Hotline"	Emily Berndt	Emily Berndt
4. Contact Person's Telephone Number	(503) 416-2617	(503) 416-2617
5. Number of Calls Received on the State MCH "Hotline"		62,573
B. Other Appropriate Methods		
1. Other Toll-Free "Hotline" Names	211INFO	211INFO
2. Number of Calls on Other Toll-Free "Hotlines"		112,646
3. State Title V Program Website Address		
	www.211info.org	www.211info.org
4. Number of Hits to the State Title V Program Website		291,544
5. State Title V Social Media Websites		
	facebook.com/211info	facebook.com/211info
6. Number of Hits to the State Title V Program Social Media Websites		2,959

Form Notes For Form 7:

Line 1. Oregon's MCH warm line operates through our 211 information and referral system. The actual phone number is just 211, but the additional numbers were added in line 1 to accommodate TVIS data entry requirements for a 10-digit number. Reporting year line 5. The methodology used to collect and report State MCH hotline calls has changed this year. Previous years' data reflected all 211 info calls regardless of caller demographics. The number reported this year reflects only calls where caller identified as pregnant or had a child under 18. Reporting year line 6. Hits to social media websites include: 575 new likes Facebook, 2330 followers on Twitter, 54followers on Instagram.

Form 8
State MCH and CSHCN Directors Contact Information

State: Oregon

Application Year 2016

1. Title V Maternal and Child Health (MCH) Director

Name	Cate Wilcox, MPH
Title	Title V Director, MCH Section Manager
Address 1	800 NE Oregon St, Ste 825
Address 2	
City / State / Zip Code	Portland / OR / 97232
Telephone	(971) 673-0299
Email	cate.s.wilcox@state.or.us

2. Title V Children with Special Health Care Needs (CSHCN) Director

Name	Marilyn Sue Hartzell
Title	OCCYSHN, Title V-CSHN Director
Address 1	PO Box 574
Address 2	
City / State / Zip Code	Portland / OR / 97207
Telephone	(503) 494-6961
Email	hartzell@ohsu.edu

3. State Family or Youth Leader (Optional)

Name	
Title	
Address 1	
Address 2	
City / State / Zip Code	
Telephone	
Email	

Form Notes For Form 8:

None

Form 9
List of MCH Priority Needs

State: Oregon

Application Year 2016

No.	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure
1.	High quality, culturally responsive preconception, prenatal and inter-conception services.	New	
2.	Improved maternal, infant, child, adolescent and family nutrition.	New	
3.	Physical activity throughout the lifespan.	New	
4.	High quality, confidential, preventive health services for adolescents	New	
5.	High quality, family-centered, coordinated systems of care for children and youth with special health care needs.	New	
6.	Improved oral health for pregnant women and children.	New	
7.	Reduced tobacco use and exposure among pregnant women and children.	New	
8.	Safe and nurturing relationships; and stable, attached families.	New	State Performance Measure to be developed this year.
9.	Improved health equity and reduced MCH disparities.	New	State Performance Measure to be developed this year.

Form Notes For Form 9:

None

Field Level Notes for Form 9:

None

Form 10a
National Outcome Measures (NOMs)

State: Oregon

Form Notes for Form 10a NPMs and NOMs:

The objectives for this measure is projected based on the indicator data from the modified National Survey of Children's Health 2011-2012. For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010.

NOM-1 Percent of pregnant women who receive prenatal care beginning in the first trimester

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	76.4 %	0.2 %	33,898	44,400
2012	76.3 %	0.2 %	33,767	44,280
2011	75.5 %	0.2 %	33,717	44,671
2010	74.1 %	0.2 %	33,499	45,223
2009	72.6 %	0.2 %	33,917	46,698

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-1 Notes:

None

Data Alerts:

None

NOM-2 Rate of severe maternal morbidity per 10,000 delivery hospitalizations

Data Source: State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	125.0	5.5 %	513	41,053
2011	121.3	5.4 %	515	42,473
2010	132.5	5.5 %	572	43,167
2009	129.4	5.4 %	583	45,070
2008	115.9	5.0 %	538	46,412

Legends:
Indicator has a numerator ≤10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

NOM-2 Notes:

None

Data Alerts:

None

NOM-3 Maternal mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2009_2013	13.2	2.4 %	30	228,049
2008_2012	10.8	2.2 %	25	231,990
2007_2011	10.6	2.1 %	25	236,301
2006_2010	9.2	2.0 %	22	239,835

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

NOM-3 Notes:

None

Data Alerts:

None

NOM-4.1 Percent of low birth weight deliveries (<2,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	6.3 %	0.1 %	2,841	45,144
2012	6.2 %	0.1 %	2,769	45,047
2011	6.1 %	0.1 %	2,764	45,140
2010	6.3 %	0.1 %	2,865	45,528
2009	6.3 %	0.1 %	2,955	47,121

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-4.1 Notes:

None

Data Alerts:

None

NOM-4.2 Percent of very low birth weight deliveries (<1,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	1.0 %	0.1 %	442	45,144
2012	1.0 %	0.1 %	436	45,047

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011	1.0 %	0.1 %	443	45,140
2010	1.0 %	0.1 %	472	45,528
2009	1.0 %	0.1 %	479	47,121

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-4.2 Notes:

None

Data Alerts:

None

NOM-4.3 Percent of moderately low birth weight deliveries (1,500-2,499 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	5.3 %	0.1 %	2,399	45,144
2012	5.2 %	0.1 %	2,333	45,047
2011	5.1 %	0.1 %	2,321	45,140
2010	5.3 %	0.1 %	2,393	45,528
2009	5.3 %	0.1 %	2,476	47,121

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-4.3 Notes:

None

Data Alerts:

None

NOM-5.1 Percent of preterm births (<37 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	7.6 %	0.1 %	3,430	45,111
2012	7.5 %	0.1 %	3,388	45,008
2011	7.4 %	0.1 %	3,335	45,129
2010	7.9 %	0.1 %	3,599	45,512
2009	7.8 %	0.1 %	3,681	47,091

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-5.1 Notes:

None

Data Alerts:

None

NOM-5.2 Percent of early preterm births (<34 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	2.1 %	0.1 %	932	45,111
2012	2.0 %	0.1 %	899	45,008

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011	2.0 %	0.1 %	885	45,129
2010	2.1 %	0.1 %	945	45,512
2009	2.0 %	0.1 %	958	47,091

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-5.2 Notes:

None

Data Alerts:

None

NOM-5.3 Percent of late preterm births (34-36 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	5.5 %	0.1 %	2,498	45,111
2012	5.5 %	0.1 %	2,489	45,008
2011	5.4 %	0.1 %	2,450	45,129
2010	5.8 %	0.1 %	2,654	45,512
2009	5.8 %	0.1 %	2,723	47,091

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-5.3 Notes:

None

Data Alerts:

None

NOM-6 Percent of early term births (37, 38 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	20.6 %	0.2 %	9,307	45,111
2012	20.8 %	0.2 %	9,356	45,008
2011	21.2 %	0.2 %	9,554	45,129
2010	22.4 %	0.2 %	10,173	45,512
2009	23.5 %	0.2 %	11,061	47,091

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-6 Notes:

None

Data Alerts:

None

NOM-7 Percent of non-medically indicated early elective deliveries

Data Source: CMS Hospital Compare

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013/Q2-2014/Q1	3.0 %			

Legends:

Indicator results were based on a shorter time period than required for reporting

NOM-7 Notes:

None

Data Alerts:

None

NOM-8 Perinatal mortality rate per 1,000 live births plus fetal deaths

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	5.6	0.4 %	254	45,281
2012	6.1	0.4 %	275	45,207
2011	5.4	0.4 %	245	45,285
2010	5.3	0.3 %	244	45,663
2009	6.1	0.4 %	286	47,287

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM-8 Notes:

None

Data Alerts:

None

NOM-9.1 Infant mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	4.9	0.3 %	223	45,155
2012	5.4	0.4 %	241	45,067
2011	4.6	0.3 %	206	45,155
2010	5.0	0.3 %	226	45,540
2009	4.9	0.3 %	229	47,132

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

NOM-9.1 Notes:

None

Data Alerts:

None

NOM-9.2 Neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	3.5	0.3 %	159	45,155
2012	3.7	0.3 %	165	45,067
2011	3.0	0.3 %	137	45,155
2010	3.4	0.3 %	155	45,540
2009	3.3	0.3 %	157	47,132

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

NOM-9.2 Notes:

None

Data Alerts:

None

NOM-9.3 Post neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	1.4	0.2 %	64	45,155
2012	1.7	0.2 %	76	45,067
2011	1.5	0.2 %	69	45,155
2010	1.6	0.2 %	71	45,540
2009	1.5	0.2 %	72	47,132

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

NOM-9.3 Notes:

None

Data Alerts:

None

NOM-9.4 Preterm-related mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	186.0	20.3 %	84	45,155
2012	148.7	18.2 %	67	45,067

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011	155.0	18.5 %	70	45,155
2010	155.9	18.5 %	71	45,540
2009	144.3	17.5 %	68	47,132

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

NOM-9.4 Notes:

None

Data Alerts:

None

NOM-9.5 Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	62.0	11.7 %	28	45,155
2012	106.5	15.4 %	48	45,067
2011	68.7	12.3 %	31	45,155
2010	92.2	14.2 %	42	45,540
2009	80.6	13.1 %	38	47,132

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

NOM-9.5 Notes:

None

Data Alerts:

None

NOM-10 The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011	8.2 %	1.0 %	3,499	42,764
2010	6.9 %	0.9 %	2,977	43,216
2009	9.0 %	1.1 %	4,056	44,989
2008	7.4 %	1.1 %	3,470	46,776
2007	8.7 %	1.1 %	4,022	46,240

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% and should be interpreted with caution

NOM-10 Notes:

None

Data Alerts:

None

NOM-11 The rate of infants born with neonatal abstinence syndrome per 1,000 delivery hospitalizations

Data Source: State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	8.9	0.5 %	367	41,054
2011	8.0	0.4 %	341	42,474
2010	7.5	0.4 %	322	43,167

Year	Annual Indicator	Standard Error	Numerator	Denominator
2009	5.5	0.4 %	249	45,070
2008	4.7	0.3 %	219	46,412

Legends:
Indicator has a numerator ≤10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

NOM-11 Notes:

None

Data Alerts:

None

NOM-12 Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

FAD Not Available for this measure.

NOM-12 Notes:

None

Data Alerts:

None

NOM-13 Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

FAD Not Available for this measure.

NOM-13 Notes:

None

Data Alerts:

None

NOM-14 Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	20.7 %	1.4 %	166,478	804,025

Legends:
Indicator has an unweighted denominator <30 and is not reportable
Indicator has a confidence interval width >20% and should be interpreted with caution

NOM-14 Notes:

None

Data Alerts:

None

NOM-15 Child Mortality rate, ages 1 through 9 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	14.6	1.9 %	62	424,820
2012	13.6	1.8 %	58	426,320
2011	19.7	2.2 %	84	427,236
2010	15.4	1.9 %	66	428,728
2009	15.0	1.9 %	64	426,907

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

NOM-15 Notes:

None

Data Alerts:

None

NOM-16.1 Adolescent mortality rate ages 10 through 19 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	27.8	2.4 %	135	486,469
2012	30.1	2.5 %	147	487,734
2011	27.4	2.4 %	135	492,336
2010	26.7	2.3 %	133	497,413
2009	25.4	2.3 %	127	499,281

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM-16.1 Notes:

None

Data Alerts:

None

NOM-16.2 Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2013	9.4	1.1 %	70	742,025
2010_2012	10.1	8.0 %	76	750,914
2009_2011	10.6	8.4 %	81	761,837
2008_2010	11.5	9.3 %	89	771,189
2007_2009	13.7	11.1 %	106	774,858

Legends:

Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

NOM-16.2 Notes:

None

Data Alerts:

None

NOM-16.3 Adolescent suicide rate, ages 15 through 19 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2013	12.0	9.6 %	89	742,025
2010_2012	8.7	6.7 %	65	750,914
2009_2011	6.8	5.1 %	52	761,837
2008_2010	7.9	6.1 %	61	771,189
2007_2009	8.4	6.5 %	65	774,858

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

NOM-16.3 Notes:

None

Data Alerts:

None

NOM-17.1 Percent of children with special health care needs

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	19.4 %	1.3 %	166,596	859,845
2007	18.1 %	1.3 %	155,504	859,256
2003	15.9 %	1.0 %	134,743	845,439

Legends:
Indicator has an unweighted denominator <30 and is not reportable
Indicator has a confidence interval width >20% and should be interpreted with caution

NOM-17.1 Notes:

None

Data Alerts:

None

NOM-17.2 Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system

Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2009_2010	14.5 %	1.7 %	15,442	106,670

Legends:
Indicator has an unweighted denominator <30 and is not reportable
Indicator has a confidence interval width >20% and should be interpreted with caution

NOM-17.2 Notes:

None

Data Alerts:

None

NOM-17.3 Percent of children diagnosed with an autism spectrum disorder

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	3.1 %	0.6 %	22,181	718,640
2007	1.9 %	0.5 %	13,785	716,953

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM-17.3 Notes:

None

Data Alerts:

None

NOM-17.4 Percent of children diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	7.4 %	0.9 %	53,098	717,878
2007	6.4 %	0.9 %	45,916	718,346

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM-17.4 Notes:

None

Data Alerts:

None

NOM-18 Percent of children with a mental/behavioral condition who receive treatment or counseling

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	67.4 %	5.5 %	51,897	77,017
2007	46.5 %	6.6 %	35,279	75,811
2003	63.5 %	5.4 %	30,714	48,380

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM-18 Notes:

None

Data Alerts:

None

NOM-19 Percent of children in excellent or very good health

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	83.3 %	1.3 %	715,649	859,196
2007	86.6 %	1.1 %	741,477	856,230
2003	86.7 %	0.9 %	732,705	845,439

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM-19 Notes:

None

Data Alerts:

None

NOM-20 Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	26.4 %	2.1 %	94,761	358,539
2007	24.3 %	2.0 %	91,331	375,580
2003	26.5 %	1.7 %	99,902	377,691

Legends:
Indicator has an unweighted denominator <30 and is not reportable
Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	34.2 %	0.2 %	14,101	41,177

Legends:
Indicator has a denominator <50 or a relative standard error ≥30% and is not reportable
Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator

Legends:
Indicator has an unweighted denominator <100 and is not reportable
Indicator has a confidence interval width >20% and should be interpreted with caution

NOM-20 Notes:

None

Data Alerts:

None

NOM-21 Percent of children without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	6.3 %	0.5 %	54,203	858,451
2012	5.6 %	0.4 %	48,003	860,266
2011	7.0 %	0.5 %	59,863	860,804
2010	8.8 %	0.5 %	75,704	865,557
2009	10.9 %	0.6 %	95,262	873,304

Legends:
Indicator has an unweighted denominator <30 and is not reportable
Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM-21 Notes:

None

Data Alerts:

None

NOM-22.1 Percent of children ages 19 through 35 months, who have received the 4:3:1:3(4):3:1:4 series of routine vaccinations

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	66.6 %	3.3 %	43,732	65,631
2012	66.7 %	3.4 %	44,433	66,581
2011	61.7 %	4.2 %	42,146	68,339
2010	51.9 %	3.5 %	36,929	71,200
2009	44.3 %	3.3 %	31,925	72,095

Legends:
Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM-22.1 Notes:

None

Data Alerts:

None

NOM-22.2 Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013_2014	53.0 %	2.1 %	429,001	808,697
2012_2013	47.7 %	2.0 %	388,583	814,457
2011_2012	44.4 %	2.5 %	356,862	802,943
2010_2011	41.6 %	3.0 %	339,013	814,935
2009_2010	31.1 %	2.2 %	263,280	846,559

Legends:
Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM-22.2 Notes:

None

Data Alerts:

None

NOM-22.3 Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

Data Source: National Immunization Survey (NIS) - Female

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	66.3 %	4.3 %	78,965	119,056
2012	58.5 %	4.8 %	69,659	118,996
2011	68.7 %	4.3 %	81,472	118,680
2010	54.1 %	4.9 %	63,628	117,680
2009	52.9 %	4.0 %	63,474	119,914

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

Data Source: National Immunization Survey (NIS) - Male

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	35.9 %	4.1 %	44,826	125,046
2012	14.5 %	3.0 %	18,072	124,920
2011	NR	NR	NR	NR

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM-22.3 Notes:

None

Data Alerts:

None

NOM-22.4 Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	87.0 %	2.2 %	212,294	244,102
2012	86.0 %	2.3 %	209,754	243,916
2011	83.1 %	2.6 %	202,268	243,453
2010	66.6 %	3.1 %	160,678	241,239
2009	55.5 %	2.9 %	136,773	246,269

Legends:
Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM-22.4 Notes:

None

Data Alerts:

None

NOM-22.5 Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	65.3 %	2.9 %	159,346	244,102
2012	58.3 %	3.2 %	142,098	243,916
2011	55.8 %	3.4 %	135,730	243,453
2010	52.4 %	3.3 %	126,353	241,239
2009	41.6 %	2.8 %	102,330	246,269

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM-22.5 Notes:

None

Data Alerts:

None

Form 10a
National Performance Measures (NPMs)

State: Oregon

NPM-1 Percent of women with a past year preventive medical visit

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	53.3	53.7	54.1	54.6	55.0

NPM-4 A) Percent of infants who are ever breastfed

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	92.0	92.2	92.4	92.6	92.8

NPM-4 B) Percent of infants breastfed exclusively through 6 months

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	26.0	26.6	27.0	27.4	27.8

NPM-8 Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	34.2	34.7	35.2	35.7	36.2

NPM-10 Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	74.2	78.4	79.6	80.8	81.9

NPM-11 Percent of children with and without special health care needs having a medical home

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	45.8	49.0	51.0	53.0	55.0

NPM-12 Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	35.6	38.0	40.0	42.0	44.0

NPM-13 A) Percent of women who had a dental visit during pregnancy

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	56.7	57.5	58.4	59.2	60.1

NPM-13 B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	77.0	78.3	78.7	79.2	79.6

NPM-14 A) Percent of women who smoke during pregnancy

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	9.9	9.6	9.4	9.1	8.8

NPM-14 B) Percent of children who live in households where someone smokes

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	20.9	20.4	19.9	19.4	18.9

Form 10b

State Performance/Outcome Measure Detail Sheet

State: Oregon

States are not required to create SOMs/SPMs until the FY 2017 Application/FY 2015 Annual Report.

Form 10c

Evidence-Based or Informed Strategy Measure Detail Sheet

State: Oregon

States are not required to create ESMs until the FY 2017 Application/FY 2015 Annual Report.

Form 10d
National Performance Measures (NPMs) (Reporting Year 2014 & 2015)

State: Oregon

Form Notes for Form 10d NPMs and SPMs

None

NPM 01 - The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.

	2011	2012	2013	2014	2015
Annual Objective	100.0	100.0	100.0	100.0	100.0
Annual Indicator	100.0	100.0	100.0	100.0	
Numerator	53	59	58	61	
Denominator	53	59	58	61	
Data Source	Or Public Health Lab	Or Public Health Lab	Newborn Screening, Oregon Public Health Lab.	Newborn Screening, Oregon Public Health Lab.	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: Year 2014 entered; 2013 data is now considered final, with no updates. Data based on the total number of referred positive as reported on Form 4, column D (Needing treatment that received treatment).	
2.	**Field Name:**	**2013**
	Field Note: Source: Newborn Screening, Public Health Lab. Year 2013 entered; 2012 data reviewed and corrected from 46 to 59. Data based on the total number of referred positive as reported on Form 6, column D (Needing treatment that received treatment).	
3.	**Field Name:**	**2012**
	Field Note: Source: Newborn Screening, Public Health Lab. Data based on the total number of referred positive as reported on Form 6, column D (Needing treatment that received treatment).	

4.	**Field Name:**	**2011**

Field Note:
Source: Newborn Screening, Public Health Lab.
Data based on the total number of referred positive as reported on Form 6, column D.

Data Alerts:

None

NPM 02 - The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)

	2011	2012	2013	2014	2015
Annual Objective	57.0	70.0	72.0	74.0	76.0
Annual Indicator	69.7	69.7	69.7	69.7	
Numerator					
Denominator					
Data Source	NS-CSHCN	NS-CSHCN	NS-CSHCN	NS-CSHCN	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2.	**Field Name:**	**2013**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT

comparable to earlier versions of the survey. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3.	**Field Name:**	**2012**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4.	**Field Name:**	**2011**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Data Alerts:

None

NPM 03 - The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)

	2011	2012	2013	2014	2015
Annual Objective	52.0	42.0	44.0	45.0	45.8
Annual Indicator	41.1	41.1	41.1	41.1	
Numerator					
Denominator					
Data Source	NS-CSHCN	NS-CSHCN	NS-CSHCN	NS-CSHCN	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2.	**Field Name:**	**2013**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3.	**Field Name:**	**2012**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4.	**Field Name:**	**2011**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws,

respondent classification and reporting errors, and data processing mistakes.

Data Alerts:

None

NPM 04 - The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)

	2011	2012	2013	2014	2015
Annual Objective	64.0	58.0	60.0	60.0	62.0
Annual Indicator	55.8	55.8	55.8	55.8	
Numerator					
Denominator					
Data Source	NS-CSHCN	NS-CSHCN	NS-CSHCN	NS-CSHCN	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.	
2.	**Field Name:**	**2013**
	Field Note: For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.	
3.	**Field Name:**	**2012**
	Field Note: For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs	

(CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4.	**Field Name:**	**2011**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Data Alerts:

None

NPM 05 - Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)

	2011	2012	2013	2014	2015
Annual Objective	92.0	65.0	67.0	65.0	68.0
Annual Indicator	63.4	63.4	63.4	63.4	
Numerator					
Denominator					
Data Source	NS-CSHCN	NS-CSHCN	NS-CSHCN	NS-CSHCN	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the

surveys are comparable.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2.	**Field Name:**	**2013**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3.	**Field Name:**	**2012**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4.	**Field Name:**	**2011**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Data Alerts:

None

NPM 06 - The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.

	2011	2012	2013	2014	2015

	2011	2012	2013	2014	2015
Annual Objective	46.0	36.0	36.0	36.0	35.6
Annual Indicator	35.6	35.6	35.6	35.6	
Numerator					
Denominator					
Data Source	NS-CSHCN	NS-CSHCN	NS-CSHCN	NS-CSHCN	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2.	**Field Name:**	**2013**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3.	**Field Name:**	**2012**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2

surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4.	**Field Name:**	**2011**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Data Alerts:

None

NPM 07 - Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.

	2011	2012	2013	2014	2015
Annual Objective	73.0	73.5	68.0	70.0	70.5
Annual Indicator	67.0	69.6	76.5	76.5	
Numerator					
Denominator					
Data Source	National Immunization Survey	National Immunization Survey	National Immunization Survey	National Immunization Survey	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
(Overall coverage by State for vaccine series 4:3:1:3:3:1, http://www.cdc.gov/vaccines/imz-managers/coverage/nis/child/data/tables-2013.html). The rate for CY 2013 is updated from 69.6 ± 6.6 to 76.5±5.9, and carried over to 2014 column. The 2014 data will be available in 2016. Numerator and denominator remain unavailable. The NIS rates for Oregon vaccine series 4:3:1:3:3:1 for years 2007 to 2013 were 70.5%, 71.1%, 64.8%, 69.3%,67.0%, 69.6%, and 76.5%; in 2013 the national average was 77.7% (with 95% CI ranging ± 1.4). The Oregon sample is small and the NIS estimates for Oregon 4:3:1:3:3:1 rates remain too large for trend analysis, at

2.	**Field Name:**	**2013**

Field Note:
Source: NIS, CDC (Overall coverage by State for vaccine series 4:3:1:3:3:1, http://www.cdc.gov/vaccines/imz-managers/coverage/nis/child/data/tables-2012.html). The rate for CY 2012 reviewed and updated from 67.0 ±8.1 to 69.6 ± 6.6, and carried over to 2013 column. The 2013 data will be available Fall 2015. Numerator and denominator remain unavailable.
The NIS rates for Oregon vaccine series 4:3:1:3:3:1 for years 2007 to 2012 were 70.5%, 71.1%, 64.8%, 69.3%,67%, and 69.9%; in 2012 the national average was 71.9% (with 95% CI ranging ± 1.4). The Oregon sample is small and the NIS estimates for Oregon 4:3:1:3:3:1 rates remain too large for trend analysis, at +/- 6.9% in 2012. While the series rate remains below the Healthy People 2020 target of 80%, Oregon rates for specific antigens are generally in accord with Healthy People targets.

Annual estimates of immunization rates from Oregon's ALERT IIS also support that the 4:3:1:3:3:1 series rate for two year-olds has been relatively unchanged from 2005, (71.8% +/- 0.4%), 2011, (72.6%, +/-0.4%), and to 2012, (67.1%, +/-0.4%, available at https://public.health.oregon.gov/PreventionWellness/VaccinesImmunization/Documents/county/OregonPBR.pdf). For tracking immunization rates over time in Oregon, the Oregon Immunization Program does not rely on the NIS estimates, but uses estimates directly from ALERT (Immunzation's Program tracking system).

3.	**Field Name:**	**2012**

Field Note:
Source: NIS, CDC. Calendar year 2011 data for vaccine series 4:3:1:3:3:1 (4 Diphtheria/Tetanus/Pertussis, 3 Polio, 1 Measles/Mumps/Rubella, 3 or more Hib, 3 Hepatitis B, 1 Varicella). Numerator and denominator remain unavailable. 2012 data will be available Fall 2014 so 2011 data copied into 2012 column. Reviewed 2010 data and updated it as final because there are no corrections.

The NIS rates for Oregon vaccine series 4:3:1:3:3:1 for years 2007 to 2011 were 70.5%, 71.1%, 64.8%, 69.3%, and 67% compared to the national average of 77.0% (with 95% CI ranging ± 1). The drop in 2009 could be correlated to the national wide shortage of Hib vaccines during 2009. Compared to 2009, there was a slight increase in 2010 and 2011, but confidence intervals continue to be too large to assess significant change in this immunization series rate -- confidence intervals range plus or minus 6 points for 2009 and 2010 rates, and plus or minus 8 points for 2011. Overall, Oregon's series rates are stagnant. Rates among specific antigens are generally strong and meet Healthy People 2020 goals.

Annual estimates of immunization rates from Oregon's ALERT IIS also support that the 4:3:1:3:3:1 series rate for two year-olds has been relatively unchanged from 2005, (71.8% +/- 0.4%), to 2011, (72.6%, +/-0.4%).

4.	**Field Name:**	**2011**

Field Note:
Source: National Immunization Survey, CDC. 2010 data for vaccine series 4:3:1:3:3:1 carried over. 2011 data will be available Fall 2012 (e.g.: Sept).

In 2008 and prior years, the NIS rates for both series 4:3:1:3:3, and 4:3:1:3:3:1 (4 Diphtheria/Tetanus/Pertussis, 3 Polio, 1 Measles/Mumps/Rubella, 3 Hib, 3 Hepatitis B, 1 Varicella) were reported on NIS web tables, but starting in 2009 the web tables excluded the data for series 4:3:1:3:3. For Title V report, year 2009 data was updated from series 43133 (66.9%) to series 4:3:1:3:3:1 (64.9%), which the Oregon Immunization Program also reports on. Data for year 2009 and subsequent years will be for vaccine series 4:3:1:3:3:1 because it is more complete by containing Varicella vaccine. Due to switch in reporting of using vaccine series 4:3:1:3:3:1, shortage of Hib in 2009 and 2010 NIS samples, and changes in current reporting method for Hib, comparison of data with 2008 and prior years is limited.

The NIS rates for vaccine series 4:3:1:3:3:1 for years 2007 to 2010 were 70.5%, 71.1%, 64.8%, and 69.3%. The drop in 2009 could be correlated to the national-wide shortage of Hib vaccines during 2009. There was an increase in 2010, but confidence intervals range plus or minus 6 points for 2009 and 2010 rates. Overall, Oregon's 4:3:1:3:3:1 series rate are stagnant. Rates among specific antigens are generally strong and meet Healthy People 2020 goals. Confidence intervals continue to be too large to assess significant changes in this immunization series rate.

Data Alerts:

None

NPM 08 - The rate of birth (per 1,000) for teenagers aged 15 through 17 years.

	2011	2012	2013	2014	2015
Annual Objective	14.0	11.0	10.8	9.5	9.3
Annual Indicator	11.5	11.0	9.7	8.3	
Numerator	834	798	699	597	
Denominator	72,806	72,465	72,179	71,981	
Data Source	Oregon Center for Health Statistics & OPR	Oregon Center for Health Statistics & OPR	Oregon Center for Health Statistics & OPR	Oregon Center for Health Statistics & OPR	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
Numerator: Preliminary 2013 birth numbers of females ages 15-17 from Oregon Center for Health Statistics. Denominator: 2013 Oregon Annual Population Report (PSU), females aged 15-17 years old. 2013 data is now considered final, without any updates. Birth rate among female teenagers aged 15 to 17 years old appears to be decreasing: 8.3 per 1,000 population in 2014 compared to a higher rate 6 years ago (15.3 per 1,000 in 2009). The trend since 2009 seems to be heading in the right direction. The data trend should be interpreted with

caution as provisional data does not include teen births that are out of state, which takes 2 or more years to incorporate the out of state births.

2.	**Field Name:**	**2013**

Field Note:
Numerator: Preliminary 2013 birth numbers of females ages 15-17 from Oregon Center for Health Statistics. Denominator: 2013 Oregon Annual Population Report (PSU), females aged 15-17 years old. 2012 data reviewed and updated from 794 births to 798, and is now considered final.

Birth rate among female teenagers aged 15 to 17 years old appears to be decreasing: 10 per 1,000 population in 2013 compared to a higher rate 5 years ago (15.3 per 1,000 in 2009). The trend since 2008 seems to be heading in the right direction. The data trend should be interpreted with caution as provisional data does not include teen births that are out of state, which takes 2 or more years to incorporate the out of state births.

3.	**Field Name:**	**2012**

Field Note:
Numerator: Number births among females aged 15-17 from Oregon Center for Health Statistics. Preliminary as of June 2013. Denominator: 2012 Oregon Annual Population Report (PSU) estimate of females aged 15-17 years-old.

Birth rate among female teenagers aged 15 to 17 years old appears to be decreasing. The trend since 2008 seems to be heading in the right direction. The data trend should be interpreted with caution as provisional data does not include teen births that are out of state, which takes 2 or more years to incorporate the out of state births.

4.	**Field Name:**	**2011**

Field Note:
Numerator: Oregon Center for Health Statistics. 2010 data updated and is now final. 2011 data is preliminary as of April 2012. Denominator: Oregon Annual Population Report (PSU).

Birth rate among teenagers aged 15 to 17 years old appears to be decreasing. The trend since 2008 seems to be heading in the right direction. The data trend should be interpreted with caution as provisional data does not include teen births that occurred out of state, which takes 2 or more years to incorporate Oregon resident mothers who gave birth out of state.

Data Alerts:

None

NPM 09 - Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

	2011	2012	2013	2014	2015
Annual Objective	44.0	44.0	55.0	55.0	55.0
Annual Indicator	42.7	52.4	52.4	52.4	

	2011	2012	2013	2014	2015
Numerator	1,261	1,794	1,794	1,794	
Denominator	2,953	3,424	3,424	3,424	
Data Source	Oregon Smile Survey	Oregon Smile 2012	Oregon Smile Survey 2012	Oregon Smile Survey 2012	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
The 2012 data is considered final as of April 2013. Numerator: Number of 3rd graders screened who have a protective sealant on at least one permanent molar tooth. The next Smile survey will be in 2017, so 2012 data carried over to 2014 column. Data in 2012 indicates improvement in dental sealants rate among third graders (52%, 95% CI: 48.6-56.2) compared to rates in 2002 (51%) and 2007 (43%), and surpasses Healthy People 2020 oral objective (28.1%).

2.	**Field Name:**	**2013**

Field Note:
Source: Smile Screening Survey completed in 2012, Oregon Health Authority. The 2012 data is considered final as of April 2013. Numerator: Number of 3rd graders screened who have a protective sealant on at least one permanent molar tooth. The next Smile survey will be in 2017, so 2012 data copied into 2013 column.

Data in 2012 indicates improvement in dental sealants rate among third graders (52%, 95% CI: 48.6-56.2) compared to rates in 2002 (51%) and 2007 (43%), and surpasses Healthy People 2020 oral objective (28.1%).

3.	**Field Name:**	**2012**

Field Note:
Source: Smile Survey completed in 2012, Oregon Health Authority. The 2012 data is considered final as of April 2013. Numerator: Number of 3rd graders screened who have a protective sealant on at least one permanent molar tooth. Passive consent was used as with Smile 2007.

Data in 2012 indicates improvement in dental sealants rate among third graders (52%, 95% CI: 48.6-56.2) compared to rates in 2002 (51%) and 2007 (43%), and surpasses Healthy People 2020 oral objective (28.1%). Dental sealants among 3rd graders are significantly higher than the state average (38%, 95% CI: 34.8-41.4), 2nd graders (42%, 95% CI: 37.0-45.9) and 1st graders (20%, 95% CI: 16.5-23.9). In comparison with other states, Oregon's dental sealant rate is significantly lower than state of Washington (51.2%, Smile 2009-10) and significantly higher than California (27.6 %, Smile 2004-05). Oregon and Illinois have similar dental sealant rates. (Source: National Oral Health Surveillance System, as of 1/4/2011).

4.	**Field Name:**	**2011**

Field Note:
Source: Oral Health Program's Smile Basic Screening Survey, Oregon Health Authority. 2007 data carried forward. The sample of 3rd graders is representative of 3rd graders in Oregon public schools that have at least 10

students in 3rd grade. If there were no 1st or 2nd grade, feeder schools were used (feeder school is defined as schools that feeds a particular high school). The 2012 Smile survey is in progress as of April 2012. Data collection is expected to be completed by Fall 2012, with data available after 3 months.

Data in 2002 and 2007 shows that less than half of 3rd grader students in Oregon received dental sealants. In comparison with other states, Oregon's dental sealant rate is significantly lower than Washington (51.2%, from Smile 2009-10) and significantly higher than California (27.6 %, from Smile 2004-05). Oregon and Illinois have similar dental sealant rates (source: National Oral Health Surveillance System: http://apps.nccd.cdc.gov/nohss/IndicatorV.asp?Indicator=1, as of 1/4/2011).

Data Alerts:

None

NPM 10 - The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.

	2011	2012	2013	2014	2015
Annual Objective	1.3	1.7	1.3	1.3	1.3
Annual Indicator	1.4	1.4	1.0	1.0	
Numerator	10	10	7	7	
Denominator	716,384	716,250	710,576	710,576	
Data Source	CDC-WISQARS & OPR	CDC-WISQARS & OPR	Numerator: Vital Statistics from the Oregon Center for Health Statistics. Denominator: Population Research Center, Portland State University.	Numerator: Vital Statistics from the Oregon Center for Health Statistics. Denominator: Population Research Center, Portland State University.	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
2013 data is considered final. 2014 data is not yet available, so 2013 data is carried over to 2014. Previous reports have used data from from CDC WISQARS, Fatal Injury Reports, 1999-2010, for National, Regional, and States (RESTRICTED). However the most recent data available from CDC WISQARS 2010 data, therefore this report uses data provided by the Oregon Injury & Violence Prevention Program. The data sources used by the

program are vital statistics from the Oregon Center for Health Statistics population data from the Population Research Center, Portland State University.

2.	**Field Name:**	**2013**

Field Note:
Sources: 2010 data (most currently available data) from CDC WISQARS, Fatal Injury Reports, 1999-2010, for National, Regional, and States (RESTRICTED). 2011-2013 data are still unavailable online, so 2010 data (numerator) was carried over to 2013 column and is noted as provisional. Denominator: 2013 Oregon Annual Population Report (PSU) for 0-14 years old. Denominator for 2011 was corrected to 716384 for population aged 0-14 years-old in 2011.

A review of an Oregon Injury Program report (http://public.health.oregon.gov/diseasesconditions/injuryfatalitydata/documents/oregoninjurypreventionplan.pdf, pp 19-20) confirms that 2010 data is the most current data available for reporting. Tthe rate for MVC deaths among 0-14 year old youth dropped by 94% between 1999 (a rate of 3.3 per 100,000) to 0.2 per 100,000 in 2010.

3.	**Field Name:**	**2012**

Field Note:
Sources: 2010 data (most currently available data) from CDC WISQARS, Fatal Injury Reports, 1999-2010, for National, Regional, and States (RESTRICTED) http://webappa.cdc.gov/sasweb/ncipc/dataRestriction_inj.html. Data query is same for 2008-2010 data: All Intents, cause of death as Overall Motor Vehicle, all Races and all Hispanic Origin, both sexes, and age-adjusted to the standardized year 2000. Denominator: 2010 Oregon Annual Population Report (PSU) for 0-14 years old. 2011 and 2012 data unavailable as of April 2013, so 2010 data carried to 2011 and 2012. Reviewed 2009 data and the denominator value should be 730,990, but can no longer be updated in TVIS.

The 2010 rate for Oregon is 1.4 and is lower than the national rate of 2.3 per 100,000 (number of deaths =1,421). Within the past 10 years Oregon rate is declining, say from 3.6 in 2006, and 1.8 in 2009. Data from Oregon State Injury and Violence Prevention Program mirrors the decreasing trend, similar to data from the national data source. See similar injury deaths data in Health Status Indicators #03B and #03C.

4.	**Field Name:**	**2011**

Field Note:
Sources: WISQARS -- Fatal Injury Reports, 1999-2009, for National, Regional and State (RESTRICTED file). Denominator: Oregon Annual Population Report (PSU), 2008 and 2009 populations for age 0-14 years old. The most current and available 2008 and 2009 data were reviewed and updated, and are now considered final. The 2008 rate is 3.1 per 100,000 (23/730,360), but can no longer be entered into TVIS. Data for 2010 and 2011 are unavailable, so 2009 data carried over.

Data Alerts:

None

NPM 11 - The percent of mothers who breastfeed their infants at 6 months of age.

	2011	2012	2013	2014	2015

	2011	2012	2013	2014	2015
Annual Objective	64.0	64.0	68.5	71.0	71.5
Annual Indicator	62.5	68.1	71.0	64.4	
Numerator					
Denominator					
Data Source	National Immunization Survey	National Immunization Survey	National Immunization Survey	National Immunization Survey	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
Numerator and denominator values remain unavailable. Note: As of 5/2015, finalized data by state is available only up to birth cohort 2011 (http://www.cdc.gov/breastfeeding/data/NIS_data/index.htm). Although the rate has dropped from last year, Oregon women continue to breastfeed their infants up to age of 6 months at rates higher than most other states, exceeded only by Vermont (Alaska and Washington have similar rates as Oregon). Oregon also surpassed the national rate (49.4%) and the breastfeeding goals outlined in Healthy People 2020 (60.6%). Also, breastfeeding rates among Oregon women enrolled in the WIC program mirror Oregon's position as a top state for breastfeeding.

2.	**Field Name:**	**2013**

Field Note:
Source: Breastfeeding Report Card 2013 (2010 births), from CDC National Immunization Surveys 2011 and 2012 provisional data (http://www.cdc.gov/breastfeeding/pdf/2013breastfeedingreportcard.pdf). Numerator and denominator values remain unavailable. Note: As of 5/2014, finalized data by state is available only up to birth cohort 2007 (http://www.cdc.gov/breastfeeding/data/NIS_data/index.htm).

The 2013 Report indicates that Oregon women continue to breastfeed their infants up to age of 6 months at rates that exceed those of other states (except for California that a similar rate as Oregon: 71.3%), and surpass the national rate (49.0%) and the breastfeeding goals outlined in Healthy People 2020 (60.6%). Also, breastfeeding rates among Oregon women enrolled in the WIC program mirror Oregon's position as a top state for breastfeeding.

3.	**Field Name:**	**2012**

Field Note:
Source: Breastfeeding Report Card 2012, based on CDC NIS 2010-11 for birth year 2009. Numerator and denominator values remain unavailable. Provisional data at http://www.cdc.gov/breastfeeding/data/reportcard2.htm, final estimates available August 2013 (http://www.cdc.gov/breastfeeding/data/NIS_data/index.htm).

The 2012 Report indicates that generally Oregon women continue to breastfeed their infants up to 6 months of

age at rates that exceed those of other states, and surpass the national rate (47.2%) and the breastfeeding goals outlined in Healthy People 2020 (60.6%). The higher rate reflects the rise in the number of mothers initiating breastfeeding in Oregon.

4.	**Field Name:**	**2011**

Field Note:
Source: Breastfeeding Report Card 2011, NIS, CDC. Provisional NIS data available at http://www.cdc.gov/breastfeeding/pdf/2011BreastfeedingReportCard.pdf. The 2011 report is for the 2008 births. Numerator and denominator values remain unavailable.

Data from the 2011 Breastfeeding Report Card (2008 birth cohort) finds that Oregon women breastfeed their infants to 6 months of age at rates that exceed those of other states, the national rate (44.3%), and the breastfeeding goals outlined in Healthy People 2020 (60.6%).

Breastfeeding rates among Oregon women enrolled in the WIC program mirror Oregon's position as a top state for breastfeeding. Data from the 2011 Pediatric Nutrition Surveillance Survey finds that 91.2% of Oregon WIC mothers initiate breastfeeding compared to 63.2% of WIC participants nationally. Likewise, 42.3% of Oregon WIC mothers breastfed at 6 months, a rate lower than the general Oregon population but still significantly higher than the WIC national average of 25%. Note: The WIC national average is for year 2010 data.

Note: NIS data will be used for 2012 data and onward for comparability across states.

Data Alerts:

None

NPM 12 - Percentage of newborns who have been screened for hearing before hospital discharge.

	2011	2012	2013	2014	2015
Annual Objective	99.5	99.5	99.5	99.5	99.5
Annual Indicator	93.6	91.0	94.3	99.0	
Numerator	42,426	41,453	42,851	42,503	
Denominator	45,341	45,566	45,444	42,953	
Data Source	EHDI and Oregon Center for Health Statistics	EHDI and Oregon Center for Health Statistics	Center for Health Statistics - Oregon Vital Events Registration System (OVERS) linked with the Early Hearing Detection and Intervention Information Sysstem (EHDIIS)	Center for Health Statistics - Oregon Vital Events Registration System (OVERS) linked with the Early Hearing Detection and Intervention Information Sysstem (EHDIIS)	

	2011	2012	2013	2014	2015
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
2014 Data are preliminary and will likely improve with time and additional reporting. 2014 data includes births from January through December 2014 for mandated reporting hospitals. Since this measure asks for data on screening before discharge, the numbers does not include non-mandated hospitals, birth centers or home births. The numerator is all infants with a completed screening within the first 30 days of life (not all infants screened that were born in the hospital setting) and the denominator is all Oregon births.

2.	**Field Name:**	**2013**

Field Note:
Data source: Center for Health Statistics - Oregon Vital Events Registration System (OVERS) linked with the EHDI-IS tracking system. The 2013 data are preliminary as of May 2014, and will be finalized in Spring 2015. The denominator is all Oregon births, including those that occurred outside the hospital setting. The numerator is the number of infants who received a hearing screen within the first 30 days of life.

The 2012 data was reviewed and updated with the final data. Starting in 2010 the numerator is all infants with a completed screening within the first 30 days of life (not all infants screened that were born in the hospital setting) and the denominator is all Oregon births.

Comparison of 2009 with data from prior years are limited due to the change in data in 2010. In 2010 the data include all births, not just hospital births. This results in a lower overall screening rate because out-of-hospital births have a lower screening rate than hospital births. Data in 2011 and 2012 showed a slight decrease of all Oregon infants receiving a newborn hearing screen within the first 30 days of life. However, between 2012 and 2013, the number of infants screened within the first 30 days increased by 3.3 percentage points (91.0% to 94.3%).

3.	**Field Name:**	**2012**

Field Note:
Data source: Center for Health Statistics - Oregon Vital Events Registration System (OVERS) linked with the EHDI-IS tracking system. The 2012 data are preliminary as of April 2013, and will be finalized in 2014. The denominator is all Oregon births, including those that occurred outside the hospital setting. The numerator is the number of infants who received a hearing screen within the first 30 days of life.

The 2011 data was reviewed and corrected, and is now considered final. Starting in 2010 the numerator is all infants with a completed screening within the first 30 days of life (not all infants screened that were born in the hospital setting) and the denominator is all Oregon births.

Comparisons with 2009 and prior years are limited due to the change in data system beginning with 2010 data. In 2010, the data includes all births, not just hospital births. This resulted in a lower overall screening rate because out-of-hospital births have a lower screening rate than hospital births. Data in 2010 and 2011 held steady at 93% of all Oregon infants receiving a newborn hearing screen within the first 30 days of life. However, between 2011

and 2012, the number of infants screened within the first 30 days increased by 1% (93.6% to 94.1%).

4.	**Field Name:**	**2011**

Field Note:
Source: Oregon Vital Events Registration System (OVERS) - Center for Health Statistics (CHS). The preliminary 2011 data (as of March 2012) is from the OVERS EHDI tracking system. The denominator is all Oregon births, including those that occurred outside the hospital setting. The numerator is the number of infants who received a hearing screen within the first 30 days of life.

The 2010 data was reviewed and updated to be consistent with reporting methods for 2011 data, and is the final data that was sent to CDC on February 2012. Starting in 2010 the numerator is all infants with a completed screening within the first 30 days of life (not all infants screened were born in the hospital setting) and the denominator is all Oregon births.

Comparisons before 2010 are limited due to the change in data system. Beginning in 2010 the data includes all births, not just hospital births. This results in a lower overall screening rate because out-of-hospital births have a lower screening rate than hospital births. Data in 2010 and 2011 held steady at 93.3% of all Oregon infants receiving a newborn hearing screen within the first 30 days of life.

Data Alerts:

None

NPM 13 - Percent of children without health insurance.

	2011	2012	2013	2014	2015
Annual Objective	11.5	10.0	9.0	5.5	5.5
Annual Indicator	9.8	9.4	5.6	5.8	
Numerator	84,907	81,358	48,474	50,496	
Denominator	866,397	865,508	865,612	866,518	
Data Source	CPS and OPRC	CPS and OPRC	Census CPS 2013 Annual Social and Economic Supplement (ASEC) and Oregon Population Report (created by Portland State University)	Census CPS 2013 Annual Social and Economic Supplement (ASEC) and Oregon Population Report (created by Portland State University)	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
Uninsured rate is from the Census CPS 2013 Annual Social and Economic Supplement (ASEC), available at http://www.census.gov/hhes/www/hlthins/data/incpovhlth/2013/acs-tables.html, Table HI05 Health Insurance Coverage Status and Type of Coverage by State and Age for All People: 2013. Survey year is 2014, but income and insurance status is 2013. Denominator: 2014 Oregon Population Report (Portland State University) of children 0-17 years old. Numerator was computed using the rate and denominator value.

2.	**Field Name:**	**2013**

Field Note:
Source: Uninsured rate is from the Census CPS 2013 Annual Social and Economic Supplement (ASEC), available at
http://www.census.gov/hhes/www/cpstables/032013/health/toc.htm. Table H105: Health Insurance Coverage Status and Type of Coverage by State and Age for All People: 2012. Survey year is 2013, but income and insurance status is 2012. Denominator: 2013 Oregon Population Report (PSU) of children 0-17 years old. Numerator was computed using the rate and denomonator value.

Data indicates a decreasing trend in percentage of children without any kind of health Insurance at anytime during the year.

3.	**Field Name:**	**2012**

Field Note:
Source: Percent uninsured children under 18 years old (0-17 years) in 2012 from U.S. Census Bureau, Current Population Survey, 2012 Annual Social and Economic Supplement (available: http://www.census.gov/hhes/www/cpstables/032012/health/toc.htm. Table HI01: Health Insurance Coverage Status and Type of Coverage by Selected Characteristics). Denominator: 2012 Oregon Population Report (PSU), version 4/2013. 2011 data reviewed and updated from 10.4% to 9.8%.

Data indicates a decreasing trend in percentage of children without any kinds of health Insurance at anytime during the year.

4.	**Field Name:**	**2011**

Field Note:
Source: Percentage of children without insurance is from U.S. Census Bureau, Current Population Survey, 2011 Annual Social and Economic Supplement, Table HI05, at: http://www.census.gov/hhes/www/cpstables/032011/health/toc.htm. Denominator: 2011 Oregon Population Report (PSU) for 0-17 years old. Number uninsured (numerator) was computed from indicator data point and denominator. Note: CPS data are reported for age group 0-17 years old.

There appears to be a decreasing trend in percentage of children without any kind of health insurance throughout the years.

Data Alerts:

None

NPM 14 - Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.

	2011	2012	2013	2014	2015
Annual Objective	31.0	30.0	34.0	32.0	31.5
Annual Indicator	33.5	33.3	32.8	32.7	
Numerator	19,922	19,547	18,207	17,268	
Denominator	59,385	58,699	55,441	52,730	
Data Source	WIC/TWIST	WIC/TWIST	Oregon WIC program's real-time database TWIST -- an Operation Data Store (ODS)	Oregon WIC program's real-time database TWIST -- an Operation Data Store (ODS)	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
A new process for calculating BMI percentiles from TWIST was finalized in 2013 which led to improved computation of BMI percentiles that were not captured direxctly by TWIST. The same methods have been applied to 2011-2014 data to ease comparison with future data. Starting in 2011, Oregon's data is no longer comparable with other states' data due to methods variability across all states (the sampling is longer from PedNNS which uses a random sample of WIC children). Also data from 2011 onward can no longer be compared with previous years' data due to the different sampling and analyses methods.

2.	**Field Name:**	**2013**

Field Note:
Same source of data for NPM #014 and HSI #09a-09b (WIC enrollment by race/ethnicity): Oregon WIC program's real-time database TWIST -- an Operation Data Store (ODS) in DB2. Calendar year 2013 finalized data.

In 2013, 32.8% of children between 24 and 59 months of age were classified as overweight or obese (>= 85th or >= 95th percentile) compared to 33.3% in 2012. There was a lower caseload in 2013, and the reason is unknown. Overall, the BMI percentages remain relatively the same, and the Oregon WIC program's rate of childhood overweight remains slightly higher than the national WIC rate of 30.5%.

A new process for calculating BMI percentiles from TWIST was finalized in 2013 which led to improved computation of BMI percentiles that were not captured by TWIST. The same methods have been applied to 2011-2013 data to ease comparison with future data. Starting in 2011, Oregon's data is no longer comparable with other states' data due to methods variability across all states (the sampling is longer from PedNNS which uses a random sample of WIC children). Also data from 2011 onward can no longer be compared with previous years' data due to the

different sampling and analyses methods.

3.	**Field Name:**	**2012**

Field Note:
Same source of data for NPM #014 and HSI #09a-09b (WIC enrollment by race/ethnicity): Oregon WIC program's real-time database TWIST -- an Operation Data Store (ODS) in DB2. The 2012 calendar year 2012 data are final. The national Pediatric Nutrition Surveillance System (PedNSS) and PNSS are no longer available for WIC reporting.

In 2012, 34 % of children between 24 and 59 months of age were classified as overweight or obese, a slight increase due mainly to change in methodology (i.e.: a different sampling than for PedNSS). Overall, the percentages remain relatively the same, and the Oregon WIC program's rate of childhood overweight remains slightly higher than the national WIC rate of 30.5%.

Starting with 2012 data, Oregon data for NPM #014 will no longer be comparable with other states due to a difference in methodology across states. In 2011 and previous years, data were obtained from PedNNS. See detailed notes in last year's report regarding the phasing out of PedNNS.

4.	**Field Name:**	**2011**

Field Note:
Source: The 2011 calendar year (final) data are from PedNSS, CDC. The prevalence (32.4%) is a summation of the percentages of overweight (17.5%) and obese (14.9%) children.

The percentage of children between 24 and 59 months of age, who were classified as overweight (17.5%) or obese (14.9%) has remained fairly stable in the last several years, with 32.4% of Oregon WIC being placed in one of these two weight categories. The Oregon WIC program's rate of childhood overweight is slightly higher than the national WIC rate of 30.5%.

Notes: The PedNSS and Pregnancy Surveillance System (PNSS) are potentially going away, and the real-time WIC database called TWIST will be used to provide data for WIC related measures. Relevant procedures from PedNSS and PNSS will be used to clean and report TWIST data. Data will no longer be comparable with other states due to difference in methodology across states. Up to 2011, data from TWIST were submitted to CDC to be cleaned and reported back to the WIC program; this direct support will no longer be available beginning 2012.

Data Alerts:

None

NPM 15 - Percentage of women who smoke in the last three months of pregnancy.

	2011	2012	2013	2014	2015
Annual Objective	11.8	10.0	10.0	10.0	9.0
Annual Indicator	10.8	10.8	10.8	10.2	
Numerator	4,619	4,619	4,619	4,585	
Denominator	42,816	42,816	42,816	45,136	

	2011	2012	2013	2014	2015
Data Source	PRAMS	PRAMS	Vital Statisticsfrom the Oregon Center for Health Statistics.	Vital Statisticsfrom the Oregon Center for Health Statistics.	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: 2012 final data is entered under 2013, 2013 provisional data is entered under 2104.	
2.	**Field Name:**	**2013**
	Field Note: Same source of data for NPM #15 and SPM #3: Pregnancy Risk Assessment Monitoring System (PRAMS), Oregon Health Authority. The most currently available PRAMS data is still survey 2011 weighted (final) counts and percentage. PRAMS 2012 and 2013 data will be available May 2015 and May 2016 due to CDC technical issues. The 2011 data was copied into 2012 and 2013 columns and marked as provisional.	
3.	**Field Name:**	**2012**
	Field Note: Source: PRAMS weighted (final) 2011 data – the most currently available PRAMS survey. There is no 2012 PRAMS survey yet, so 2011 data was copied into 2012 column. Between 2010 and 2011, there appears to be a small increase in smoking within survey margin of error.	
4.	**Field Name:**	**2011**
	Field Note: Source: PRAMS weighted (final) 2010 data – from the most currently available PRAMS survey. There is no 2011 PRAMS survey yet, so 2010 data carried over. The 2010 PRAMS data (10.1%) showed that the percentage of women who smoked in the last 3 months of pregnancy declined compared to what was observed in 2008 (11.1%) and 2009 (12.1%).	

Data Alerts:

None

NPM 16 - The rate (per 100,000) of suicide deaths among youths aged 15 through 19.

	2011	2012	2013	2014	2015

Annual Objective	7.0	6.5	6.5	16.0	16.0
Annual Indicator	7.2	12.2	16.2	16.7	
Numerator	18	30	40	41	
Denominator	249,715	246,339	246,339	245,971	
Data Source	Injury and Violence Prevention Program	Injury and Violence Prevention Program	Numerator: Vital Statistics from the Oregon Center for Health Statistics. Denominator: Population Research Center, Portland State University.	Numerator: Vital Statistics from the Oregon Center for Health Statistics. Denominator: Population Research Center, Portland State University.	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
2013 data is considered final. 2014 data is not yet available, so 2013 data is carried over to 2014. Previous reports have used data from from CDC WISQARS, Fatal Injury Reports, 1999-2010, for National, Regional, and States (RESTRICTED). However the most recent data available from CDC WISQARS 2010 data, therefore this report uses data provided by the Oregon Injury & Violence Prevention Program. The data sources used by the program are vital statistics from the Oregon Center for Health Statistics population data from the Population Research Center, Portland State University.

2.	**Field Name:**	**2013**

Field Note:
Source: State Injury and Violence Prevention Program, Oregon Violent Death Reporting System, Oregon Health Authority. Preliminary 2013 data entered. Year 2012 data updated from 18/249,715 to 30/246,339 and is now considered final. Denominator: NSCH, Vintage Bridge-Race Population Estimates.

Oregon suicide rates among ages 15 to 19 remained unchanged from 2004 to 2011. In 2012 there was an increase of cases (to 30), with a rate of 12.2 per 100,000 compared to 7.2 per 100,000 in 2011; however the increase was not statistically significant. The cases increased in 2013 to 40 and that was significant. Reason or solid evidence is unknown at the moment for the increase.

3.	**Field Name:**	**2012**

Field Note:
Source: State Injury and Violence Prevention Program, Oregon Violent Death Reporting System, Oregon Health Authority. There is about two years of lag time in reporting data (the 2012 data will be available May 2014), so 2011 data was copied into 2012 column. Denominator: CDC-National Center for Health Statistics (NCHS), Vintage Bridge-Race Population Estimates, 2012 population estimates for youth aged 15 through 19 years old.

The suicide rates vary from year to year. A trend analysis showed that Oregon suicide rates among ages 15 to 19 remained unchanged from 2004 to 2011.

4.	**Field Name:**	**2011**

Field Note:
Source: State Injury and Violence Prevention Program, Oregon Violent Death Reporting System, Oregon Health Authority. Year 2010 data updated and is final as of 5/2012. Denominator: CDC-National Center for Health Statistics (NCHS), Vintage 2010 population estimates. There is 2 years of lag time in reporting data (the 2011 data will be available May 2013), so 2010 data carried over.

The suicide rates vary from one year to another. Overall the suicide rates among ages 15 to 19 have remained at same level since 2004. There is not a statistical difference on the rate between 2008 and 2010. Note: Two to three years of data isn't sufficient to do trend analysis.

Data Alerts:

None

NPM 17 - Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

	2011	2012	2013	2014	2015
Annual Objective	99.8	99.8	90.0	90.0	90.0
Annual Indicator	99.5	89.6	84.6	84.6	
Numerator	428	379	378	379	
Denominator	430	423	447	448	
Data Source	Oregon Center for Health Statistics	Oregon Center for Health Statistics	Oregon Center for Health Statistics	Oregon Center for Health Statistics	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
2012 final data is entered under 2013, 2013 provisional data is entered under 2104. Caution must be used in interpreting these data. In collaboration with the state's Center for Health Statistics, the Maternal and Child Health Section monitors VLBW births where they occur. However, there are a number of measurement challenges such as the need to capture births to state residents that occur in other states and the lack of a formal level designation for NICUs.

2.	**Field Name:**	**2013**

Field Note:
Source: Oregon Center for Health Statistics, 2013 preliminary birth counts. Numerator: very low birth weight (VLB) infants from any of the 7 NICUs in Oregon. Denominator: total very low birth weights infants born in any hospitals or birthing facilities in Oregon. The final 2012 data was reviewed and is 442 instead of 423; however those 19 additional cases are VLB infants occurred out of state so the data was not updated to 442.

In 2013, 85% of very low birth weight infants were delivered at hospitals or birthing centers with NICUs. The finalized data to be available Spring 2015 should provide a more accurate estimate.

The numerator for this Performance Measure changed in 2012. From 2009-2011 the numerator was the number of very low birth weight infants born in any hospital in Oregon to an Oregon resident woman. For 2012-2013, the new numerator was the number of very low birth weight infants born in one of the 7 Oregon hospitals with a NICU. The denominator (the total number of very low birth weight infants born in Oregon to an Oregon resident women) did not change. The result is that the Performance Measure annual indicator decreased after 2011. There is no indication that the actual pattern of birthplaces has changed since 2009.

3.	**Field Name:**	**2012**

Field Note:
Source: CHS, 2012 preliminary data. In 2012 data, there was a change to the numerator to include only very low birthweight infants from any 7 NICUs in Oregon. The denominator remains unchanged: total very low birth weights infants from any hospitals or birthing facilities.

In 2012, about 89% of very low birth weight infants were delivered at hospitals or birthing centers with NICUs.

Notes: Data from 2012 onward, based on very low birth weight infants from only NICUs (numerator), is similar to methods used for 2006 and prior years that are no longer visible in the data table for NPM #17). Seconldy, as mentioned in field notes from previous years: From 2007-2011, the numerator was based on very low birthweight infants born in any hospitals, so the prevalence for years 2007-2011 are higher than 2006 data and prior years. Comparison of data across years is limited due to the different reporting methods. The data for this measure does not imply that approximately 100% of very low birthweight infants are being delivered at birthing centers designed for high risk infants.

4.	**Field Name:**	**2011**

Field Note:
Source: CHS, 2011 preliminary data. The 2010 data was reviewed and updated, and is now considered final.

As mentioned in field notes from previous years: Starting in 2007, reporting for this measure was based on very low birthweight infants born in any hospitals, so the prevalence for years 2007 and onward are higher compared to 2006 data. Comparison of data across years is limited due to the different reporting method. The data for this measure does not implies that approximately 100% of very low birthweight infants are being delivered at birthing centers designed for high risk infants.

Since 2007, about 99% of very low birth weight infants were delivered at hospitals or birthing centers designed for high risk infants.
Note: As part of quality improvement for this indicator, next year's report will refine the numerator to being "very low birth weight infants born in 7 NICUs" (see Narrative Section for the list of the 7 hospitals with NICUs).

Data Alerts:

None

NPM 18 - Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

	2011	2012	2013	2014	2015
Annual Objective	74.0	75.0	78.2	79.0	79.5
Annual Indicator	74.9	78.1	78.3	76.5	
Numerator	32,754	34,609	34,782	34,546	
Denominator	43,732	44,329	44,433	45,136	
Data Source	Oregon Center for Heatlh Statistics	Oregon Center for Heatlh Statistics	Oregon Center for Heatlh Statistics	Oregon Center for Heatlh Statistics	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: 2012 final data is entered under 2013, 2013 provisional data is entered under 2104.	
2.	**Field Name:**	**2013**
	Field Note: Source: Center for Health Statistics (CHS), 2013 preliminary birth certificate data. Percentages are calculated by excluding missing cases in the denominator following CHS's computation method. Year 2012 final data updated from 34,481/44,155 (78.1%) to 34,609/44,329 (78.1%). Compared to 2011 (74.9%), there is a slight increase in infants born to pregnant women who received prenatal care in the first trimester. The increase is not statistically significant.	
3.	**Field Name:**	**2012**
	Field Note: Source: Center for Health Statistics (CHS), 2012 preliminary birth certificate data. Percentages are calculated by excluding missing cases in the denominator following CHS's computation method. There is a slight increase in infants born to pregnant women who received prenatal care in the first trimester. The increase is not statistically significant compared to 2011.	
4.	**Field Name:**	**2011**
	Field Note: Source: Center for Health Statistics (CHS), 2011 preliminary data. The year 2010 data was reviewed and updated, and is now final. Percentages are calculated by excluding missing cases in the denominator following CHS's computation method.	

There is an increase trend of infants born to pregnant women who received prenatal care in the first trimester.

Data Alerts:

None

Form 10d
State Performance Measures (SPMs) (Reporting Year 2014 & 2015)

State: Oregon

SPM 1 - Percent of family planning clinic encounters in which relationship safety was discussed with the client.

	2011	2012	2013	2014	2015
Annual Objective	12.4	14.0	16.0	18.0	20.0
Annual Indicator	16.4	27.9	35.2	37.9	
Numerator	27,184	45,473	51,106	43,835	
Denominator	165,815	163,148	145,162	115,807	
Data Source	Region X Ahlers Family Planning database	Region X Ahlers Family Planning database	Region X Ahlers Family Planning database	Region X Ahlers Family Planning database	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d SPMs:

1. **Field Name:** **2014**

Field Note:
The Clinic Visit Record (CVR) is an encounter form used for all publicly-funded family planning clients statewide. Clients must be of reproductive age to receive services. The measure is defined as any visit/encounter (not necessary the first encounter) with a relationship safety component within the report time period (numerator). This is not unduplicated client-level data; and it is possible that one client could have had more than one visit/encounter within the reported time period.

2. **Field Name:** **2013**

Field Note:
Source: Ahlers Family Planning Client Data-Clinic Visit Record (CVR), Reproductive Health Program. The Clinic Visit Record (CVR) is an encounter form used for all publicly-funded family planning clients statewide. Clients must be of reproductive age to receive services. The measure is defined as any visit/encounter (not necessary the first encounter) with a relationship safety component within the report time period (numerator). This is not unduplicated client-level data; and it is possible that one client could have had more than one visit/encounter within the reported time period.

In calendar year 2013, 35.2% of visits/encounters included counseling on relationship safety. There was a dramatic increase between 2010 and 2013 in the proportion of visits that included counseling on relationship safety (12.4% in 2010, 16.4% in 2011, 27.9% in 2012, and 35.2% in 2013). Demographic characteristics of the population who received relationship safety information are: 99.2% female, 78.3% aged 20 years old or more (compared to 21.7% being 19 years old or younger), and 82.7% white.

The increasing trend may be due, in part, to a special session devoted to domestic violence screening in the clinic

setting during the fall 2011 Reproductive Health Coordinators' Meeting. Representatives from family planning clinics throughout the state attended and received resources and materials to share with other clinic staff. In addition, the percentage of Oregon's family planning providers reporting they are screening for IPV has gone up significantly since addressing IPV became a Title V priority. This increase has been noted especially since Oregon started the Project Connect Grant in 2013. Since then the percentage went from 27.9% reporting to 35.2%, and is expected to be increasing with screening issues resolved and all number of screenings tracked appropriately. Project Connect is a 3 year grant from Futures without Violence to implement clinic-based intensive screening and referral intervention at three family planning sites (North Central Public Health District, Washington County, and Deschutes County).

3.	**Field Name:**	**2012**

Field Note:
Source: Ahlers Family Planning Client Data-Clinic Visit Record (CVR), Reproductive Health Program. Data are based on calendar year. The Clinic Visit Record (CVR) is an encounter form used for all publicly-funded family planning clients statewide. Clients must be of reproductive age to receive services. The measure is defined as any visit/encounter (not necessary the first encounter) with a relationship safety component within the report time period (numerator). This is not unduplicated client-level data; and it is possible that one client could have had more than one visit/encounter within the reported time period.

In 2012, 27.9% of visits/encounters included counseling on relationship safety. There was a dramatic increase between 2011 and 2012 in the proportion of visits that included counseling on relationship safety (16.4% in 2011 and 27.9% in 2012). This may be due, in part, to a special session devoted to domestic violence screening in the clinic setting during the fall 2011 Reproductive Health Coordinators meeting. Representatives from family planning clinics throughout the state attended and received resources and materials to share with other clinic staff. It is too early to determine whether this increase will be sustained. Demographic characteristics of the population who received relationship safety information are: 99.2% female, 76.3% aged 20 years old or more (compared to 23.7% being 19 years old or younger), and 82.1% white.

4.	**Field Name:**	**2011**

Field Note:
Source: Ahlers Family Planning Client Data-Clinic Visit Record (CVR), Women's & Reproductive Health Program. Data based on calendar year. The Clinic Visit Record (CVR) is an encounter form used for all publicly-funded family planning clients statewide. Clients must be of reproductive age to receive services. The measure is defined as any visit/encounter (not necessarily the first encounter) with a relationship safety component within the reported time period (numerator). This is not unduplicated client-level data; and it is possible that one client could have had more than one visit/encounter within the report time period.

In 2011, 16.4% of visits/encounters included counseling on relationship safety. There are fluctuations between 2008 and 2011, and it is too early to assess if these changes indicate a real trend. Demographic characteristics of the population who received relationship safety information are: 98.6% female, 67.9% aged 20 years old or more (compared to 32.1% being 19 years old or younger), and 84.7% white.

Data Alerts:

None

SPM 2 - Percent of 11th grade students who were 14 years old or younger when they had more than a sip or two of beer, wine, or hard liquor for the first time

	2011	2012	2013	2014	2015
Annual Objective	43.0	43.0	42.0	42.0	40.0
Annual Indicator	40.1	40.1	37.9	37.9	
Numerator	15,272	15,272	14,096	14,096	
Denominator	38,063	38,063	37,185	37,185	
Data Source	Oregon Healthy Teens (OHT)	Oregon Healthy Teens (OHT)	Oregon Healthy Teens (OHT)	Oregon Healthy Teens (OHT)	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2014**

Field Note:
Most recent data available is 2013, as the Oregon Healthy Teens Survey is only conducted every two years (on odd years). 2013 data copied over to 2014 reporting year. Data presented includes weighted counts and percentages. Weighted counts do not represent the actual number of students that were surveyed, but the estimated number of 11th grade population attending public schools, not counting charter or private schools. Unweighted counts and weighted percentages available at http://public.health.oregon.gov/BirthDeathCertificates/Surveys/OregonHealthyTeens/results/Pages/ohtdata.aspx.

2.	**Field Name:**	**2013**

Field Note:
Source: 2013 Oregon Healthy Teens Survey, Oregon Health Authority. Weighted counts and percentages. Weighted counts do not represent the actual number of students that were surveyed, but the estimated number of 11th grade population attending public schools, not counting charter or private schools. Unweighted counts and weighted percentages available at http://public.health.oregon.gov/BirthDeathCertificates/Surveys/OregonHealthyTeens/results/Pages/ohtdata.aspx.

Fewer 11th grade youth reported having their first sip of alcohol before age 14 in school year 2013/14 (37.9%) than in 2009/10 (43.5%) and 2007/2008 (47.5%), continuing a slight downward trend. While the downward trend in the data are encouraging, single-year fluctuations should be interpreted with caution. The survey only captures one point in time, and changes could be due to differences in the survey sample from previous years or other secular trends. This trend will continue to be closely monitored, as the Addictions and Mental Health Division roll out a statewide media campaign to address norms around drinking and the Public Health Division implements strategiesto increase provider awareness and screening of alcohol use among youth.

3.	**Field Name:**	**2012**

Field Note:
2011 data carried forward. 2012 data is unavailable because OHT was not conducted. As of 2011, OHT is only conducted in odd-numbered years and the Student Wellness Survey (SWS) is conducted in even-numbered years; contingent on funding.

Source: 2011 Oregon Healthy Teens Survey, Oregon Health Authority. Weighted counts and percentages. Weighted counts do not represent the actual number of students that were surveyed, but the estimated number of 11th grade population attending public schools, not counting charter or private schools. Unweighted counts and weighted percentages available at http://public.health.oregon.gov/BirthDeathCertificates/Surveys/OregonHealthyTeens/results/Pages/ohtdata.aspx.

4.	**Field Name:**	**2011**

Field Note:
Source: 2011 Oregon Healthy Teens survey, Oregon Health Authority. Weighted counts and percentages. Unweighted counts and weighted percentages for years 2008 and 2009 available at http://public.health.oregon.gov/BirthDeathCertificates/Surveys/OregonHealthyTeens/results/Pages/ohtdata.aspx. Weighted counts do not represent the actual number of students who were surveyed, but the estimated number of 8th grade population attending public schools, not counting charter or private schools.

Fewer 11th grade youth reported having their first sip of alcohol before age 14 in 2011 (40.1%) than in 2009/10 (43.5%) and 2008 (47.5%), continuing a slight downward trend. While the downward trend in the data are encouraging, single-year fluctuations should be interpreted with caution. The survey only captures one point in time, and changes could be due to differences in the survey sample from previous years or other secular trends. This trend will continue to be closely monitored, as the Addictions and Mental Health Division roll out a statewide media campaign to address norms around drinking and the Public Health Division implements strategies to increase provider awareness and screening of alcohol use among youth.

Data Alerts:

None

SPM 3 - Percent of women who reported that they received education about depression during their most recent pregnancy from a prenatal care provider.

	2011	2012	2013	2014	2015
Annual Objective	76.0	76.0	76.0	76.0	77.0
Annual Indicator	79.3	79.3	79.3	79.3	
Numerator	33,750	33,750	33,750	33,750	
Denominator	42,568	42,568	42,568	42,568	
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2014**

Field Note:
The most currently available data is from 2011. The data presented includes final weighted counts and percentage. PRAMS 2012 and 2013 data will be available after May 2015 due to CDC technical issues, so there is no PRAMS data for reporting years 2013 and 2014. The 2011 data was copied into 2013 and 2014 columns as placeholders. The data used for this indicator was based on the following survey question that was incorporated into PRAMS in 2009: During any of your prenatal care visits, did a doctor, nurse, or other health care worker talk with you about any of the things listed below? A dichotomous (No/Yes) response category: What to do if I feel depressed during my pregnancy or after my baby is born. The survey question is not specific to being screened for depression during pregnancy; however, it provides information about whether the woman received depression education during her most recent pregnancy. 79.3% of women who gave births in 2011 reported having received education on depre

2.	**Field Name:**	**2013**

Field Note:
Same source of data for NPM #15 and SPM #3: Pregnancy Risk Assessment Monitoring System (PRAMS), Oregon Health Authority. The most currently available PRAMS 2011 weighted (final) counts and percentage. PRAMS 2012 and 2013 data will be available after May 2015 due to CDC technical issues, so there is no PRAMS data for reporting years 2012 and 2013. The 2011 data was copied into 2012 and 2013 columns as placeholders. The question used for this indicator was administered in PRAMS phase VII (PRAMS 2012 through PRAMS 2015 for births from 2012-2015). In PRAMS 2012 the question was numbered as #21 and not #23 as in PRAMS 2011.

As stated in previous reports: Based on the following survey question that was incorporated into PRAMS starting 2009 (question #23) and was asked among women who gave births in 2009: During any of your prenatal care visits, did a doctor, nurse, or other health care worker talk with you about any of the things listed below? A dichotomous (No/Yes) response category: What to do if I feel depressed during my pregnancy or after my baby is born. The survey question is not specific to being screened for depression during pregnancy; however, it provides information about whether the woman received depression education during her most recent pregnancy. Seventy-nine percent of women who gave births in 2011 reported having received education on depression during prenatal care visits for that pregnancy. This is slightly higher than women who gave birth in 2009 (76.0%) and 2010 (78%).

3.	**Field Name:**	**2012**

Field Note:
Source: Pregnancy Risk Assessment Monitoring System (PRAMS), Oregon Health Authority. The most currently available PRAMS 2011 weighted (final) counts and percentage. 2012 data unavailable so 2011 data copied into 2012 column.

Based on the following survey question that was incorporated into PRAMS starting 2009 (question #23) and was asked among women who gave births in 2009: During any of your prenatal care visits, did a doctor, nurse, or other health care worker talk with you about any of the things listed below? A dichotomous (No/Yes) response category: What to do if I feel depressed during my pregnancy or after my baby is born. The survey question is not specific to being screened for depression during pregnancy; however, it provides information about whether the woman received depression education during her most
recent pregnancy.

Seventy-nine percent of women who gave births in 2011 reported having received education on depression during prenatal care visits for that pregnancy. This is slightly higher than women who gave
birth in 2009 (76.0%) and 2010 (78%).

4.	**Field Name:**	**2011**

Field Note:
Source: Pregnancy Risk Assessment Monitoring System (PRAMS), Oregon Health Authority. PRAMS 2010 weighted (final) counts and percentage. The data entered for 2011 is considered preliminary because 2010 data was carried over.

Based on the following survey question that was incorporated into PRAMS starting 2009 (question #23) and was asked among women who gave births in 2009: During any of your prenatal care visits, did a doctor, nurse, or other health care worker talk with you about any of the things listed below? A dichotomous (No/Yes) response category: What to do if I feel depressed during my pregnancy or after my baby is born. 2009 was the first year of data for this measure. The survey question is not specific to being screened for depression during pregnancy; however, it provides information about whether the woman received depression education during her most recent pregnancy.

Seventy-seven percent of women who gave births in 2010 reported having received education on depression during prenatal care visits for that pregnancy. This is slightly higher women who gave birth in 2009 (76.0%).

Data Alerts:

None

SPM 4 - Percent of children less than 4 years of age on Medicaid who received preventive dental services from a dental provider in the year.

	2011	2012	2013	2014	2015
Annual Objective	18.0	18.0	20.0	20.0	21.0
Annual Indicator	19.2	18.6	20.4	20.4	
Numerator	20,671	20,003	21,509	21,509	
Denominator	107,837	107,270	105,301	105,301	
Data Source	Medicaid data	Medicaid data	Medicaid data	Oregon Division of Medical Assistance Programs (Oregon's Medicaid agency).	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2014**

Field Note:
Most recent availble data is from 2013, because a 6 month period is needed for providers to submit all claims for

the reporting year, therefore data for 2014 will not be available until July 2015. Among children 4 years old and under, there is an increasing trend in having received preventive dental services from dental providers. Between 2009 and 2013, the percentage of children who received preventive dental services increased from 17.6% to 20.4% (includes children enrolled for at least one day in Medicaid, and also includes those enrolled in SCHIP).

2.	**Field Name:**	**2013**

Field Note:
Source: DMAP (Oregon's Medicaid agency). Calendar year 2013 final data. Data was extracted July 2014 because a 6 month period is needed for providers to submit all claims for the reporting year.

Among children 4 years old and under, there is an increasing trend in having received preventive dental services from dental providers. Between 2009 and 2013, 18% to 20% children received preventive dental services. This is for children enrolled for at least one day (ever enrolled) in Medicaid, and also include those enrolled in SCHIP.

3.	**Field Name:**	**2012**

Field Note:
Source: DMAP (Medicaid agency). Year 2011 data updated, and 2012 final data entered.

Among children 4 years old and under, there is an increasing trend in having received preventive dental services from dental providers. Between 2009 and 2012, 18% to 19% children received preventive dental services. This is for children enrolled for at least one day (ever enrolled) in Medicaid, and includes SCHIP.

4.	**Field Name:**	**2011**

Field Note:
Source: DMAP, calendar year 2010 final data. As with HSCI #2, 3, 7A and 7B, data will be available after Fall 2012 so 2010 data carried over.

Among children 4 years old and under, there is an increasing trend in having received preventive dental services from dental provider. Between 2009 and 2010, 17.6% to 18.7% children received preventive dental services. This is for children enrolled for at least one day (ever enrolled) in Medicaid, and includes SCHIP.

Data Alerts:

None

SPM 5 - Using benchmarks develop a Public Health Action Plan for improving parenting skills and education within MCH policies, programs, and outcomes.

	2011	2012	2013	2014	2015
Annual Objective	1.0	4.0	5.0	6.0	6.0
Annual Indicator	2.5	3.5	4.0	4.0	
Numerator	3	4	4	4	
Denominator	6	6	6	6	

	2011	2012	2013	2014	2015
Data Source	Benchmarks	Benchmarks	Benchmarks	Benchmarks	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2014**

Field Note:
The indicator is a calculated ratio, based on self-evaluation of the progress for each step of the benchmark. Each step is valued at 1.0, and may be scored at 0.5 if only part of a benchmark has been completed. The steps are as follows: 1. Complete an inventory of existing parenting resources, unmet parenting needs, and opportunities. 2. Select a framework for assessment and planning that aligns with the statewide early childhood health and education policy initiatives and programs. 3. Participate and engage with parent(s) and stakeholder groups working on parenting skills and early childhood policies and programs 4. Develop goals and outcomes for the Public Health Action Plan that are identified by and aligned with parent(s) and stakeholder groups for early childhood initiatives and programs such as the state's Early Learning Council, LAUNCH grant, and MIECHV (home visiting) grant. 5. Select parenting skills, knowledge and behavior needs that are feasible for action by public health a

2.	**Field Name:**	**2013**

Field Note:
SAME NOTE AS 2011.

3.	**Field Name:**	**2012**

Field Note:
SAME NOTE AS 2011.

4.	**Field Name:**	**2011**

Field Note:
As a new measure in 2010, no data available prior to 2011.

Calculation: A ratio. Self-evaluation of the progress for each step of the benchmark. Each step is valued at 1.0, and may be scored at 0.5 if only part of a benchmark has been completed.

1. Complete an inventory of existing parenting resources, unmet parenting needs, and opportunities.
2. Select a framework for assessment and planning that aligns with the statewide early childhood health and education policy initiatives and programs.
3. Participate and engage with parent(s) and stakeholder groups working on parenting skills and early childhood policies and programs
4. Develop goals and outcomes for the Public Health Action Plan that are identified by and aligned with parent(s) and stakeholder groups for early childhood initiatives and programs such as the state's Early Learning Council, LAUNCH grant, and MIECHV (home visiting) grant.
5. Select parenting skills, knowledge and behavior needs that are feasible for action by public health and Title V agencies.
6. Complete the Public Health Action Plan, which will include an evaluation process, for improving parenting skills

and education by September, 2015.

Data Alerts:

None

SPM 6 - Percent of 8th grade students with a BMI below the 85th percentile

	2011	2012	2013	2014	2015
Annual Objective	73.5	74.0	74.5	75.5	76.0
Annual Indicator	77.9	77.9	75.1	75.1	
Numerator	28,817	28,817	26,814	26,814	
Denominator	36,971	36,971	35,724	35,724	
Data Source	Oregon Healthy Teens (OHT)	Oregon Healthy Teens (OHT)	Oregon Healthy Teens (OHT)	Oregon Healthy Teens (OHT)	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2014**

Field Note:
Data presented includes weighted counts and percentages. Weighted counts do not represent the actual number of students that were surveyed, but the estimated number of 11th grade population attending public schools, not counting charter or private schools. Unweighted counts and weighted percentages available at http://public.health.oregon.gov/BirthDeathCertificates/Surveys/OregonHealthyTeens/results/Pages/ohtdata.aspx.

2.	**Field Name:**	**2013**

Field Note:
Source: 2013 Oregon Healthy Teens Survey, Oregon Health Authority. Weighted counts and percentages. Weighted counts do not represent the actual number of students that were surveyed, but the estimated number of 11th grade population attending public schools, not
counting charter or private schools. Unweighted counts and weighted percentages available at http://public.health.oregon.gov/BirthDeathCertificates/Surveys/OregonHealthyTeens/results/Pages/ohtdata.aspx.

Since 2007 the number of 8th grade students with a BMI below the 85th percentile has stayed relatively constant with minor fluctuations. This trend continued between 2011 and 2013, with a slight decrease in the proportion of 8th graders with a BMI below the 85th percentile. This is true not only for students whose BMI falls below the 85th percentile, but also for those with a BMI in the 85th < 95th percentile (overweight) and those with a BMI in the > 95th percentile (obese) category. The survey only captures one point in time, and changes could be due to differences in the survey sample and other secular trends. Reducing overweight and obesity has been identified as a priority for the Oregon Public Health Division, and this trend will be closely monitored in the coming years as

it moves forward with new strategies and activities.

Note: the terminology for childhood overweight and obesity has changed. In the past, childhood overweight BMI > 85th percentile was referred to as "at risk of overweight" (now "overweight") and a BMI > 95th percentile was referred to as "overweight" (now "obese").

3.	**Field Name:**	**2012**

Field Note:
There was no OHT survey in 2011 so the 2011 data was copied into 2012 column as placeholder, and the 2012 data is marked as "provisional." See last year's field-level notes for the source of data.

From 2009 onward, OHT is only conducted in odd-numbered years and the Student Wellness Survey (SWS) in even-numbered years by another state program. Administration of OHT or SWS is contingent on funding.

4.	**Field Name:**	**2011**

Field Note:
Source: 2011 Oregon Healthy Teens survey, Oregon Health Authority. Weighted counts and percentages. Unweighted counts and weighted percentages for years 2008 & 2009 available at http://public.health.oregon.gov/BirthDeathCertificates/Surveys/OregonHealthyTeens/results/Pages/ohtdata.aspx. Weighted counts do not represent the actual number of students that were surveyed, but the estimated number of 8th grade population attending public schools, not counting charter or private schools.

Since 2007 the number of 8th grade students with a BMI below the 85th percentile has stayed relatively constant with minor fluctuations. This is true not only for students whose BMI falls below the 85th percentile, but also for those with a BMI in the 85th < 95th percentile (overweight) and those with a BMI in the > 95th percentile (obese) category. The increase in the proportion of 8th grade students below the 85th percentile in 2011 is encouraging, but should be interpreted with caution. The survey only captures one point in time, and changes could be due to differences in the survey sample and other secular trends. Reducing overweight and obesity has been identified as a priority for the Oregon Public Health Division, and this trend will be closely monitored in the coming years as it moves forward with new strategies and activities. Note: the terminology for childhood overweight and obesity has changed. In the past, childhood overweight BMI > 85th percentile was referred to as "at risk of overweight" (now "overweight") and a BMI > 95th percentile was referred to as "overweight" (now "obese").

Data Alerts:

None

SPM 7 - Percent of 8th grade students who went to a doctor or nurse practitioner for a check-up or physical exam when they were not sick or injured during the past 12 months.

	2011	2012	2013	2014	2015
Annual Objective	44.0	44.0	46.0	46.0	48.0
Annual Indicator	56.7	56.7	56.0	56.0	
Numerator	23,151	23,151	23,043	23,043	
Denominator	40,856	40,856	41,118	41,118	

	2011	2012	2013	2014	2015
Data Source	Oregon Healthy Teens	Oregon Healthy Teens	Oregon Healthy Teens	Oregon Healthy Teens	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2014**

Field Note:
Most recent data available is 2013, as the Oregon Healthy Teens Survey is only conducted every two years (on odd years). 2013 data copied over to 2014 reporting year. Data presented includes weighted counts and percentages. Weighted counts do not represent the actual number of students that were surveyed, but the estimated number of 11th grade population attending public schools, not counting charter or private schools. Unweighted counts and weighted percentages available at http://public.health.oregon.gov/BirthDeathCertificates/Surveys/OregonHealthyTeens/results/Pages/ohtdata.aspx.

2.	**Field Name:**	**2013**

Field Note:
Source: 2013 Oregon Healthy Teens Survey, Oregon Health Authority. Weighted counts and percentages. Weighted counts do not represent the actual number of students that were surveyed, but the estimated number of 11th grade population attending public schools, not
counting charter or private schools. Unweighted counts and weighted percentages available at http://public.health.oregon.gov/BirthDeathCertificates/Surveys/OregonHealthyTeens/results/Pages/ohtdata.aspx.

Based on the following OHT survey question among 8th graders: When did you last go to a doctor or nurse practitioner for a check-up or physical exam when you were not sick or injured? More 8th graders saw a doctor or a nurse practitioner for a check-up or physical exam when they were not sick or injured in 2013 (56.0%) and 2011 (56.7%) than in 2009/10 (45.1%) or 2007/2008 (47.4%). The increase could be attributed to the State's increased focus on expanding insurance coverage among this population through programs like Healthy Kids, and increasing access points through School- Based Health Centers. However, changes in the data should be interpreted with caution, as the survey only captures one point in time, and changes could be due to differences in the survey sample and other secular trends. This trend will be closely monitored as the State forwards efforts to transform the delivery of Medicaid services through Coordinated Care Organizations in the coming years.

3.	**Field Name:**	**2012**

Field Note:
There was no OHT survey in 2011 so the 2011 data was copied into 2012 column as placeholder, and the 2012 data is marked as "provisional." See last year's field-level notes for the source of data.

From 2009 onward, OHT is only conducted in odd-numbered years and the Student Wellness Survey (SWS) in even-numbered years by another state program. Administration of OHT or SWS is contingent on funding.

4.	**Field Name:**	**2011**

Field Note:
2011 Oregon Healthy Teens survey, Oregon Health Authority. Weighted counts and percentages. Unweighted

counts and weighted percentages for years 2008 and 2009 available at http://public.health.oregon.gov/BirthDeathCertificates/Surveys/OregonHealthyTeens/results/Pages/ohtdata.aspx. Weighted counts do not represent the actual number of students that were surveyed, but the estimated number of 8th grade population attending public schools, not counting charter or private schools.

Based on the following OHT survey question among 8th graders: When did you last go to a doctor or nurse practitioner for a check-up or physical exam when you were not sick or injured?

More 8th graders saw a doctor or a nurse practitioner for a check-up or physical exam when they were not sick or injured in 2011 (56.7%) than in 2009/10 (45.1%) or 2008 (47.4%). The increase could be attributed to the State's increased focus on expanding insurance coverage among this population through programs like Healthy Kids, and increasing access points through School-Based Health Centers. However, changes in the data should be interpreted with caution, as the survey only captures one point in time, and changes could be due to differences in the survey sample and other secular trends. This trend will be closely monitored as the State forwards efforts to transform the delivery of Medicaid services through Coordinated Care Organizations in the coming years.

Data Alerts:

None

SPM 8 - Among CYSHN who needed mental health care or counseling in the past 12 months, percent of CYHSN who received all needed care.

	2011	2012	2013	2014	2015
Annual Objective	85.0	85.0	85.0	85.0	85.0
Annual Indicator	72.0	72.0	72.0	72.0	
Numerator	72	72	72	72	
Denominator	100	100	100	100	
Data Source	NS-CSHCN	NS-CSHCN	ns-cshcn	ns-cshcn	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2011**

Field Note:
Data for this Performance Measure are from the 2009/2010 National Survey of CSHCN. This is the most current data available for progress toward this indicator. The specific items used to compute this information are C4Q05_6 – Needed mental health or counseling in the past 12 months and C4Q05_6A – Received all needed mental health or counseling in the past 12 months.

Data Alerts:

None

SPM 9 - Among CYSHN who needed specialty care in the past 12 months, percent of CYHSN who received all needed care.

	2011	2012	2013	2014	2015
Annual Objective	81.0	81.0	81.0	81.0	81.0
Annual Indicator	90.0	90.0	90.0	90.0	
Numerator	90	90	90	90	
Denominator	100	100	100	100	
Data Source	NS-CSHCN	NS-CSHCN	NS-CSHCN	NS-CSHCN	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2011**

Field Note:
Data for this Performance Measure are from the 2009/2010 National Survey of CSHCN. This is the most current data available for progress toward this indicator. The specific items used to compute this information are C4Q05_2 – Needed specialty care in the past 12 months and C4Q05_2A – Received all needed specialty care in the past 12 months.

Data Alerts:

None

SPM 10 - Progress in developing an Action Plan to improve access to family support services for families of children with special health needs statewide

	2011	2012	2013	2014	2015
Annual Objective	1.0	2.0	3.0	4.0	4.0
Annual Indicator	1.0	1.5	2.0	3.0	
Numerator	1	2	2	3	
Denominator	4	4	4	4	

	2011	2012	2013	2014	2015
Data Source	OCCYSHN Benchmarks	OCCYSHN Benchmarks	OCCYSHN Benchmarks	OCCYSHN Benchmarks	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2011**

Field Note:
The data source for this measure is a benchmark checklist developed by OCCYSHN (Oregon's Title V CSHCN program). The checklist includes specific action steps for each benchmark. OCCYHSN monitors the checklist and determines when each benchmark has been completed. Documentation includes: benchmark checklist, work plans, timelines, meeting minutes, and completion of work products and activities.

Data Alerts:

None

Form 11
Other State Data

State: Oregon

While the Maternal and Child Health Bureau (MCHB) will populate the data elements on this form for the States, the data are not available for the FY 2016 application and FY 2014 annual report.

State Action Plan Table

State: Oregon

Please click the link below to download a PDF of the State Action Plan Table.
State Action Plan Table