Maternal and Child Health Services Title V Block Grant

Oregon

FY 2020 Application/ FY 2018 Annual Report

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I. General Requirements

I.A. Letter of Transmittal

PUBLIC HEALTH DIVISION
Center for Prevention and Health Promotion
Maternal and Child Health Section
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Oregon Health Authority

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July 9, 2019

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

Dear Ms. Lawler:

Enclosed are the FY 2020 Maternal & Child Health (MCH) Title V Block Grant Application and FY 2018 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 priorities 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 F of the 2018 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 *"Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms,"* OMB NO: 0915-0172; Expires: December 31, 2020.

II. Logic Model

Please refer to figure 4 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms," OMB No: 0915-0172; Expires: December 31, 2020.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

Oregon's Title V framework and leadership role

Oregon's Title V program relies on shared leadership between the Oregon Health Authority (OHA) Public Health Division's Maternal and Child Section (MCH), it's Adolescent and School Health program (ASHP), and the Oregon Center for Children and Youth with Special Health Needs (OCCYSHN) at Oregon Health and Science University. A leadership team makes Title V program and policy decisions and ensures alignment across the programs and agencies. Each Title V priority has a designated state lead who oversees state level program and policy work and provides technical assistance and oversight to the local level Title V grantees (public health and tribal). Title V also has a designated Tribal liaison who supports/oversees the work of the tribal Title V grantees. The state priority leads, Title V Coordinator, Title V MCAH and CYSHCN research analysts and Title V tribal liaison coordinate work across populations/domains.

The five-year needs assessment structure and activities are developed and coordinated by a steering committee with representatives from OHA MCH, Adolescent Health, and OCCYSHN, with input from Title V grantees and other stakeholders. Findings from the needs assessment are presented to a stakeholder group which uses them to recommend state and national Title V priorities, which are finalized by the Title V MCAH and CYSHCN Directors with Title V staff input. Ongoing needs assessment and surveillance activities are conducted in the interim years to support development of evidence based/informed activities, monitor progress, and identify emerging issues.

Title V strategies, activities and measures are developed by Oregon's Title V staff subject matter experts, in consultation with researchers, MCHB, and state and local partners. Thirty percent of Title V funding to implement and monitor performance related to the developed plans is allocated to OCCYSHN to address the Title V CYSHN priorities at both the state and local levels. The remaining funds are administered through the OHA PHD to implement and monitor state and local level Title V work in the maternal/women, perinatal/infant, child, adolescent, and cross-cutting domains.

MCAH Population Needs, Title V priorities, strategies, and plans

The findings of Oregon's 2015 Maternal Child and Adolescent Health (MCAH) Title V Needs Assessment identified 8 national priorities and 3 state-specific priorities for 2016-2020. They are: well woman care, breastfeeding, child physical activity, adolescent well care, medical home, and transition to adult health care for children and youth with special health care needs, oral health, smoking, toxic stress/trauma/ACEs, food insecurity, and culturally and linguistically responsive MCAH services (CLAS). An overview of Oregon's priority MCAH Title V needs, strategies, progress and plans for each domain is outlined below (see map of priority work, Supporting Document 4).

Maternal/Women's Health

Oregon's Title V program provides leadership for policy and system development efforts related to maternal/women's health including: ensuring that health system transformation addresses the need for comprehensive, culturally responsive maternal health services.

Needs/priorities

Based on the 2015 MCAH needs assessment, high quality, culturally responsive preconception, prenatal and inter-conception services are a priority need for this population. This need is being addressed through work on NPM 1

well-woman care (WWC). Improved oral health and reduced tobacco exposure for pregnant women were identified and are being addressed through work on NPM 13 oral health, and NPM 14.

Strategies

Well woman care strategies being implemented at the state level and by 8 grantees include: case-management and use of the postpartum health care visit to improve utilization of well-woman care; marketing to educate the population and promote well-woman care; training of health care providers, support for access through Family Planning Clinics.

Perinatal/Infant Health

Oregon Title V provides leadership and technical assistance for linkages to prenatal care, oral health, maternal mental health, and other perinatal services; infant mortality reduction; PRAMS and PRAMS2 surveillance systems; early hearing detection and intervention (EHDI); breastfeeding support; and integration of perinatal/infant health into programs and policies across state and local agencies.

Needs /priorities

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 through Oregon's food insecurity work.

Strategies

Breastfeeding strategies being implemented at the state level and by 17 grantees include: education of non-nursing partners and family members about the importance of breastfeeding; filling unmet needs for peer support of breastfeeding; education of pregnant women about breastfeeding; workforce support for breastfeeding; access to workplace breastfeeding support; and support for breastfeeding at child care settings.

Child Health

Title V's work in child health focuses on increasing community and caregiver capacity to promote the foundations of health: stable responsive relationships, safe supportive environments, and nutrition and healthy behaviors. A major focus is integration of child health into programs and policies across state and local agencies, including the early learning and education systems.

Needs/priorities

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 through Oregon's cross-cutting/systems work. Improved oral health for children; and reduced tobacco exposure for pregnant women and children were also identified and are being addressed through work on NPM 13 oral health, and NPM 14.

Strategies

Physical activity strategies being implemented at the state level and by 4 grantees include: physical activity in child care settings; physical activity before, during and after school; improving the physical environment for physical activity; expanding safe and active transportation options; policies and programs for healthy worksites; and partnerships with clinical care providers to support anticipatory guidance for physical activity.

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.

Needs/priorities

Based on the 2015 needs assessment, high quality, confidential preventive health services for adolescents is a priority need for this population. Title V will address this need through continued work on adolescent well-visit (NPM 10) and through Oregon's cross-cutting/systems work.

Strategies

Adolescent well care strategies being implemented at the state level and by 7 grantees include: outreach to key populations; promoting the practice of going beyond sports physicals to wellness exams; partnerships with public and private entities invested in adolescent health; policies and practices to make health care more youth-friendly; investigating barriers to adolescent well visits; and strengthening health care privacy and confidentiality policies and practices.

Children and Youth with Special Health Needs (CYSHCN)

Title V CYSHCN program 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 efforts that support access to care for CYSHCN, and partners with families and communities in policy and program development.

Needs/priorities

Medical home (MH) and youth health care transition (HCT) are Oregon's current state Title V CYSHCN priorities. Additionally, culturally and linguistically responsive services are a state CYSHCN priority. Findings from the needs assessment showed that high quality, family-centered coordinated systems of care are required to meet CYSHCN's complex needs. The *National Standards for Systems of Care for CYSHCN* include MH and HCT as 2 of its 10 domains of standards. The priorities will be addressed through work on NPM 11 and 12.

Strategies

Medical Home (MH) strategies focus on increasing cross-systems care coordination (CSCC) for CYSHCN and their families through public health nurse home visiting; supporting local public health in convening cross-sector child health teams to develop family-centered shared care planning; promoting family health literacy and family engagement in healthcare settings; promoting regional and state level infrastructure development to support CSCC; and building an evidence base to describe the effectiveness of these strategies.

Health Care Transition (HCT) strategies are integrated with those of MH given the interrelationship of these 2 priorities. Led by local public health entities, child health teams identify youth with special health care needs and build capacity to provide Shared Plan of Care services. Professional development for both pediatric and adult providers increases the capacity for provide necessary HCT services. Families receive HCT education, and we are exploring alternative payment models to support facilitated transition of care between pediatric and adult providers.

Life course and Cross-cutting/systems

Oregon's Title V program uses a life course focus and equity lens to maximize investment in policies, systems and programs that support lifelong health. Cross-cutting/systems work includes work on upstream state-specific priorities and investment in foundational capabilities such as epidemiology, communications, and leadership. Life course priorities of oral health and smoking priorities are also reported here.

Needs/priorities

Based on the 2015 needs assessment, improved oral health for pregnant women and children; reduced tobacco

use/exposure among pregnant women and children; nutrition; safe and nurturing relationships/stable, attached families; and improved health equity are all high priority cross-cutting needs for Oregon's MCAH population. These are addressed through work on NPM 13 oral health, NPM 14 smoking, as well as Oregon's state-specific priorities/performance measures of toxic stress/ACEs/resilience, food insecurity, and culturally and linguistically responsive services (CLAS).

Strategies

Oral health strategies being implemented at the state level and by 18 grantees include: oral health preventive services through Oregon's Home Visiting System and during well-child visits; collaboration with primary care providers on oral health guidelines for pregnant women; oral health preventive services for adolescents through schools; education about oral health & the importance of dental visits; and promotion of community water fluoridation.

Smoking strategies being implemented at the state level and by 5 grantees include: policy agenda to decreases youth exposure; 5As Intervention and Quit Line Referral within MCH Programs; collaboration with health systems and providers on screening and intervention processes and workforce training; promotion of health insurance coverage benefits for pregnant and postpartum women.

Toxic stress, ACEs and resilience strategies being implemented at the state level and by 7 grantees include: family friendly policies that decrease stress and adversity; outreach and education to increase understanding of NEAR science (neurobiology, epigenetics, ACEs and resilience) and the impact of childhood adversity; engaging partners to build capacity for safe, connected, equitable and resilient communities; assessment, surveillance, and epidemiological research; development of trauma-informed workforce, workplaces, systems, and services; support for programs that build protective factors.

Culturally and linguistically responsive services strategies being implemented at the state level and by 5 grantees include: effective, equitable, understandable, and culturally responsive services; organizational policy, practices, and leadership to promote CLAS and health equity; assessments of organization's CLAS-related activities and integration of CLAS-related measures into continuous quality improvement.

Food insecurity strategies being implemented at the state level and by 7 grantees include: screen clients for food insecurity & provide referrals for food assistance; food security education; access to healthy, affordable food; economic stability for individuals and families

Progress on State and National Performance measures

Title V MCAH and OCCYSHN staff monitor progress on state and national performance measures (SPMs and NPMs). Oregon's NPMs have shown mixed results during the past year. The NPMs that have improved moderately include NPM 8: Child physical activity, NPM 10: Adolescent well visit, NPM 13 B: Dental care among children, and NPM 14 A: Smoking during pregnancy. The NPMs that have worsened slightly are NPM 1: Well woman care, NPM 4 A & B: Breastfeeding initiation and exclusivity at 6 months, and NPM 13 A: Dental visit during pregnancy. Although the rates of breastfeeding and dental visits during pregnancy have both worsened slightly, Oregon consistently performs better in these areas than the national average. Both the increases and decreases in NPMs are small should be interpreted with caution.

According to the 2016-17 National Survey of Children's Health (NSCH), 39% of CYSHCN have a medical home (NPM 11) and 17% of YSHCN received services necessary to make transitions to adult health care (NPM 12). These data are not comparable to previous NSCH/NS-CSHCN estimates because of significant sampling and administration changes, but will be comparable to future data.

All SPMs either show improvement since last year's report or have remained stable. For SPM 2 B: Food insecurity among households with children, no new data is available to compare to data included in the previous report."

Title V partnerships and stakeholder engagement

Stakeholder engagement and partnerships are central to all phases of Oregon's Title V work. The Title V Director, CYSHCN Director, Adolescent Health Director, and Title V staff all work with external and internal stakeholders to provide MCAH leadership and ensure that Title V work is represented and integrated within and across agencies. These partnerships – including with the Governor's Children's Cabinet, Coordinated Care Organizations, the Early Learning Division, Local Health Authorities, and Tribes - provide critical opportunities to leverage Title V's work and develop collaborations which benefit the MCAH population and maximize use of funds. This work - especially with families and communities - also informs ongoing needs assessment, strategy implementation, evaluation, and modification of strategies/activities throughout the 5-year cycle.

III.A.2. How Federal Title V Funds Support State MCH Efforts

Title V funds complement and support overall state MCAH efforts. The 30% of funding that goes to OCCYSHN provides capacity for work with partners and local grantees on the Title V priorities of transition and medical home for CYSHCN, and provide expertise, advocacy, and partnership both within OHSU and externally with a wide range of external partners to change systems and services to improve and the health of children and youth with special health needs and their families.

The remaining 60% of Title V funding, administered through the Public Health Division, is used to support maternal, child, and adolescent health specialists, nurses, epidemiologists, and policy analysts working in: local health departments, tribes, and at the state level. The MCAH capacity provided through Title V supports work on both the identified Title V priorities, as well as ongoing MCAH assessment and surveillance, policy and partnership work, and multiple planning and system development efforts to which Title V staff contribute at the state and local level.

Partnerships described in III.A.1. above allow Title V to leverage work across the state on behalf of the MCAH and CYSHCN populations. This enhances the scope and ability of Title V funding to impact the health of Oregon's women, children, youth, and families, including children and youth with special health needs.

III.A.3. MCH Success Story

Community and partner engagement is at the core of our MCAH successes this year.

The 2020 Title V Needs assessment is using innovative strategies, including 8 small grants to engage communities that experience MCAH disparities and/or have been underrepresented in past Title V assessments. A PhotoVoice project with youth with disabilities, and two qualitative research partnerships with African American and Latinx families of children with disabilities are also underway to broaden engagement of diverse communities.

The Title V program, with champions including the Governor, Senator Steiner Hayward, the Early Learning Council and the Governor's Children's Cabinet passed legislation making Oregon the first state to support universally offered nurse home visiting for families with newborns. SB 526 requires commercial insurance plans to offer this benefit, and OHA will support it for the Medicaid population. Oregon will implement the Family Connects evidence-based model and roll it out statewide over the next 6 years.

OCCYSHN has developed a novel approach to building a distance-based learning community among Title V CYSHN grantees. Using the Extension for Community Healthcare Outcomes model, 5 county-based teams are piloting a standing cross sector community team to facilitate family-centered shared plans of care, as well as ACT.md, a cloud-based platform for shared care planning across sectors. This peer coached learning community model holds promise for future OCCYSHN programming.

III.B. Overview of the State

Geography and environment

At 96,981 square miles, Oregon 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 create challenges for the Maternal, Child, and Adolescent 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.

Demographics

Oregon's population of 4 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. Approximately 84 % of Oregonians live in urban areas, while 16 % live 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 2.4 million people. Other urban centers include Salem, the state capital, Eugene, in the mid-Willamette Valley, Bend, in Central Oregon, and Medford, in Southern Oregon. There are 9 Federally recognized Native American tribes in Oregon and Indian people from over 100 tribes make up the approximately 72,000 Native Americans and Alaska Natives living in Oregon. The Portland area has the 9th largest urban Native American population in the US, and 43-member tribes participate in the Northwest Portland Area Indian Health Board.

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%.

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. In 2017, about 6% of the population was under 5 years of age, and 15% was 5-17. Overall the median age of Oregonians 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 2017 National Survey for Children's Health (NSCH) estimated that 18.8% (162, 853) of Oregon children 0 to 18 years have special health care needs. These CYSHCN were mostly White, non-Hispanic. About 24% were of Hispanic ethnicity and 11% identified as other, non-Hispanic.

Nearly 44% of Oregon CYSHCN have a condition that affects their daily activities and over 36% experience 2 or more difficulties related to functionality (NSCH, 2016). According to the most recent state-level prevalence rates, 2.7% of Oregon children age 3 – 17; currently have Autism Spectrum Disorder (ASD) compared to 3.1% nationally (NSCH, 2017). In 2017, about 10,500 Oregon youth age 3 – 21 who receive special education were identified as having ASD (Oregon Department of Education [ODE], 2017).

Significant advances in science and technology have reduced the risk of mortality for CYSHCN, resulting in an increase in morbidity due to chronic illness and disability. Of children under age 18 insured through Oregon Medicaid in 2015-2016, 6.1% of children met criteria to identify as having complex chronic disease. Of those, 6.7% were Black/African

American, 5.6% were Native American, and 5.6% were multiracial (OPIP, OHA, DHS, 2018). Eighteen percent were categorized as having non-complex chronic disease. Of those, 19.2% were Black/African American, 17.8% were multiracial, and 17.6% were Native American (OPIP, OHA, DHS, 2018). Youth and young adults with special health care needs (YSHCN) are living longer and assuming productive lives. However, only 51% of Oregon YSHCN graduated from high school in 2014 (NCES, 2013-14). NSCH (2017) estimates suggest that less than 29% of YSHCN have worked in the previous 12 months, likely due to challenges in managing their own health, difficulty accessing available resources to support their health needs, and other social factors.

Oregon's Birth Anomalies (birth defects) Surveillance System (BASS) tracks prevalence of select birth anomalies using birth certificate, hospital discharge, and Medicaid data. Children with risk factors or conditions that receive services through our intensive home-based public health nursing care coordination program, CaCoon, are tracked through a statewide database. The most frequent risk factors and conditions cited for CaCoon recipients during FY2017 were developmental delay (DD), other chronic conditions, Autism Spectrum Disorder (ASD), and heart disease. Children can have more than one risk factor recorded. During FY2017, approximately 70% of children in the CaCoon program had multiple risk factors.

Economy and poverty

Economy

Oregon's economy impacts maternal and child health, as well as population growth and state revenues. 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. In 2017, Oregon's population grew by 64,700 people, 56,800 of those due to in-migration.

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, 6.9% in 2014, and 5.5% in 2015. Oregon's unemployment rate for April 2019 is at 4.3%, placing it 40th among states. However, rates around the state range from 3.4% to 8.4%, with southern and central Oregon counties experiencing greater unemployment.

Income and poverty

Oregon's median household income was $64,610 in 2017, placing it 27th among US states. The Small Area Income and Poverty estimates (SAIPE) report for 2014 estimated poverty at 16.4%, with 21.3% under age 18 and 25% under age 5 living below poverty. Almost all racial/ethnic minority populations have higher poverty rates than non-Hispanic Whites (African American 41%, Hawaiian/PI 36%, Native American 34%, Latino 30%, non-Hispanic whites 15%, Asian 12%). Nearly one-third of CYSHCN ≤18 years live in households with incomes less than 100% of the Federal poverty level, although this estimate should be interpreted with caution (CAHMI, 2018).

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 recent attempts to increase corporate taxes through ballot measures have failed to pass. Furthermore, state law mandates a "kicker" refund to taxpayers in any year in which state revenues exceed projected by more than 2%. Consequently, even with robust employment and income tax, the state continues to face budget shortfalls.

Housing and education

Housing

Oregon has 1.7 million housing units estimated by the American Community Survey (U.S. Census Bureau). Of households that spend 30% or more of income on housing, 54.4% rent, 38.2% had mortgages, and 15.4% own without mortgages. The median monthly housing cost for each group was $894 for renters, $1,591 for mortgaged owners, and $464 for other owners. 2.5% of households did not have a telephone service and 8% were without a car or vehicle for transportation. According to the Portland Housing Bureau 2018 report on housing costs and income, the rent growth has slowed in the past 2 years to just over 2%, and the average rental unit now costs $1,430 per month. Rising rental and home sale prices in recent years have displaced many Portlanders, disproportionately affecting people of color and lower incomes.

Education

Over their lifespan, children in Oregon have access to private and public preschools, Head Start, public schools, community colleges, universities, and graduate education.

Oregon's Early Learning Division (ELD) supports all of Oregon's young children and families to learn and thrive. The Division is focused on: Child Care, Early Learning Programs and Cross Systems Integration, Policy and Research, and Equity. Programs provided through the ELD include Early Head Start, Head Start and Oregon Pre-K, Healthy Families Oregon, Preschool Promise, and Relief Nurseries.

Oregon has 197 public school districts, 1,246 public schools, and 580,690 students enrolled from kindergarten through grade 12. Among k-12 public school students in Oregon, 37% are students of color; 52% qualify for free or reduced lunches; 13% are in special education, and 9% are English Language Learners. Oregon's 4-year high school graduation rate is 79%, up slightly in past two years.

Every child in Oregon identified as needing special education has at least one of the disabilities defined in the IDEA. In Oregon, children must have an established diagnosis of developmental delay to receive EI services; EI or Early Childhood Special Education does not serve children who are at risk of DD. In 2017, 87,156 Oregon children age 3 – 21 years, were in special education and 4,114 children age 0 – 3 years, received EI services (ODE, 2017). Students in special education made up 13.6% of the K-12 population.

Oregon's higher education system includes seven public universities and the Oregon Health & Science University, 17 public community colleges, over 50 private colleges and universities, and hundreds of private career and trade schools.

Insurance coverage

According to the most recent Oregon Health Insurance Survey, more than 3.7 million Oregonians - nearly 94% - are covered by health insurance. However, 11% were uninsured at some point in time in the past year. While insurance coverage is high in Oregon, low income people are less likely to be covered. Young adults, between ages 19 – 34 were less likely to be covered than any other population. Among children 18 and under, 97 % were covered for insurance. Disparities in uninsurance by race and ethnicity are evident, with Asian Oregonians having the lowest uninsurance rates, and Hispanic Oregonians having the highest. About 21% of Hispanics were uninsured at some time in the past year.

Despite Oregon's high rate of health coverage, more people could be covered. Most people who were uninsured when the study was conducted were eligible for the Oregon Health Plan or a subsidy to reduce the cost of

commercial health coverage.

- **Children**: 9 out of 10 children who lack health coverage are eligible under OHP or a premium-reduction subsidy through the health insurance marketplace.
- **Adults**: Similarly, nearly 9 in 10 young adults and 8 in 10 older adults (ages 35-64) qualify for OHP or a subsidy for commercial health coverage.
- **Reasons for lack of OHP coverage**: A large portion of the uninsured were eligible for OHP. The top three reasons Oregonians cited for not being covered by OHP were: concerned about high costs of coverage (44 percent); not eligible, make too much money (36 percent); and concerned about quality of care (21 percent).

Oregon has expanded Medicaid coverage (Oregon Health Plan – or OHP), to cover adults whose income is 133% of the Federal Poverty Level (FPL). Pregnant women are covered to 185% FPL, and children to 300%. OHP pays for medical, dental and mental health services for low-income Oregonians. Since ACA implementation, OHP enrollment has grown by 557,000 people, and OHP now covers nearly 1 million 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) program. About 20 % of all Medicaid enrollees are Hispanic, 3 % African American, 1.5 % American Indian/Alaskan Native, 3 % Asian or Pacific Islander, 58.5% Caucasian, and 14% “Other” or “Unknown”. More than one-third (36%) of Oregon CYSHCN < 18 years were insured through Medicaid (NSCH 2016-2017).

Oregon Health Plan (OHP), Oregon’s Medicaid program (medical, dental, and mental health care services), is provided primarily through Coordinated Care Organizations (CCOs) - Oregon’s version of Accountable Care Organizations. CCOs currently serve nearly 90% of OHP clients. The innovative structure and function of CCOs is a central component of health reform in Oregon, as described in previous reports. Oregon is currently reviewing applicants for the second round of CCO contracts which will be awarded in January 2020 for 2020-2024.

In July 2017, the Oregon Legislature passed Senate Bill 558, which expanded the Oregon Health Plan to include all children and teens under 19, regardless of immigration status, up to a household income of 305 percent of poverty. The estimated impact is that 17,000 undocumented children and teens are eligible for healthcare as of January 1, 2018.

Also passed into law in July, 2017, was House Bill 3391, known as the Reproductive Health Equity Act (RHEA). This bill provides for expanded coverage for Oregonians to access reproductive health services, especially those who, in the past, may have not been eligible for coverage of these services. It also provides protections for the continuation of reproductive health services with no cost sharing, and prohibits discrimination in the provision of reproductive health services. The Reproductive Health Equity Act ensures that people with Oregon private health insurance plans, including employee-sponsored coverage, have access to reproductive health and related preventive services with no cost sharing regardless of what happens with the Affordable Care Act. Medical care for undocumented women up to 60-day postpartum will also be covered.

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 Conference 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 62 Hospitals
- Federally Qualified Health Centers: 154 Clinics in 63 Cities and 26 Counties
- Rural Health Clinics: 63 Clinics in 44 Cities and 26 Counties
- Migrant Health Centers: 15 centers in 12 cities in 10 Counties
- Tribal and Indian Health Service: 21 Clinics among 9 Tribes and 11 Counties
- School-Based Health Centers: 76 Clinics in 25 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 Oregon 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 Areas (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 (SBHCs) which are statutorily defined, certified and funded. During the 2017-18 service year, there were 76 school-based health centers in 45 high schools, 7 middle schools, 11 elementary schools and 13 combined-grade campuses. During the 2017-18 services year, SBHCs provided services to 35,815 clients.

Geography presents a significant barrier to obtaining care for CYSHCN. Twenty-three percent of CYSHCN live in rural areas of Oregon (NSCH, 2011/12). 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 and behavioral health services are one of the most difficult services to access geographically for CYSHCN and their families, due to a lack of providers in rural and frontier communities.

Current and emerging state issues impacting maternal, child, and adolescent health

Key state issues impacting Maternal, Child, and Adolescent Health include: health systems transformation, Oregon's Early Learning System transformation, medical home for CYSHCN including cross-systems care coordination and shared care planning, and the modernization of Oregon's Public Health system. Upstream factors, 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, Child, and Adolescent 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, Child, and Adolescent Health work with health system transformation is a key priority for the state. Oregon's health system transformation, and the unique role Coordinated Care Organizations (CCOs) in serving the MCAH population is described in detail in section III.E.2.b.iv.

CYSHCN needs and health systems transformation

Children make up over half of Oregon's Medicaid population. 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 significant unmet needs for the CYSHCN population. Families also experience confusion about which entities are responsible for coordinating care for CYSHCN across multiple systems. CCO incentive metrics do not incentivize 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, except for the Applied Behavioral Analysis (ABA) mandate for children with Autism Spectrum Disorder.

Early learning system transformation

Oregon's early learning system transformation, guided by the Early Learning Council (ELC), is a key partnership for Title V, and another effort that is shaping the changing context for maternal and child health in our state. The vision for early learning system transformation is to: 1) Ensure all Oregonian children arrive at Kindergarten ready to learn and having received the early learning experiences they need to thrive; 2) Children are living in families that are healthy, stable and attached and 3) Oregon's early learning system is aligned, coordinated and family-centered. The ELC, which includes representation from Oregon's Title V director, directs the Early Learning Division of the Oregon Department of Education, which is responsible for numerous activities and initiatives including but not limited to:

- 16 regional Early Learning Hubs which coordinate services for children 0 to Kindergarten entry across five sectors: Early learning, human services, health, K-12 and business.
- The Office of Child Care, which manages child care licensing and monitoring throughout the state.
- Implementation of a tiered quality rating improvement system for child care known as Spark.
- Coordination with Early Intervention/Early Childhood Special Education services.
- The P-3 Alignment initiative which collaborations with the K-12 system to align curricula and activities across preschool/Pre-K programs and grades K through 3.

In 2018, The Early Learning Council (ELC) completed a strategic planning and engagement process, which resulted in the Raise up Oregon plan. Title V was a key partner in its development, and now in its implementation.

Changes resulting from early learning system transformation have the potential to be particularly relevant to CYSHCN, as they will incorporate 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; ensuring 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 supporting families to make choices about programs that will best ensure the school readiness of their children.

Patient-Centered Primary Care Home (PCPCH) Program

The PCPCH Program is Oregon's realization of the patient-centered medical home concept. The program's goal is to accomplish the Triple Aim of health care. OHA established a set of recognition criteria, a technical assistance guide,

and a self-assessment tool to aid practices in applying for PCPCH recognition. Initially the program consisted of 3 tiers of recognition, with the 3rd tier being the most advanced level of recognition. In 2017, the program revised the recognition criteria and expanded to 5 tier levels, with the 5th tier being the highest. One of the CCO incentive metrics is the percentage of CCO members who are enrolled in a recognized PCPCH. In turn, CCOs may offer practices incentive payments for achieving recognition status within the program.

Modernization of Public Health

Governmental public health in Oregon is currently undergoing a major restructuring and modernization based on the recommendations of a legislative Task Force and the core functions 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. A Public Health Modernization manual has been developed, along with a Modernization Plan based on assessment of the capacity and gaps in the governmental public health structure across Oregon Phase one funding of $5 million was spent to enhance CD capacity in select communities; phase 2 funding, approved by the 2019 Legislature provides an additional $10 million to modernize the public health approach to communicable disease, emergency preparedness and impacts of climate change on health. State Title V and local grantees are integrally involved in ensuring that maternal, child, and adolescent health programs are aligned with and central to public health modernization.

Alignment with Oregon Health Authority, Public Health Division, and Institute on Development & Disability's priorities and initiatives

Oregon's Title V work is interwoven with the priorities and initiatives of OHA and the Public Health Division, the OHSU Institute on Development & Disability (IDD), and those of the local health departments and tribes. At the state level, Title V aligns with the OHA Triple Aim, IDD's priorities, the Oregon State Public Health Improvement Plan, and the Public Health Division Strategic Plan, as well as with the priorities of the CCOs.

Oregon Health Authority (OHA) Triple Aim

OHA is the central agency that 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 on Development & Disability

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 with 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, which was updated this year with new 2020-24 priorities. The new SHIP priorities include: Institutional bias; Adversity, trauma and toxic stress; Economic drivers of health; Access to equitable preventive

health care, and Behavioral health. Title V is a critical partner whose work is threaded across all the new SHIP priorities.

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, and is required report on those plans annually. The CCOs are also being measured on their health outcomes in key MCAH areas such as adolescent well 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. Currently, Oregon is in midst of generating a new round of CCO contracts, so the landscape and assessments conducted by the CCOs may change as new CCOs come on board.

State statutes with relevance to Title V

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

- **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.
- **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.
- **HB 3650,** passed in 2011, sets the framework for health system transformation and the CCOs which are a cornerstone of Oregon health system transformation and provide care to Oregon's Medicaid (OHP).
- **HB 3100,** passed In July 2015, implements the recommendations made by the *Task Force on the Future of Public Health Services* and sets forth a path to modernize Oregon's public health system so that it can more proactively meet the needs of Oregonians. Legislation to expand support for Public Health modernization is being considered in the current session.
- **ORS 326.425** Establishes the Early Learning Council, which oversees the Oregon Early Learning System.
- **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 CYSHCN, including the administration of federal funds made available to Oregon for services for children with disabilities and CYSHCN.
- Oregon is one of 39 states that 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.
- **HB 4133**, passed in 2018, created Oregon's Maternal Mortality and Morbidity Review Committee (MMRC).

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 focus Title V work more narrowly. Budgetary constraints, and alignment with State as well as Federal Agency priorities, impact priority-setting. Both the MCAH and CYSHCN Title V Directors have multiple ongoing mechanisms for determining the importance, magnitude, value, and priority of competing factors which impact maternal, child, and adolescent 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. The MCH Section's new strategic plan is also a key tool for priority setting, particularly for the MCH portions of the Title V program.

III.C. Needs Assessment

FY 2020 Application/FY 2018 Annual Report Update

MCAH Needs Assessment Summary Update

Ongoing needs assessment activities:

Ongoing needs assessment for the MCAH population in Oregon is conducted throughout the year through various needs assessment and surveillance projects. Many of the ongoing activities have been described in previous years' needs assessment updates. Additional activities this year include interim assessment activities, as well as activities related to initiating the five-year MCAH Title V Needs Assessment:

- In relation to the Maternal and Child Health Section Strategic Plan, development of process measurement in the form of accountability metrics, to track and monitor work towards the section's strategic priorities and goals, including Title V programming.
- Review of disparities and data trends in National Performance Measures, National Outcome Measures, and State Performance Measures.
- Assessment of local grantee measurement and evaluation.
- Collaboration with Oregon Office of Health Analytics to ensure the representation of maternal and child health outcomes, including Title V priorities, in Coordinated Care Organization metrics.
- Partnership with the Oregon Early Learning Division to develop performance measurement metrics which are inclusive of maternal and child health indicators, including those relevant to Title V priority areas.
- Partnership with the Oregon Maternal, Infant, and Early Childhood Home Visiting Program to align needs assessment activities, to facilitate collaboration and avoid duplication of efforts.
- Development of the Five-Year Title V MCAH Needs Assessment framework including: research questions, approach, methodologies, partnerships, etc. (see section below)
- Initiation of Five-Year Needs Assessment data collection including the environmental scan, analysis of health status data, development of community voices grant RFP, and development of the partners and providers online survey.
- Qualitative assessment of the impact on families of struggles to find safe, high quality, affordable infant childcare through the Social Determinants of Health CoIIN digital story-telling project.

Changes in health status and needs

Changes in health status in Title V areas of identified need are noted below.

- Percent of infants breastfed exclusively through six months increased
- Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day increased
- Percent of adolescents, age 12-17 years, with a preventive medical visit in the past year increased
- Percent of women who had a preventive dental visit during pregnancy decreased
- Percent of children, ages 1 through 17, who had a preventive dental visit in the past year increased

Oregon has recently completed a 5-year state health assessment which resulted in the following new State Health Improvement Plan (SHIP) priorities: Institutional bias; Adversity, trauma and toxic stress; Economic drivers of health (including issues related to housing, living wage, food security and transportation; Access to equitable preventive health care; and Behavioral health (including mental health and substance use). Each of these priorities has MCAH implications which will be further explored through the upcoming 2020 Title V MCAH Needs Assessment process.

Changes in Oregon's Title V program capacity and MCAH systems of care

The state level Title V MCAH program has not has not experienced significant changes in capacity over the past year. Although Title V funding has remained stable, local level MCAH systems of care around the state are being impacted by changes in local public health capacity as they respond to health systems transformation and Oregon's public health modernization initiative. Several local health authorities have chosen to contract out their functions, and others are contemplating or initiating the process of relinquishing local public health authority to the state. These changes have varying but significant impact on local staffing capacity, types of MCAH services offered, and relationships with other partners in the state and local systems of care. One local grantee – Wallowa County – currently has no local public health capacity and will have no Title V program for FY2020. Title V will use the Needs Assessment process over the coming year to further explore local MCAH public health system capacity and related questions.

Partnerships

Oregon's extensive list of partnerships and collaborations included in the previous years' grants are all ongoing. Additional Title V staff needs assessment partnership activities of note this year include:

- Title V Research Analyst worked in partnership with the Early Learning Division to develop performance measurement which is inclusive of maternal and child health indicators.
- Partnered with the Oregon Office of Health Analytics to provided consultation on the development of Coordinated Care Organization metrics to ensure inclusion of prioritized maternal and child health outcomes.
- Title V Coordinator served on Public Health Division's Trauma Informed Workgroup, as well as the Oregon Health Authority Trauma Policy Work group, and the Trauma Informed Oregon Advisory Board.
- Title V Research Analyst and Adolescent Health staff served on Oregon Healthy Teens Survey Advisory Board.
- Title V Research Analyst served on Oregon Behavioral Risk Factor Surveillance System Advisory Board.
- Title V Research Analyst served on the Oregon Public Health Division's Health Equity Workgroup.
- Title V MCH and adolescent health staff partnered with the chronic disease program in a process to "reimagine prevention" in Oregon, with an emphasis on childhood and adolescence, and recognizing childhood trauma and its role in drug and alcohol prevention.
- Adolescent Health staff shared data on Positive Youth Development and youth mental health with the Confederation of Oregon School Administrators (COSA) Social Determinants of Health and Education Workgroup and Oregon Department of Education's Workgroup on Safe and Effective Schools.
- Adolescent Health staff worked with youth and educators to make changes to content and process improvements to youth health surveillance tools. This including adding new social-emotional health questions, limiting survey length, and changing the timing of survey to limit conflict with other assessments.
- Title V and MIECHV are partnering on coordination of the two 5-year needs assessments
- The Title V and MIECHV Coordinators are serving on the Preschool Development Block Grant Advisory Group
- The MCH Title V Director is serving on the Early Learning Council, as well as on the newly convened Governor's Early Children's Cabinet.
- The MCH Title V Director is serving as the president of AMCHP.

Efforts undertaken to operationalize Oregon's Five-Year Needs Assessment

Section III.E of this application details how Oregon's state action plan operationalizes the findings of Oregon's Five-Year Needs Assessment through strategies and activities across the MCAH population domains.

2020 Title V Needs Assessment Planning

2020 Needs Assessment planning and implementation has been underway since December 2018. These include:

- Development of a Needs Assessment Plan, including guiding principles, research questions, methodologies, stakeholders, data sources, etc. with multiple partners (see Supporting Document 3).
- Conducting a scan of Oregon needs assessments from the previous 3 years.
- Analyzing health status data.
- Conducting a “Community Voices” rfp process to recruit community partners who are conducting outreach in 9 identified communities of focus.
- Conducting an online partner survey to identify MCAH priorities and systems issues.

Data from all the Needs Assessment components will be synthesized and used in the Title V priority selection process in the coming year.

Changes in organizational structure and leadership

State MCAH Title V program leadership has stayed consistent this year, as has the Public Health Division and OHA leadership. The hiring of a new Maternal Mortality Review Coordinator, as well as an anticipated additional MCH manager in the coming year will both support Title V capacity. Additional staff will also be hired to implement the universally offered home visiting program—another support to the Title V program.

Emerging MCAH issues

Emerging issues have been identified as noted above in the new SHIP priorities identified, through the State Health Assessment. Needs related to equitable access to affordable childcare identified in the state Infant Toddler Assessment –are highlighted in the SDOH CoIIN work.

The emerging issues identified during the February 2018 meeting of Local Public Health and Tribal Title V grantees; the new SHIP priorities; and other emerging issues being identified through the environmental scan of community assessments and the analysis of health status data will be integrated into the Title V needs assessment. In addition, information about emerging needs will be gathered through the community voices and provider/partner survey segments of the Needs Assessment.

Emerging issues were also identified and discussed by Local Public Health and Tribal Title V grantees during a two-day grantee meeting held in February 2018. A list of emerging needs noted by local Title V grantees, which will be further explored during the upcoming five-year needs assessment includes:

- Neonatal abstinence assessment
- Domestic violence
- Low immunization rates/anti-vaccination messages
- Housing insecurity/homelessness
- Drug use/opioids/marijuana
- Childcare affordability and quality
- Behavioral health/suicide
- Lice
- Providing access to services to our undocumented community members
- Lack of providers in rural areas
- Serving children and adolescents in foster care
- Bed bugs

- Working with families prior to DHS intervention/Increasing numbers of child involvement with CPS
- Access to health care services and coverage among women in the justice system
- Leveraging faith communities to provide needed services and/or materials

OCCYSHN Needs Assessment Summary Update

Process

OCCYSHN reviewed NSCH results (CAHMI Data Resource Center) and OHA's Office of Health Analytics application of the PMCA (Simon et al., 2014) to Oregon Medicaid data. OCCYSHN continues to collaborate with an OHSU-PSU School of Public Health colleague, Neal Wallace, PhD, and Sara Bachman, PhD, Catalyst Center, to replicate quantitative analyses examining service use and cost for children with medical complexity (CMC) served in Patient-Centered Primary Care Homes (PCPCHs) versus CMC served in non-PCPCHs.

Findings

Approximately 39% of CYSHCN < 18 receive care that met medical home criteria (NSCH 2016-17). Deficits center on getting referrals and receiving effective care coordination. Nearly 98% of CYSHCN were insured; however, only 67% reported that their insurance was adequate and continuous (NSCH 2016-17). About 18% reported that their health insurance "sometimes" or "never" offered benefits or covered services that meet their mental/behavioral health needs (NSCH 2016-17). Less than one-fifth (17%) of youth with special health care needs (12 through 17 years) received services necessary for transitioning to adult healthcare. Physicians appear not to be discussing the shift to adult providers. Additional findings appear in the State Overview section.

Title V Program Capacity

Organizational Structure

See last year's report for more detail about OCCYSHN's organizational structure. OCCYSHN's work is described in section III.E.2.a.

Agency & Workforce Capacity

See the 2015 Needs Assessment Summary section for a description of OCCYSHN's capacity to promote health for CYSHCN.

Support for Coordinated System of MCAH Services

OCCYSHN ensures a statewide system of services that provides comprehensive, community-based, coordinated, and culturally informed family-centered care. Core activities include assessment and evaluation (A&E), systems and workforce development (S&W), family involvement (Family Involvement Program [FIP], Oregon Family to Family Health Information Center [ORF2FHIC], Sidney and Lillian Zetosch fund, and special projects and initiatives (e.g., CMC CoIIN).

Workforce Strengths & Needs

The Title V CYSHCN Director is Benjamin Hoffman, MD. OCCYSHN currently employs 17 staff with 11.95 FTE, and is augmented with community partnerships.

State level staffing

OCCYSHN has a Director, 4 Managers (Administration, A&E, FIP, and S&W), 2 administrative staff, 2 A&E Research Associates, a Communications Coordinator, 7 FIP staff who are all parents of CYSHCN, a Medical Consultant (developmental pediatrician), and 4 S&W staff. Additional consultative resources are available at IDD, such as developmental pediatricians and allied health providers. The Director, Managers, and Communications Coordinator comprise OCCYSHN's leadership team. The Director and A&E Manager are members of the Oregon Title V Leadership Team.

Local level staffing

OCCYSHN state staff is augmented with contracted time and effort delivered by PHNs, LPHAs, ESDs, and other health and health-related professionals who implement OCCYSHN's community-based efforts to improve systems serving CYSHCN. A copy of OCCYSHN's contract with LPHAs is included in Supporting Document 2.

Partnerships, collaboration & coordination

OCCYSHN values strong collaboration among its partners including state and community-based agencies and organizations, healthcare and community-based providers, and families of CYSHCN. Community-based professional partners are integral to implementing all OCCYSHN's program efforts, including CaCoon, shared care planning, and PACCT teams. Please refer to Supporting Document 1 which provides a list of OCCYSHN partners.

Emerging Issues

Accessing mental health services continues to be a significant issue for OR CYSHCN and their families. Consistent with our 2015 NA findings, around 58% of OR CYSHCN age 3 – 17 years reported having a problem getting mental health treatment or counseling (NSCH, 2016). There is a serious shortage of mental and behavioral health providers for CYSHCN, especially in rural and frontier communities. OCCYSHN and partners continue to advocate for mental-physical health integration, as reflected by OCCYSHN's recommendations for 2019 OHA-CCO contracts. A&E further explored this issue by analyzing NS-CSHCN 2009-10 data focusing on the needs of OR CYSHCN with behavioral health conditions. Findings were summarized in a paper and submitted for publication.

Ensuring that CMC receive coordinated care is an emerging concern within the child health community. Currently OHA Office of Health Analytics is collaborating with the Oregon Pediatric Improvement Partnership and Oregon's Department of Human Services to develop and disseminate methods for identifying children with health complexity, which includes medical complexity. OCCYSHN's CMC CoIIN project aligns with the CMC definition used by this state effort, and OCCYSHN will incorporate the identification method into the project.

FY 2019 Application/FY 2017 Annual Report Update

MCAH Needs Assessment Summary Update

Ongoing needs assessment activities:
Ongoing needs assessment for the MCAH population in Oregon is conducted throughout the year through various needs assessment and surveillance projects. Many of the ongoing activities have been described in previous years' needs assessment updates. Additional activities that have been initiated this year include:

Cross-walk of MCAH metrics to reduce duplication of surveillance activities and maximize capacity.

Development of MCAH State Public Health Indicators and related fact sheets for: infant mortality, infant breastfeeding, premature births, first trimester prenatal care, childhood developmental screening, tooth decay, dental sealants, teen pregnancy and birth, effective contraceptive use, dental visits, adolescent well-care visits, and well woman visits (see Supporting Document # 5).

Review of disparities and data trends in National Performance Measures, National Outcome Measures, and State Performance Measures.

Assessment of local grantee measurement and evaluation, and development of standard process measures for use with local grantee plans and reports.

Compilation of MCAH outcome indicators and development of accountability metrics for use in conjunction with the MCH strategic plan, to assess progress over time.

Partnership with the OHA Transformation Center to convene a work group and develop a set of OHA recommendations related to early childhood health disparities (see Supporting Document #5).

Partnership with the Oregon Early Learning Division to support the Infant Toddler State Assessment (https://oregonearlylearning.com/infant-toddler-state-assessment).

Convening of Title V grantees for a two-day meeting in February 2018, at which local needs related to both current and emerging priorities were identified and addressed.

Changes in health status and needs
Changes in health status in Title V areas of identified need are noted below.

Well woman visit rate increased
Smoking rate among pregnant women decreased

Oregon is also in the process of completing its 5-year State Health Assessment, and maternal and child health needs identified through that process will be addressed in the coming year. Emerging needs identified in the State Health Assessment can also be further explored through the upcoming 2020 Title V MCAH Needs Assessment process.

Changes in Oregon's Title V program capacity and MCAH systems of care
The state level Title V MCH program has not has not experienced significant changes in capacity over the past year. Although Title V funding has remained stable, local level MCAH systems of care around the state are being impacted by changes in local public health capacity as they respond to health systems transformation and Oregon's public health modernization initiative. Several local health authorities have chosen to contract out their functions, and others are contemplating or initiating the process of relinquishing local public health authority to the state. These changes have varying but significant impact on local staffing capacity, types of MCAH services offered, and relationships with other partners in the state and local systems of care. One local grantee – Wallowa County – currently has no local public health capacity and will have no Title V program for FY2019. Title V will continue to work with local grantees to accommodate local changes while continuing to seek out opportunities to strengthen Title V services over the coming year.

Partnerships
Oregon's extensive list of partnerships and collaborations included in the previous years' grants are all ongoing. Additional Title V staff needs assessment partnership activities of note this year include:

Early Learning Division Workgroups: Title V Research Analyst has served on two ELD workgroups; one to examine health among infants and toddlers in Oregon, using a variety of indicators, and another to develop an indicator to measure the ELD's success in reaching underserved priority populations.

Provided consultation on the development of substance use indicators for a Public Health Division wide assessment/indicator dashboard

Initiated partnership with OHSU/PSU School of Public Health, to streamline process of finding student interns to work on projects at the MCH Section.

Title V Research Analyst served on Oregon Healthy Teens Survey Advisory Board

Title V Research Analyst served on Oregon Behavioral Risk Factor Surveillance System Advisory Board

Title V MCH and adolescent health staff are partnering with the chronic disease program in a process to "reimagine prevention" in Oregon, with an emphasis on childhood and adolescence, and recognizing childhood trauma and its role in drug and alcohol prevention.

Adolescent Health staff shared data on Positive Youth Development and youth mental health with the Confederation of Oregon School Administrators (COSA) Social Determinants of Health and Education Workgroup and Oregon Department of Education's Workgroup on Safe and Effective Schools.

The early childhood systems coordinator led the development of the OHS Early Childhood Health Disparities Advisory Committee report and recommendations.

The MCH Title V Director is serving on the Early Learning Council, as well as on the newly convened Governor's Early Childhood Cabinet.

The MCH Title V Director is also serving as the incoming president of AMCHP.

Efforts undertaken to operationalize Oregon's Five-Year Needs Assessment

Section III.E of this application details how Oregon's state action plan operationalizes the findings of Oregon's Five-Year Needs Assessment through strategies and activities across the MCAH population domains.

Changes in organizational structure and leadership

State MCAH Title V program leadership has stayed consistent this year. Noted changes at other levels of the organization include the appointment of Patrick Allen as the Director of the Oregon Health Authority in September 2017. New management in the Maternal and Child Health Section will also impact the Title V program. John Putz, PhD was selected to lead the Assessment, Evaluation, Epidemiology and Informatics unit in October 2017, and Jordan Kennedy, MPH, MBA, joined as the Community Systems Manager in June 2018.

Emerging MCAH issues

Emerging issues have been identified as noted above, through the State Health Assessment and the Oregon Infant Toddler State Assessment, as well as through a variety of additional partner assessments. Emerging needs identified in these assessments included equitable access to affordable childcare – particularly for infants in the Infant Toddler Assessment. The State Health Assessment recognized the emerging importance of early childhood trauma and the lifelong impact of toxic stress, and added State Public Health Indicators tracking both ACEs and Flourishing in children (National Survey of Children's Health indicators).

Emerging issues were also identified and discussed by Local Public Health and Tribal Title V grantees during a two-day grantee meeting held in February 2018. A list of emerging needs noted by local Title V grantees, which will be further explored during the upcoming five-year needs assessment includes:

Neonatal abstinence assessment
Domestic violence
Low immunization rates/anti-vaccination messages
Housing insecurity/homelessness
Drug use/opioids/marijuana
Childcare affordability and quality
Behavioral health/suicide
Lice

Providing access to services to our undocumented community members
Lack of providers in rural areas
Serving children and adolescents in foster care
Bed bugs
Working with families prior to DHS intervention/Increasing numbers of child involvement with CPS
Access to health care services and coverage among women in the justice system
Leveraging faith communities as options to provide needed services and/or materials

OCCYSHN Needs Assessment Summary Update

Process
OCCYSHN reviewed 2016 NSCH survey results (CAHMI Data Resource Center) and results of OHA's Office of Health Analytics application of the Pediatric Medical Complexity Algorithm (PMCA; Simon et al., 2014) to Oregon Medicaid data. OCCYSHN hopes that OHA will provide these results disaggregated by race/ethnicity. OCCYSHN continues to collaborate with an OHSU-PSU School of Public Health health economist, Neal Wallace, PhD, and Sara Bachman, PhD, Catalyst Center, to replicate quantitative analyses examining service use and cost for CMC served in PCPCHs versus CMC served in non-PCPCHs.

Findings
2016 NSCH results show that 158,652 (18.5%) of Oregon's children under 18 years have a special health care need. Less than one-third (31%) of these children receive care that meet medical home criteria. Less than one-fifth (17%) of youth with special health care needs (12 through 17 years) received services necessary for transitioning to adult healthcare. Approximately 4.2% of Oregon's Medicaid-enrolled children under 18 years of age have complex chronic medical conditions (OHA Office of Health Analytics, 04-24-18).

Title V Program Capacity
Organizational Structure
Please refer to last year's report for more detail about OCCYSHN's organizational structure. Brian Rogers, MD, has retired and IDD is now under the direction of Kurt Freeman, PhD, ABPP. OCCYSHN's programmatic efforts are described in section III.E.2.a.

Agency & Workforce Capacity
Please refer to the 2015 Needs Assessment Summary section for a description about OCCYSHN's capacity to promote health for CYSHCN.

Support for Coordinated System of MCH Services
OCCYSHN ensures a statewide system of services reflecting comprehensive, community-based, coordinated, and culturally informed family-centered care. Its core activities include assessment and evaluation (A&E), systems and workforce development (S&WD), family involvement (Family Involvement Program [FIP], Oregon Family to Family Health Information Center [ORF2FHIC], Sidney and Lillian Zetosch fund, and special projects and initiatives (e.g., CMC CollN).

Workforce Strengths & Needs
In October 2017, IDD hired Benjamin Hoffman, MD, as the permanent OCCYSHN director. OCCYSHN currently employs 12 staff with 10.35 FTE and is augmented by partnerships at the local level.

State level staffing
OCCYSHN is composed of a Director, ORF2FHIC/FIP Coordinator (parent of CYSHCN), Communications Coordinator, developmental pediatrician as Medical Consultant, A&E Coordinator and Research Associate, Administrative Coordinator, and public health genetics counselor. In addition, the community based programs unit restructured as S&WD, which is composed of 3 staff who support the implementation of CaCoon, SPOC, and REACH. Additional consultative resources are

available within IDD such as developmental pediatricians and allied health providers.

Local level staffing
OCCYSHN state staff is augmented by contracted time and effort delivered by PHNs, LPHAs, ESDs, and other health and health related professionals that implement initiatives to improve the systems serving OR CYSHCN. A copy of OCCYSHN's contract with LPHAs is included in supporting document #2.

Partnerships, collaboration & coordination
OCCYSHN values strong collaboration among its partners including state and community-based agencies and organizations, healthcare and community based providers, and families of CYSHCN. It partners with LPHAs, ESDs, and providers to implement CaCoon, SPOC, and ReACH teams. Please refer to last year's report for more detail about how OCCYSHN collaborates with partners and supporting document #1, which provides a list of its partners

Emerging Issues
Accessing mental health services continues to be a significant issue for OR CYSHCN and their families. Consistent with our 2015 NA findings, around 58% of OR CYSHCN age 3 – 17 years reported having a problem obtaining needed mental health treatment or counseling (NSCH, 2016). There is a serious shortage of mental and behavioral health providers for CYSHCN, especially in rural and frontier communities. OCCYSHN and partners continue to advocate for mental-physical health integration, including in its CYSHCN-focused recommendations for 2019 OHA-CCO contracts. A&E further explored this issue by analyzing NS-CSHCN 2009-10 data focusing on the needs of OR CYSHCN with behavioral health conditions. Findings were summarized in a paper and submitted for publication.

Ensuring that CMC receive coordinated care is an emerging concern within the child health community. Currently OHA Office of Health Analytics is collaborating with the Oregon Pediatric Improvement Partnership and Kaiser Permanente to develop and disseminate methods for identifying children with health complexity, which includes medical complexity. OCCYSHN's CMC CollN project aligns with the CMC definition used by this state effort, and OCCYSHN will seek to incorporate the identification method into the project.

FY 2018 Application/FY 2016 Annual Report Update

Oregon Health Authority (OHA) MCH Needs Assessment Summary Update

1. Process and findings for ongoing MCH needs assessment

Ongoing needs assessment for the MCH population in Oregon has been conducted through a variety of surveillance and assessment projects addressing different populations over the past year. A brief summary of the process and key findings for each follows:

Development of Evidence based/informed strategies for state specific priorities

In September 2016, a work group of state and local MCH leaders was formed for each of Oregon's 3 state-specific Title V priorities: food insecurity, ACEs and trauma, and culturally/linguistically responsive services. Each group reviewed available literature, policy and practice recommendations; developed a set of potential strategies, and conducted webinars and outreach to partners around the state to solicit input on needs and refine the strategies. Findings of the work are summarized in the list of state-specific priority strategies attached below. Detailed strategy and activity tables are included in Attachment 3.

Oregon MCH Title V Block Grant
Summary list of state-specific strategies for local grantee planning: January 2017

Toxic stress/trauma/ACEs

1. Promote family friendly policies that decrease stress and adversity for all parents, increase economic stability, and/or promote health.
2. Provide outreach and education on the importance of early childhood, NEAR science, and the impact of childhood adversity on lifelong health.
3. Develop community partnerships, inter-agency collaborations, and cross-systems initiatives to prevent/address ACEs and trauma.
4. Conduct assessment, surveillance, and epidemiological research. Use data and NEAR science to drive policy decisions.
5. Develop a trauma-informed workforce and workplaces.
6. Integrate trauma-informed care and culturally-specific approaches into services and systems for children, adolescents and families.
7. Identify children, youth and families experiencing adversity and connect them to needed supports and services.
8. Implement community level equity initiatives, and trauma and violence prevention programs.
9. Build community capacity for cohesion, safe and secure places, and equitable opportunities.
10. Strengthen protective factors for individuals and families; support programs that build parent capabilities, social emotional competence, and supportive/nurturing relationships; and foster connection to community, culture and spirituality.

Food Insecurity

1. Screen clients for food insecurity
2. Provide referrals for food assistance
3. Address risk factors related to food insecurity (e.g. access, cost & health outcomes, social determinants) during clinic visits
4. Support or provide food security education
5. Advocate, support or develop partnerships for accessibility to healthy & affordable food; consider wide array of partnerships beyond public health and food advocacy groups
6. Promote access to healthy and affordable food
7. Improve access to food assistance safety net programs
8. Increase economic stability for individuals and families

Culturally and Linguistically responsive services (CLAS)

1. Provide effective, equitable, understandable, and culturally responsive services
2. Develop and improve organizational policy, practices, and leadership to promote CLAS and health equity
3. Recruit, promote and support a culturally and linguistically diverse workforce that reflects local communities.
4. Educate and train leadership and workforce CLAS policies and practices on an ongoing basis.
5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them.
6. Establish CLAS/health equity goals, policies, and accountability, and infuse them throughout the organizations' planning and operations.
7. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into continuous quality improvement activities.
8. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes.
9. Communicate the organization's progress on CLAS to all stakeholders, constituents and the general public.

Identification of local needs in Title V priority areas

Ongoing assessment of needs related to each priority area is reflected in local Title V grantees' selection of priorities and strategies in which to invest Title V funds each year. One key enhancement in capacity for ongoing identification of local needs has been the development of an online Title V plan/report database. This database will allow state Title V staff to track and analyze changes in local MCH needs and priorities as reported in their annual plans and funding allocation decisions. The list of selected priorities and strategies for the upcoming grant year, included at the beginning of section II.F.1. summarizes the priority and strategies selected by communities across Oregon in response to their evolving local needs. Attachment 4 contains the guide to the Title V online plan/report database.

Needs assessment through ongoing MCH surveillance

The Title V program's many MCH surveillance projects provide another source of ongoing Title V needs assessment. Surveillance projects include the Oral Health Surveillance system, PRAMS and PRAMS 2; BRFSS ACEs module, Oregon Health Teens Survey, home visiting data system. Special analyses and reports conducted this year include:

- Maternal and Child Health Indicators Report (MCH Data Book).
- Analysis of paid family leave among Oregon women for use in a policy brief
- Analysis of maternal and child health status of Oregon's Asian/Pacific Islander population.
- Analysis of BRFSS ACEs module in partnership with Adolescent, Genetics & Reproductive Health and Public Health Director's Office staff.
- Analysis and production of MCH data briefs for Oregon's State Health Improvement Plan.
- Analysis and production of MCH data briefs for Oregon's State Population Health Indicators.

Needs Assessment for pregnant and parenting students

The MCH Section conducted a needs assessment in response to an opportunity to be awarded Pregnancy Assistance Funds (PAF) to Support Expectant and Parenting Teens, Women, Fathers, and their Families. The needs assessment utilized a multi-pronged approach which included a survey of Oregon's Community Colleges Council & Higher Education Coordinating Council, and an examination of vital statistics and survey data, with a focus of Adverse Childhood Events and Positive Youth Development. The needs assessment has provided valuable

knowledge which can be leveraged to improve the focus of Title V efforts.

Racial/Equity Assessment for state MCH

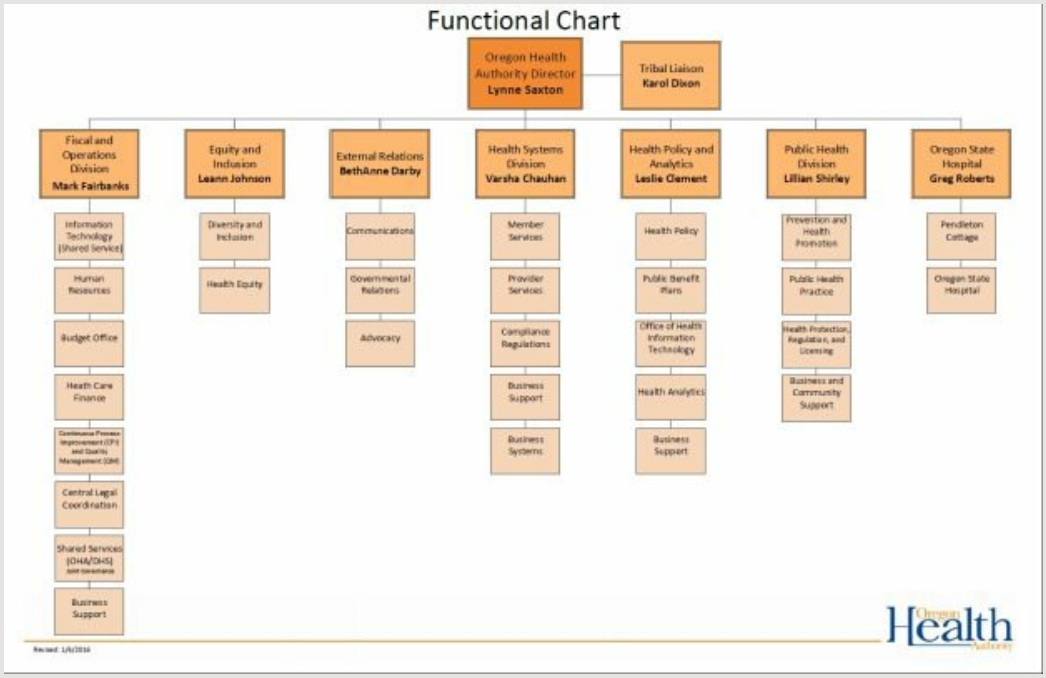
The MCH Section used the Tool for Organizational Self-assessment related to Racial Equity developed by the Coalition of Communities of Color to assess our policy and practices related to racial equity. This assessment is being used to inform changes in our policies, staffing and programs for the Title V MCH population

Infant and Toddler Health Assessment

In partnership with the Early Learning Division, the MCH Section participated in a workgroup to examine health among infants and toddlers in Oregon, using a variety of indicators. The results of this assessment will be used to direct Early Learning Division policies and practice, with an ultimate goal of reducing disparities.

2. Title V MCH program capacity: changes in organizational structure, agency capacity, and workforce development and capacity

There have been no major changes in the organizational structure of OHA's Title V Block grant program this year. Oregon continues to be a state in which the Title V Block Grant is administered by two separate agencies – OHA and the Institute of Development & Disability (IDD) within OHSU. Title V remains in the Public Health Division, which is led by State Public Health Director Lillian Shirley. The Center for Prevention and Health Promotion is led by Tim Noe, and Cate Wilcox continues to serve as the Title V Director and MCH Section manager. An OHA organizational chart is attached below.



State level Title V MCH agency capacity has remained relatively stable over the past year, as Oregon has implemented the new structure to support local Title V grantees' implementation of BG 3.0 priorities. A strengthened partnership with SSDI informatics staff has further supported the transition and enhanced Title V data collection capacity. However, looming state budget deficits, and uncertainty about the FY 2018 federal budget limit the program's ability to predict or plan effectively for future capacity. Local level capacity to address population needs through implementation of Title V BG 3.0 varies across the state, as grantees respond to evolving fiscal, operational and workforce changes. Strong collaboration between the Conference of Local Health Officials and state Title V has been critical to ongoing partnership to address the changing landscape of public health, health transformation and Title V programming around the state.

3. Changes in partnership, collaboration and coordination efforts

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 updated 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. SSDI funded informatics staff have also developed and maintain an online database for Title V grantees to report their activities and plans and measures.
Maternal, Infant and Early Childhood Home Visiting (MIECHV)	Oregon has received 4 MIECHV grants including the formula, development, expansion, and competitive grants, which are administered jointly with Title V through the MCH section. 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 (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.
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 Initiative, 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 grants from the CDC and HRSA. The CDC grant is focused on the development, maintenance and enhancement of the EHDI information system and surveillance program; and the HRSA grant 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.
Rape Prevention Education	Title V coordinates with the CDC Rape Prevention Education grant to support the work of the Oregon Sexual Assault Task Force.
Personal Responsibility Education Program (PREP)	The Adolescent & School Health Unit within Adolescent, Reproductive and Genetic Health Section, 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.
Birth Anomalies Surveillance	Oregon has recently obtained CDC funding to support our birth anomalies surveillance system, including expanded critical congenital heart defect tracking and monitoring.
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's 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 physical activity, nutrition, adolescent and school health.
CDC Core Violence and Injury Prevention Program	The Core VIPP in Oregon collects and uses data for a better understanding of injury issues, and protects Oregonians by putting science into action to save lives and prevent injuries.
Race to the Top	Title V partners on a variety of health and early learning initiatives with the Department of Education's Race to the Top Early Learning grant, administered through the Early Learning Division.

iii. 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.
iv. 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.
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.
v. 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.
School-Based Health Centers (SBHCs)	State general funds support 77 SBHCs in 24 counties. SBHCs are primary care clinics located on school grounds that provide clinical preventive mental and physical health services to school-aged youth. The Adolescent & School Health Unit certifies and supports state-funded SBHCs.
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 in the Oregon Health Authority's Health Systems Division 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.
vi. 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, sexual health education 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.
vii. 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.
viii.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.	
ix. Health systems	

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.
x. 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 Parenting Education Collaborative.
xi. 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 Early Learning Council and Best Beginnings Committee, and the MIECHV Home Visiting Steering Committee.

OCCYSHN Needs Assessment Summary Update

1. Process

OCCYSHN began exploring the utility of claims data to surveil Oregon CYSHCN and their families on an ongoing basis. It initiated a collaboration with OHA's Office of Health Analytics to (a) disaggregate CCO incentive metrics by CYSHCN and (b) develop surveillance projects utilizing All Payers All Claims (APAC) and Medicaid data. The results will produce a more current (than the NSCH) approximation of the number and percentage of CYSHCN, and also provide an approximation of transition-aged YSHCN, in Oregon by county. OHA produced a first round of CCO metric results, but discovered that the adult, rather than the pediatric algorithm was used. From this discovery, OCCYSHN advocated for revising OHA's method of identifying CYSHCN in claims data to the Pediatric Medical Complexity Algorithm (PMCA). Because the implications of this change required discussion, final metric results were not obtained this year. OCCYSHN also is collaborating with a health economist at Portland State University, Neal Wallace, PhD, to explore disaggregating findings from evaluation of Oregon's PCPCH program by CYSHCN.

2. Findings

The needs for Oregon CYSHCN continue to revolve around developing high quality, family-centered, coordinated and integrated systems of care. Successes this past year include: (a) launching a medical neighborhood pilot in Central Oregon to inform the development of OCCYSHN's REgional Approach to Child Health (ReACH) teams, and (b) developing a structure for LPHA contracts for local public health staff to convene child health teams to implement Shared Plans of Care (SPOC).

2.1. Organizational Structure

Title V CYSHCN strategies are administered through IDD within OHSU School of Medicine, by OCCYSHN, under Oregon statutes 444.010, 444.020 and 444.030. OCCYSHN is the designated entity 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, under the direction of Brian Rogers MD, is composed of 2 "arms" as shown below.

Child Development & Rehabilitation Center (CDRC)	Public Health, Research and Education
Clinical program which includes CDRC clinics located in Portland and Eugene	OCCYSHN, Oregon Office on Disability & Health (OODH), OHSU's University Center for Excellence in Developmental Disabilities (UCEDD), Disability & Health Research Group

a. **Responsibility for programs funded under Title V (Federal and state)**

OCCYSHN consists of 6 programmatic efforts, as described in Attachment #1, including 2 statewide community-based programs receiving Title V funds.

2.2 Agency Capacity

a. Agency capacity to promote health for each population domain

Please refer to the 2015 Needs Assessment Summary section for a description about OCCYSHN's capacity to promote health for CYSHCN.

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

OCCYSHN ensures a statewide system of services reflecting comprehensive, community-based, coordinated, and culturally competent family-centered care. Its core activities include: assessment and evaluation, policy and systems development, family partnerships and involvement (Family Involvement Program [FIP], Oregon Family to Family Health Information Center [ORF2FHIC], Sidney and Lillian Zetosch fund), community-based programs (CaCoon, CCN), and special projects/initiatives. Attachment #1 has detailed information about OCCYSHN's programs.

2.3 Workforce Development and Capacity

a. Strengths and needs of the CYSHCN MCH Workforce

Brian Rogers, MD continues to serve as interim director during OCCYSHN's search for a permanent director. OCCYSHN employs 22 staff with 10.4 FTE, including 5 community-based Parent Partners (PPs). PPs are parents or other full-time caregivers of CYSHCN, who have lived experience navigating the many complex systems of care. They are part-time, work-from-home employees of OHSU. The ORF2FHIC/FIP Coordinator recruits, hires, and supervises PPs. As part of the onboarding process, PPs receive training and complete competencies in confidentiality and the responsible conduct of research per OHSU personnel guidelines. Other initial training includes mandated reporting, effective peer communications, and maintaining professional boundaries. OCCYSHN hires, contracts with, and supports family representatives from diverse cultural and linguistic backgrounds, including Spanish and ASL.

b. **State level staffing**

OCCYSHN is staffed with a Registered Nurse as CaCoon Lead Program Consultant/Care Coordination Specialist, 3 community consultants (a special education specialist and a specialist in learning disabilities and community development), ORF2FHIC/FIP Coordinator (parent of CYSHCN), public health genetics counselor, Communications Coordinator, developmental pediatrician as Medical Consultant, Assessment & Evaluation Coordinator and Research Associate, Systems and Policy analysts, Administrative Program Manager, and 2 administrative staff. Additional consultative resources are available within IDD including developmental pediatricians, speech pathologists, occupational therapists, physical therapists, etc.

c. Local level staffing

OCCYSHN's state staff is augmented by contracted time and effort delivered by Public Health Nurses, other health and health related professionals and PPs who implement community-based programs around the state. A copy of OCCYSHN's contract with LPHAs is included in attachment # 2.

3. Partnerships, collaboration and coordination

OCCYSHN values strong collaboration among its partners including state and community-based agencies and organizations, healthcare and community based providers, and families of CYSHCN. By virtue of its location, it has collaborative relationships with CDRC clinics, Doernbecher Children's Hospital and the NICU, Department of Pediatrics, OPIP, and Shriners Hospital. It partners with LPHAs, ESDs, and providers to implement 2 statewide community-based programs. ORF2FHIC and OCCYSHN maintain relationships with parent organizations, which bring critical perspectives to state level system, policy, and program development and implementation. They inform OCCYSHN of the unmet needs of families of CYSHCN. Through its D70 grant, OCCYSHN has strengthened its relationship with state-level entities, such as OHA's Division of Health Policy & Analytics, including Medicaid, the PCPCH Program, and the Transformation Center. See Attachment #1 for more information about OCCYSHN's partnerships.

FY 2017 Application/FY 2015 Annual Report Update

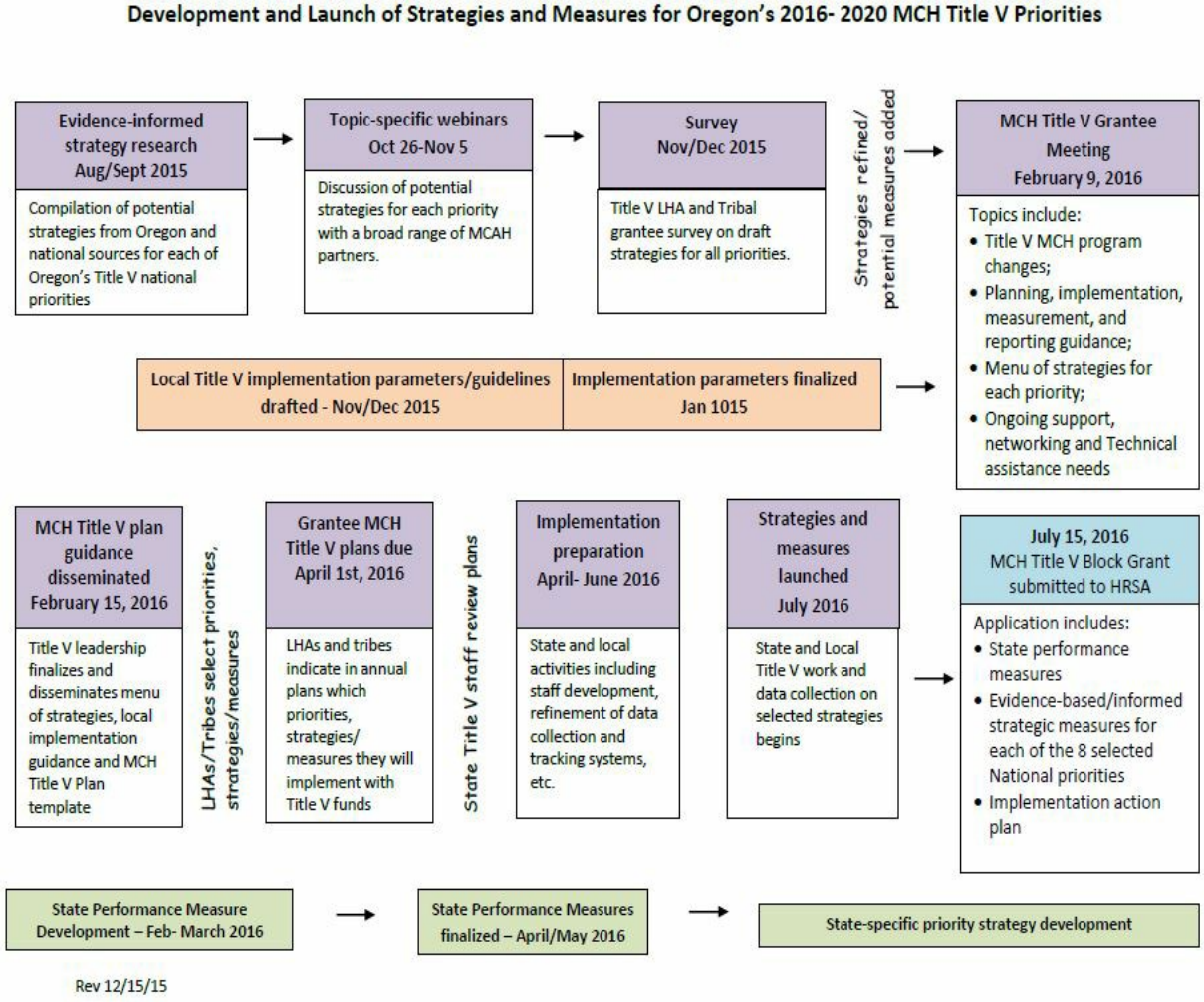
Oregon Health Authority (OHA) MCH Needs Assessment Summary Update
1. Process

Ongoing needs assessment over the past year focused on engagement of stakeholders around the state to further understand local needs and the current status of initiatives related to Oregon's new MCH priorities; and to develop a set of evidence based/informed strategies/measures to address each of Oregon's selected Title V national performance measures.

The process used to gather data and assess community and stakeholder and community needs related to potential strategies and measures included:

- Development of a steering committee with state and local leads for each priority/domain.
- Background research including a review of national literature, and use of local health needs assessment plans and state leads to identify current Oregon strategies and investments in each MCH priority area.
- Convening of a broad array of partners from around the state through topic-specific webinars to discuss needs, strategies, and Title V role for each of the priorities.
- A survey of local Title V grantees to gain a deeper understanding of local needs and perceived relevance of various potential strategies for impacting new Title V priorities.
- Title V grantees convened in early February to: learn about and discuss the final set of strategies, explore options for selecting priorities and strategies based to meet the needs of diverse Oregon communities, and to solicit further input on local needs related to BG 3.0 implementation.
- A new local grantee annual plan process was implemented and each grantee submitted an annual plan in April. Plan development included assessment of local needs in relation to Title V priorities and strategies; selection of Title V priorities, strategies, and measures; rationale in relation to local need; and anticipation of ongoing needs related to the new priority work.

The graphic below depicts the process and timeline, as well as products of this year's MCH Title V assessment and engagement activities.



1. Findings

MCH population needs

The table below summarizes findings of Oregon's MCH work to assess potential strategies and measures, by population domain (Findings for the CYSHN domain are in the following section). Attachment #3 contains the full report of findings from the six months of Title V strategy development research, assessment and engagement activities by population domain, as well as detailed strategy and sample activity tables for each domain.

Priority/State Lead	Performance Measure	Strategies
Maternal and Women's Health		
Well woman care (Anna Stiefvater)	Percent of women with a past year preventive visit	1. Case-management to improve utilization of well-woman care 2. Provide outreach for insurance enrollment and referral to services 3. Use traditional and social marketing to educate the population and promote well woman care 4. Provide education/training on preconception/ inter-conception health for providers (all types) 5. Provide access to well-woman care through Family Planning Clinics 6. Use of the postpartum health care visit to increase utilization of well-woman visits 7. Research to identify barriers to well woman care 8. Enhance OHP billing policies for well woman care 9. Increase the number of women covered by health insurance 10. Improve continuity of care among insurance plans
Perinatal and Infant Health		
Breastfeeding (Robin Stanton)	A) Percent of infants who are ever breastfed; B) Percent of infants breastfed exclusively through 6 months	1. Increase the number of fathers, non-nursing partner and family members, especially grandmothers, who learn about the importance of breastfeeding 2. Fill unmet needs for peer support of breastfeeding 3. Education/training of health care providers about breastfeeding 4. Education of pregnant women about breastfeeding 5. Increase the availability of breastfeeding support from professionals 6. Increase access to workplace breastfeeding support 7. Increase the support of breastfeeding at child care settings through policy, training, and workforce development 8. Advocate for program policies that support breastfeeding

(Rev 6/28/16)

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

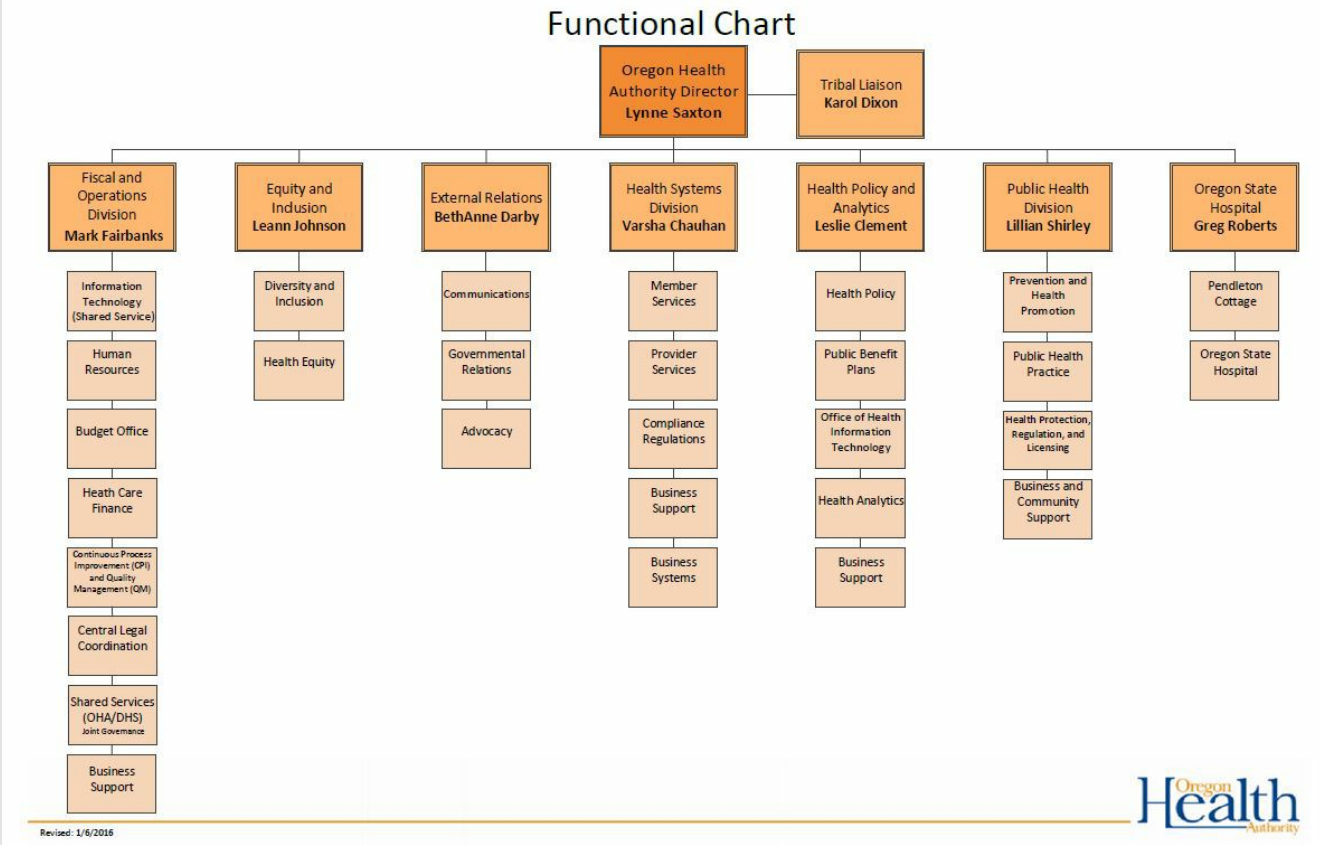
Priority/State Lead	Performance Measure	Strategies
Cross-cutting or Life course		
Oral health (Amy Umphlett)	A) Percent of women who had a dental visit during pregnancy B) Percent of children ages 1 to 17 years who had a preventive dental visit in the last year	1. Provide oral health services, education and referral/case management services through Oregon's Home Visiting System 2. Provide oral health services during well-child visits as recommended in the American Academy of Pediatrics Bright Futures Guidelines 3. Collaborate with primary care providers to follow the American Congress of Obstetricians and Gynecologists (ACOG) oral health recommendations for pregnant women 4. Collaborate with Early Childhood Care and Education to plan and implement methods to increase preventive dental services for children 5. Incorporate oral health services for adolescents into School-based Health Centers (SBHCs) and adolescent well-child visits 6. Promote the provision of dental sealants and oral health education in schools 7. Educate pregnant women, parents/caregivers of children, and children 0-17 about oral health 8. Promote community water fluoridation
Smoking (Lesa Dixon-Gray)	A) Percent of women who smoke during pregnancy B) Percent of children who live in households where someone smokes	1. Develop a policy agenda that decreases youth exposure to tobacco products and decreases likelihood for initiation and use. 2. 5As Intervention within MCH Programs including Home Visiting, Oregon MothersCare, Family Planning, and WIC (if applicable) 3. Develop customized programs for specific at-risk populations of women who are smokers and of reproductive age. 4. Collaborate w/CCOs, DCOs, and medical and early childhood/education providers to build prevention, screening, and intervention processes into their work practices, including workforce training. 5. Implement a media campaign that targets women during childbearing years. 6. Collaborate with the Oregon Quit Line Program to improve outreach and quit rates for pregnant and postpartum women 7. Promote expansion and utilization of health insurance coverage benefits for pregnant and postpartum women.

Priority/State Lead	Performance Measure	Strategies
State-Specific Priorities		
Toxic stress, trauma, and adverse childhood experiences (Nurit Fischler)	A.)Percentage of new mothers who experienced stressful life events before or during pregnancy; B.) Percentage of mothers of 2 year olds who have adequate social support.	TBD
Food insecurity and nutrition (Robin Stanton)	A.) #2 % of households experiencing food insecurity; B.) % of households with children <18 years of age experiencing food insecurity	TBD
Culturally and linguistically responsive services (Wendy Morgan)	A.) Percentage of children age 0 - 17 years who have a healthcare provider who is sensitive to their family's values and customs; B.) Percentage of new mothers who have ever experienced discrimination while getting any type of health or medical car	TBD

Title V MCH program capacity: changes in organizational structure, agency capacity, and workforce development and capacity

Oregon continues to be a state in which the Title V Block Grant is administered by two separate agencies – the Oregon Health Authority (OHA, and the Institute on Development & Disability (IDD) within Oregon Health & Science University.

As referenced in last year's grant, the Oregon Health Authority has been re-structured this year, and the new OHA organizational chart is attached. Title V remains in the Public Health Division, which is led by State Public Health Director Lillian Shirley. The Center for Prevention and Health Promotion is now led by Tim Noe, and Cate Wilcox continues to serve as the Title V Director and MCH Section manager. An updated OHA organizational chart is attached below.



Local capacity and infrastructure needs related to implementation of the new Title V BG 3.0 requirement and priorities were explored through the Title V Steering Committee and an implementation work group consisting of representatives of local health departments and tribes as well as state Title V staff. The product of this work was a new implementation guideline for local Title V grantees, which is included in Attachment 4.

The primary change in Title V capacity to address needs across the population domains comes from the re-alignment of the state agreement with local grantees (local public health agencies and tribes) to deliver Title V services. Capacity for work on the identified priorities as well as accountability and transparency have been enhanced by the development of a process for priority sections, planning, reporting, and ongoing technical assistance and communications between OHA and local Title V grantees. Outside of this change, OHA's agency capacity to promote health for each population domain remains as described in last year's grant, as does Title V support for state-wide coordinated systems of care and MCH workforce development and capacity.

1. Changes in partnership, collaboration and coordination efforts

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 updated 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 4 MIECHV grants including the formula, development, expansion, and competitive grants, which are administered jointly with Title V through the MCH section. 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 (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 MCH program (under the direction of the Title V Director), 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 Initiative, and the Health Care Coalition of Southern Oregon's Healthy Start Program.
Oregon Family to Family Health Information Center (ORF2FHIC)	ORF2FHIC, administered through OCCYSHN, provides peer support to families of CYSHCN across the state. Support is provided through telephone support, publications, family meetings, tip sheets and other printed information, and a website/Facebook page with current resources, news and information. ORF2FHIC partners with OCCYSHN's Family Involvement Program to provide this support to families of CYSHCN.
Assuring Comprehensive Care through Enhanced Service Systems for Children with ASD and Other Developmental Delays(ACCESS)	ACCESS is implemented by OCCYSHN and supports 8 medical-education teams around the state. These community-based teams provide timely and valid evaluations to identify Autism Spectrum Disorder (ASD) and other developmental delays in children under the age of five.

Enhancing Oregon's System of Care for CYSHCN (SOS)	SOS is funded by one of 16 D70 state implementation grants awarded in 2014 by the federal MCHB, and is administered through OCCYSHN. SOS aims to ensure a comprehensive, coordinated, integrated and sustainable system of care for Oregon's CYSHCN. SOS focuses on 3 strategies: cross-systems care coordination; integration between education, mental, and physical health; creation of a statewide shared resource. A cross-systems CYSHCN Advisory Group informs and collaborates on ways to implement these strategies. The group is comprised of families of CYSHCN and professionals who work with CYSHCN (Attachment #1 lists those representatives).
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 grants from the CDC and HRSA. The CDC grant is focused on the development, maintenance and enhancement of EHDI information systems and surveillance programs; and the HRSA grant 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.
Birth Anomalies Surveillance	Oregon has recently obtained CDC funding to support our birth anomalies surveillance system, including expanded critical congenital heart defect tracking and monitoring.

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's 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 physical activity, nutrition, adolescent and school health.
CDC Core Violence and Injury Prevention Program	The Centers for Disease Control and Prevention has awarded Oregon's Injury & Violence Prevention Program a 5-year State Violence & Injury Prevention Program (SVIPP) Core grant to focus on four priorities: reducing child maltreatment, domestic & sexual violence, traumatic brain injury, and motor vehicle-related impaired driving August 2016 through July 2021.
Race to the Top	Title V partners on a variety of health and early learning initiatives with the Department of Education's Race to the Top Early Learning grant, administered through the Early Learning Division.
iii. 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.
iv. 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.
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.
v. 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's Health Systems Division 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.
vi. 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.
vii. 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

BG 2017 IIB Title V Partner table (rev 6/30/16)

	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.
viii. 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.	
ix. Health systems	
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.	
x. 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 Parenting Education Collaborative.	
xi. 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 Oregon Perinatal Collaborative, and the Home Visiting Steering Committee.	

Oregon Center for Children and Youth with Special Health Needs (OCCYSHN) Needs Assessment Summary Update

1. Process

An important part of OCCYSHN's Title V work is ongoing surveillance of the needs of Oregon CYSHCN and their families. OCCYSHN is developing surveillance projects using All payers, All claims (APAC) data. This is described in more detail in the state plan.

OCCYSHN developed needs assessment dissemination briefs based on findings related to our performance measures and other key topics (see attachment #2). These briefs will be disseminated statewide to OCCYSHN's key partners and participants in the needs assessment process.

In developing strategies, OCCYSHN's leadership team meet regularly to review evidence-based/informed program materials Johns Hopkins in conjunction with other opportunities going on in the state. Opportunities included SOS grant efforts, payment reform, and primary care reform. In April, OCCYSHN met with the Region X HRSA consultant for technical assistance in developing its state plan.

2. Findings

The needs in Oregon continue to revolve around developing high quality, family-centered, coordinated and integrated

systems of care for CYSHCN. Successes in the past year include efforts toward building regional cross-systems care coordination (CSCC) teams through work on the SOS grant and leveraging the Community Connections Network (CCN) child health team model. Work groups have been formed to focus on 3 required strategies for the SOS grant: CSCC, integration, and shared resource.

2.1. Organizational Structure

Title V CYSHCN services are administered through IDD within OHSU School of Medicine, by OCCYSHN, under Oregon statutes 444.010, 444.020 and 444.030. OCCYSHN is the designated entity 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, under the direction of Brian Rogers MD, is composed of 2 "arms":

- **Child Development & Rehabilitation Center (CDRC)** clinical program includes CDRC clinics located in Portland and Eugene.
- **Public Health, Research and Education** includes OCCYSHN, the Oregon Office on Disability & Health (OODH), OHSU's University Center for Excellence in Developmental Disabilities (UCEDD) and OHSU, and the Disability & Health Research Group.

Responsibility for programs funded under Title V (Federal and state)

OCCYSHN consists of 6 program efforts, as described in attachment #1, including 2 statewide community-based programs receiving Title V funds.

2.2 Agency Capacity

a. Agency capacity to promote health for each population domain

Please see last year's Block Grant report for a description about OCCYSHN's capacity to promote health for CYSHCN.

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

OCCYSHN ensures a statewide system of services reflecting comprehensive, community-based, coordinated, and culturally competent family-centered care. Its core program activities include: assessment and evaluation, policy and systems development, family partnerships and involvement (Family Involvement Network [FIN] which is now referred to as the Family Involvement [FI] Program, Oregon Family to Family Health Information Center [ORF2FHIC], Sidney and Lillian Zetosch fund), community-based programs (CaCoon, CCN, ACCESS), and special projects/initiatives. Attachment #1 has detailed information about OCCYSHN's programs.

2.3 MCH Workforce Development and Capacity

a. Strengths and needs of the MCH Workforce

Marilyn Sue Hartzell, MEd, the Title V CYSHCN Director for the past 8 years has retired. Brian Rogers. MD, serves as interim director during the recruitment process. OCCYSHN employs 31 staff with 14.54 FTE that include 9 community-based Parent Partners (PPs) with Title V. OCCYSHN hires, contracts with, and supports family representatives from diverse cultural and linguistic backgrounds, including Spanish and ASL.

State level staffing

OCCYSHN is staffed with a Registered Nurse as CaCoon Lead Program Consultant, 3 community consultants (a special education specialist and 2 specialists in learning disabilities and community development), nutrition consultant, ORF2FHIC/ FI Program Coordinator (parent of CYSHCN), public health genetics counselor, Communications Coordinator, developmental pediatrician as Medical Consultant, Assessment & Evaluation Coordinator and Research Associate, Systems and Policy Specialist, 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

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

3. 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. It has collaborative relationships with CDRC clinics, DCH and the NICU, Department of Pediatrics within the School of Medicine, OPIP, and Shriners Hospital. It partners with local health departments, ESDs, and local health providers and professionals to implement 2 statewide community-based programs. ORF2FHIC and OCCYSHN establish relationships with parent organizations, which brings critical perspectives to state level system, policy, and program development and implementation. They inform OCCYSHN of the unmet needs of families of CYSHCN. See attachment #1 for more information about OCCYSHN's partnerships.

Five-Year Needs Assessment Summary
(as submitted with the FY 2016 Application/FY 2014 Annual Report)

II.B.1. Process

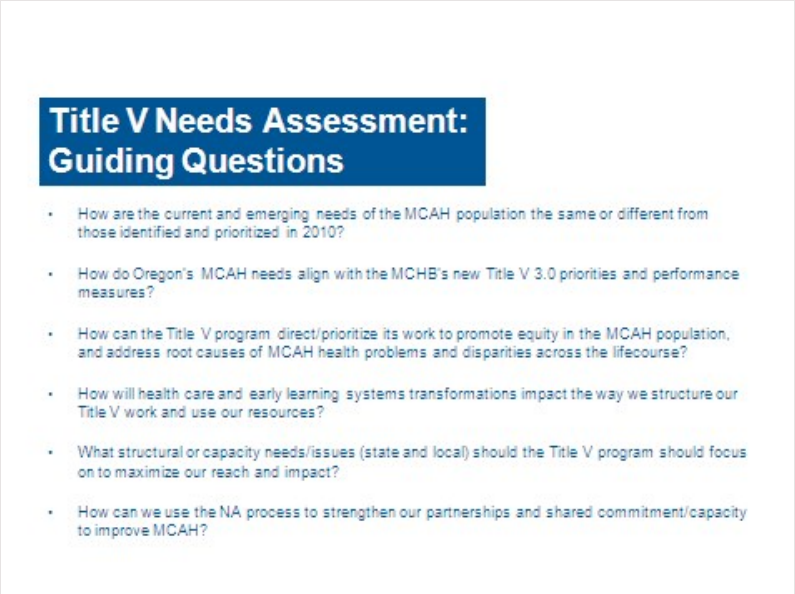
IIB.1 Process

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,

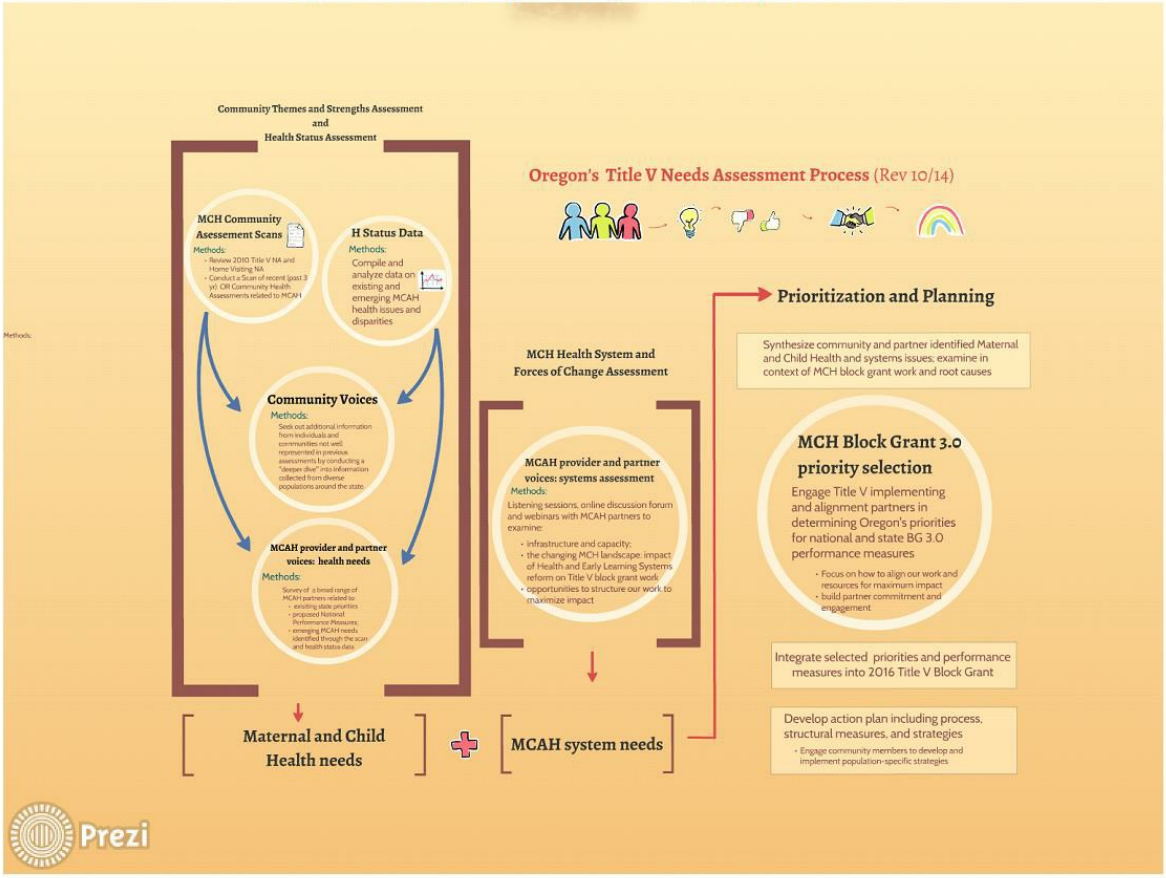
2014) and because of the changing landscape of care coordination.

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)

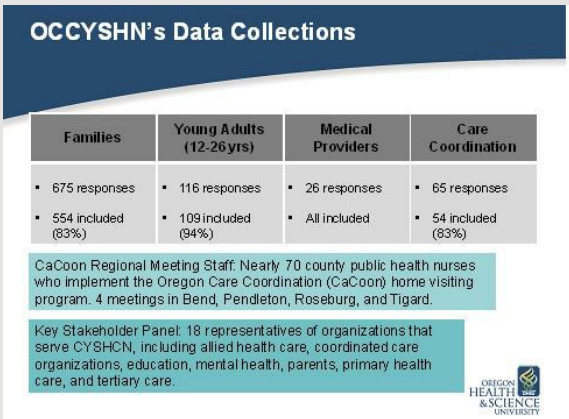
Eighty-eight Title V partners were invited to participate in the MCH online discussion forum. This moderated web-based discussion was conducted over a two-week period, and allowed Title V partners to respond to a set of prompts and react to each other's comments.

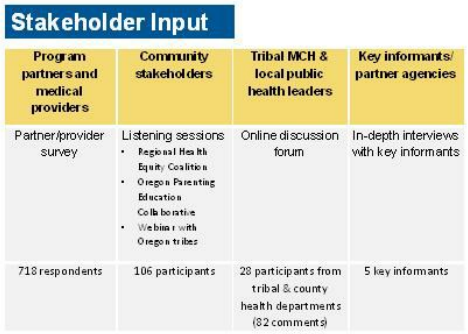
d. Listening sessions and webinar (106 participants)

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

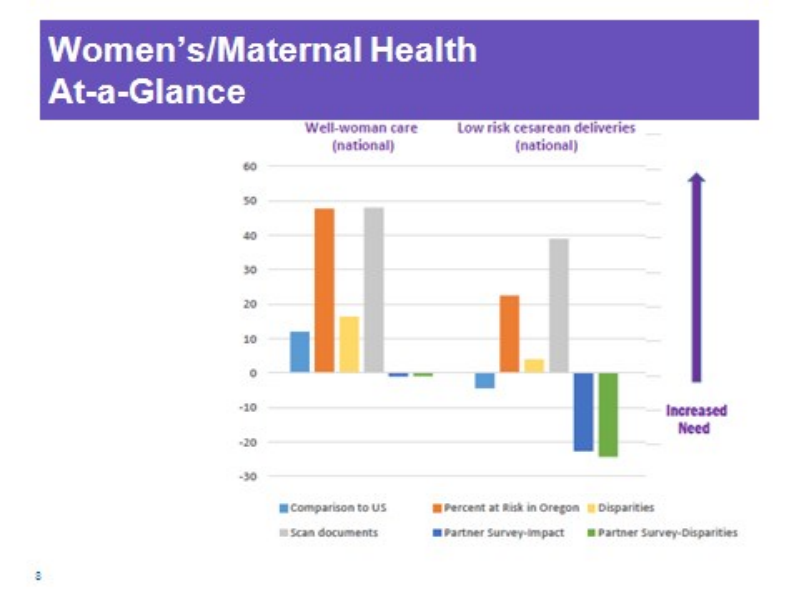
Many Oregon hospitals have started to implement practices and quality improvement efforts aimed at reducing cesarean rates. Oregon's success in decreasing early elective deliveries through a "hard stop" campaign led by the Oregon Perinatal Collaborative offers a model for a reduction in cesarean deliveries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

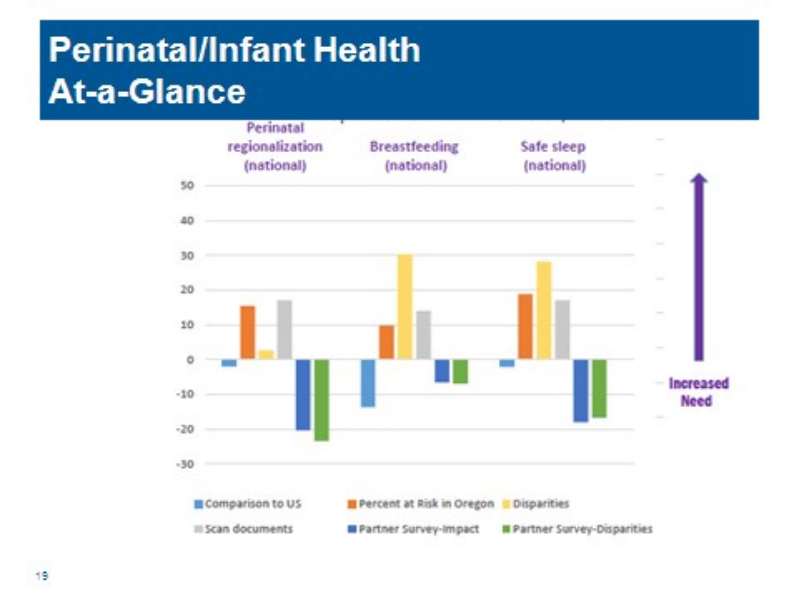
Oregon has among the highest breastfeeding rates in the US; most Oregon mothers initiate breastfeeding, however rates of exclusive breastfeeding at 6 months are much lower. Oregon hospitals have better than the national average of maternity care practices that support breastfeeding. Oregon has many supports 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:

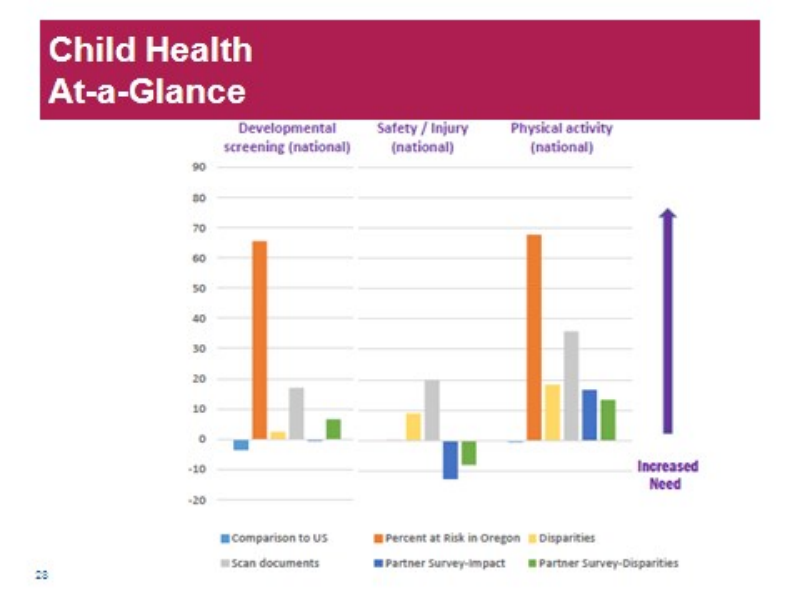
- Coordination of developmental screening results across providers.
- Reduction of screening process burden for families

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.

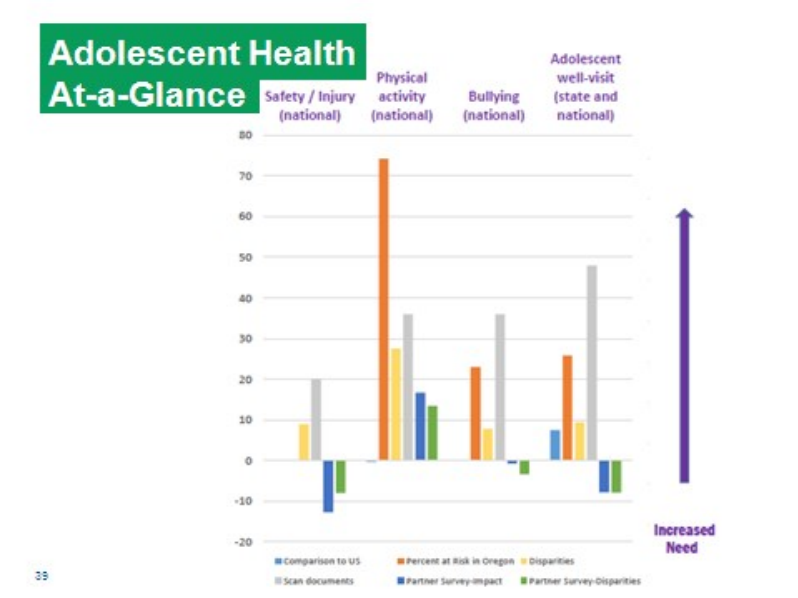
Bullying

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.
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

	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.

III.D. Financial Narrative

	2016		2017	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$6,122,592	$6,150,471	$6,198,272	$6,129,512
State Funds	$8,272,612	$8,888,929	$8,482,655	$10,163,564
Local Funds	$6,360,256	$6,026,894	$6,299,075	$7,003,170
Other Funds	$5,583,777	$7,299,003	$7,136,279	$7,468,578
Program Funds	$0	$0	$0	$0
SubTotal	$26,339,237	$28,365,297	$28,116,281	$30,764,824
Other Federal Funds	$33,903,443	$41,651,229	$36,772,879	$35,420,484
Total	$60,242,680	$70,016,526	$64,889,160	$66,185,308

	2018		2019	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$6,150,471	$6,178,818	$6,129,512	
State Funds	$8,888,929	$9,068,855	$10,116,862	
Local Funds	$6,026,893	$5,594,166	$7,003,170	
Other Funds	$7,236,918	$7,531,186	$7,684,389	
Program Funds	$0	$0	$0	
SubTotal	$28,303,211	$28,373,025	$30,933,933	
Other Federal Funds	$38,871,933	$39,324,236	$37,139,702	
Total	$67,175,144	$67,697,261	$68,073,635	

	2020	
	Budgeted	Expended
Federal Allocation	$6,178,818	
State Funds	$10,720,618	
Local Funds	$5,594,165	
Other Funds	$8,527,525	
Program Funds	$0	
SubTotal	$31,021,126	
Other Federal Funds	$39,882,886	
Total	$70,904,012	

III.D.1. 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. 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 are allocated approximately 30% in Enabling services and the remainder in Public Health Services and Systems for the federal MCAH block grant and 100% in enabling services for the non-federal MCAH block grant.

The Oregon Title V expenditures represent actual expenditures at the time of the report preparation.

To ensure compliance with BG 3.0 reporting, we thoroughly reviewed all expenditures in CP&HP to determine Oregon's total investment in the health of the maternal, child and adolescent populations. Only slight variances exist from last year's reported expenditures. County expenditures continue to be included as Local Funds. The tobacco cessation program funding includes a percentage of that program's funding based on the portion of program services provided to the Title V population.

III.D.2. 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 MCAH 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 MCAH 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. To ensure compliance with BG 3.0 reporting, we thoroughly reviewed all expenditures in CP&HP to determine Oregon’s total investment in the health of the maternal, child and adolescent populations and make budget projections accordingly. Only slight variances exist from last year’s reported expenditures. County expenditures continue to be included as Local Funds. The tobacco cessation program funding includes a percentage of that program’s funding based on the portion of program services provided to the Title V population.

III.E. Five-Year State Action Plan

III.E.1. Five-Year State Action Plan Table

State: Oregon

Please click the links below to download a PDF of the Entry View or Legal Size Paper View of the State Action Plan Table.

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

III.E.2. State Action Plan Narrative Overview

III.E.2.a. State Title V Program Purpose and Design

Overview of Oregon's MCAH Title V Partnership and leadership roles

Oregon's Title V program relies on shared leadership between the Public Health Division's Maternal and Child Section, it's Adolescent and School Health program, and the Oregon Center for Children and Youth with Special Health Needs at Oregon Health and Science University. A leadership team consisting of the Title V MCH Director (Cate Wilcox), Title V CYSHCN Director (Ben Hoffman), Title V Adolescent Health Director (Jessica Duke), Title V CYSHCN evaluator (Alison Martin), Title V Coordinator (Nurit Fischler) and the MCH Assessment and Evaluation Manager (John Putz) meet twice monthly to address Title V program and policy issues and ensure alignment across the agencies. Each Title V priority has a designated state lead who oversees state level program and policy work and provides technical assistance and oversight to the local level Title V grantees (public health and tribal) working on that priority (see Supporting Document #4 and table below). MCAH Title V also has a designated Tribal liaison who supports/oversees the work of the tribal Title V grantees. The state priority leads from MCH, Adolescent Health, and OCCYSHN, Title V Coordinator, Title V research analyst and Title V tribal liaison meet monthly to coordinate work across populations and domains.

The Title V leadership team and priority leads participate in external and internal work teams and committees to provide MCAH leadership and ensure that Title V work is represented by appropriate subject matter experts and integrated into related work within the agency, across state agencies, and with external partners. Key policy and system development initiatives which Title V MCAH staff either convene or contribute to include the: Governor's Children's Cabinet, Health Aspects of Kindergarten Readiness metrics work group, Reach Out & Read Advisory Committee, Social Determinants of Health CoIIN, Childhood Obesity CoIIN, Early Learning Council and its committees, OHA Health Disparities Advisory Committee, CCO Metrics and Scoring Committee, Oregon Pediatric Improvement Project, State Health Improvement Plan work groups on obesity prevention and substance abuse prevention, Trauma Informed Oregon Advisory Board, OHA Trauma Informed Policy Committee, Regional Kindergarten Readiness Network, and the Preschool Development Grant Needs Assessment Coordinating Committee, Oregon Safe Kids, State Child Fatality Review Team, and Domestic Violence fatality Review Team. Adolescent Health staff provide expertise and leadership to: Confederation of Oregon School Administrators Workgroup on Social Determinants of Health, Oregon Department of Education Safe and Effective Schools Working Group, Student Health Systems Division and Oregon School Activities Association workgroup on student athletes, Oregon Pediatric Improvement Project, and the Healthy Kids Learn Better Coalition.

MCAH Program Purpose and Design

The MCH Section strategic plan, and the Adolescent & School Health strategic plan (Supporting Document #3), as well as the OHA Performance Management System, PHD strategic plan and PH Modernization provide a framework for how the Title V program addresses MCAH priorities in Oregon.

The Mission of the MCH Section is to foster the foundations of lifelong health: safe and responsive environments; resilient and connected families and communities; and nutrition and healthy development. The lenses that the section uses in all its work are: life course science, health equity, social determinants, trauma and resilience, and multi-generational impact. The work is focused on four domains: Policy and systems; workforce capacity and effectiveness; assessment, surveillance and epidemiology; and community & family capacity. Each domain has a goal and several strategic priorities (see plan), and Title V's work is integrated across all of these.

Title V's Adolescent Health work sits within the Adolescent & School Health Unit, with a mission of supporting the

health of all youth in Oregon through evidence-based and data driven policies, practices, and programs. The Unit's work is comprised of four program areas: policy and assessment; school-based health centers, school nursing, and youth sexual health.

Oregon's state and local public health system is undergoing extensive re-structuring to ensure capacity and focus on core public health functions. This initiative is called Public Health Modernization, and the Title V program is providing leadership for the MCAH community's participation in this effort. Public Health Modernization legislation currently passed in June 2019 allocates $25 million to enhance state and local public health modernization efforts. Title V strategies and activities, mapped out in Title V priority-specific logic models, demonstrate foundational public health capabilities in practice across the Title V program (see supporting document #4).

OCCYSHN Program Purpose & Design

Mission, Vision, and Priorities

OCCYSHN improves the health, development, and well-being of all of Oregon's children and youth with special health care needs (OR CYSHCN). OCCYSHN's vision is that all OR CYSHCN are supported by a system of care that is family centered, community-based, coordinated, accessible, comprehensive, continuous, and culturally appropriate. Additionally, OCCYSHN provides subject matter expertise, data, and provider and family perspective to policy-makers and administrators.

OCCYSHN partners with families, communities, providers, and policy-makers to improve the health of OR CYSHCN. It partners with OHSU/IDD's Child Development and Rehabilitation Center to foster interdisciplinary, family-centered clinical care for CYSHCN. OCCYSHN collaborates with health, education, and social service agencies on committees and task forces addressing the needs of CYSHCN.

OCCYSHN's current priorities are to ensure patient-centered medical homes, effective transition from pediatric to adult health care, and culturally and linguistically appropriate care and services. Strategies to address these priorities were developed using our 2015 needs assessment results, reported experience of OCCYSHN stakeholders about their experience with the systems serving CYSHCN, and evidence-based/informed resources such as the AMCHP National Consensus Standards for Systems of Care for CYSHCN. OCCYSHN's efforts to address these priorities include family involvement, systems and workforce development, and assessment and evaluation.

Family Involvement

OCCYSHN incorporates the family perspective to ensure family-centered care at every level of program design and implementation, through its Family Involvement Program (FIP) and its close partnership with the Oregon Family to Family Health Information Center (ORF2FHIC). FIP supports families and professionals to collaborate as equals in caring for CYSHCN. FIP hires, trains, and supervises family members of CYSHCN to provide peer support and to advise professionals in their communities. ORF2FHIC provides peer support to families of CYSHCN, and offers targeted publications, toll free call line, family meetings, trainings, a Facebook page, and website with a wide range of resources. ORF2FHIC also partners with Oregon 211info to increase support for families of CYSHCN contacting 211.

OCCYSHN administers an annual distribution of the Oregon Community Foundation's Sidney and Lillian Zetosch Fund to purchase adaptive educational equipment, such as computers and tablets, for CYSHCN from low-income families. In 2018, OCCYSHN purchased educational equipment for 86 CYSHCN.

Systems & Workforce Development (S&W)

OCCYSHN provides resources and technical assistance to partners across the state to improve local systems of care and increase local capacity to meet the needs of CYSHCN. S&W supports the implementation of CaCoon, Regional Approach to Child Health (REACH) teams, shared care planning, and Piloting ACT.md for Care Coordination Teams (PACCT).

OCCYSHN contracts with LPHAs across Oregon to implement CaCoon, which offers public health nurse home visiting to families of CYSHCN. OCCYSHN provides training and guidance to the nurses. These nurses share resources and care coordination expertise with families, building family capacity to coordinate the complex care and service needs of their CYSHCN.

REACH convenes inter-professional local and regional groups of decision-makers and administrators from various systems that serve CYSCHN. These teams employ QI methodology to identify shared goals, address issues in regional systems of care, and coordinate for greater efficiency and effectiveness on behalf of CYSHCN.

OCCYSHN contracts with LPHAs to implement an innovative care coordination model, Shared Care Planning for CYSHCN. LPHAs convene families and multiple health and service providers. The team develops and monitors an actionable plan to achieve family goals. Professionals share accountability and build connections. The process strengthens local systems of care while improving the well-being of CYSHCN and families. Five of these LPHAs are also piloting the use of ACT.md, a cloud-based tool for shared care planning.

Assessment & Evaluation (A&E)

A&E staff conduct surveillance, needs assessment (NA), and program evaluation for OCCSYHN. A&E carries out ongoing population surveillance to assess the wellbeing of Oregon's CYSHCN and monitor issues that affect them. The staff designs and implements ongoing and 5-year NA activities to inform strategic planning and program development. A&E implements program evaluation and QI activities for OCCYSHN's community-based and grant-funded programs. The staff work with program leadership to disseminate results of these activities to OCCYSHN stakeholders.

MCAH Staff Development and Capacity

Overview of Oregon's MCAH Workforce strengths and capacity

Oregon's MCAH 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, MCAH staff and programs are deeply connected to community needs and integrated into local systems of health care social services, and education, making them a vital voice for MCAH population health in many policy and planning arenas.

Staff training and workforce development

MCAH 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 MCAH landscape in Oregon, have been a central focus of workforce development efforts over the past year including: public health modernization, health equity and cultural/linguistic responsiveness, and early childhood/home visiting.

- State MCAH 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 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 MCAH staff. Current areas of focus include:

    - Training to enhance capacity for trauma-informed and equitable workforce and workplace are a major focus of MCAH workforce development. All MCH staff completed the Intercultural Development Inventory this year, and results were used at the individual, work group, and section levels. This work with state and local MCAH workforce aligns with Oregon's state-specific priorities and strategies, as well as Public Health Division and OHA priorities.

    - The state MCAH program is active in mentoring MCAH students and new professionals. This year, Title V supported expanded our traditional mentoring to include hosting 2 interns from a local high school.

- Local MCAH programs receive ongoing technical assistance and training through state MCAH nurse consultants, program, policy, and research staff, and nutrition consultants. Title V has been working to build grantee capacity in: assessment, priority selection, and planning and measures development in alignment with the BG 3.0. This year, grantees participated webinars and conference calls with colleagues around the state working on shared priorities to build skills in the above topics.

- A critical and ongoing consultation/workforce development activity is the training of new MCH supervisors and staff in local health departments around the state. Training is conducted through a combination of state public health orientation trainings and individualized consultation delivered on site or by phone.

- The Oregon MothersCare (OMC) program provides quarterly training and ongoing technical assistance to local OMC coordinators and supervisors across the state to facilitate enrollment in Oregon Health Plan (OHP)

and other forms of health insurance, and access to prenatal services.

- Local MCAH 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.

Recruitment and Retention

- The MCH Section and Title V program have focused extensively over the past year on the implementation of a racial equity policy statement and instituting new policies and practices to ensure recruitment and retention of a diverse and trauma informed workforce. The policy and guidelines are included in Supporting Document # 3.
- The MCH Section has piloted the use of the new recruitment and hiring practices targeted at increasing equity in hiring and retention.

Innovations in staffing structure and workforce financing

- Oregon's modernization of public health initiative provides a framework for ensuring capacity to deliver foundational public health programs and ensure foundational public health capabilities across both state and local level public health. Title V programming and staffing at both the state and local level are aligned with modernization efforts.
- A partnership with Oregon Community Colleges through the "Support for Expectant and Parenting Students" grant has provided capacity to expand support for health, parenting, education and economic success among young families in five Oregon communities. We are currently in year 3 of this grant.

OCCYSHN Staff Development and Capacity

OCCYSHN increased capacity this year. OCCYSHN hired 3 Systems & Workforce Development staff: Implementation Support Coordinator, Development & Implementation Specialist, and a Care Coordination Nurse Specialist to lead the CaCoon program. An Administrative Assistant and Assessment & Evaluation Research Associate were also hired. In addition, OCCYSHN's Title V funds partially support the FTE of 9 clinical staff within CDRC. Efforts continue to shift Title V resources away from direct services to non-clinical/systems building efforts, in alignment with BG 3.0.

Actions to Build CYSHCN Workforce Capacity

Annual goals for professional development and annual performance reviews are part of all state staff positions. Staff professional development opportunities ranged from internal discussion of relevant professional publications to participating in national and OHSU sponsored webinars and trainings.

OCCYSHN partners with IDD/CDRC to improve health care for CYSHCN. This partnership prioritizes care coordination, behavioral health, medical consultation, feeding and nutrition, genetics, and high-risk infant care and follow-up. CDRC provides direct services to Oregon CYSHCN and their families in Portland, Eugene, and at outreach clinics. Services offer a family-centered, team based, interdisciplinary care model. Multiple specialists evaluate a child on the same day, and develop holistic, integrated diagnostic summary and family recommendations. CDRC's approach helps families "pull the pieces together" for their children. CDRC maintains the care model due in large part due to the support of Title V. OCCYSHN draws on CDRC clinical expertise, strengthening its overall capacity.

OCCYSHN's co-location and coordination with the University Center for Excellence in Developmental Disabilities Education, Research, and Service (UCEDD), Leadership Education in Neurodevelopmental & Related Disabilities (LEND), and Oregon Office on Disability and Health (OODH) programs strengthens OCCYSHN's capacity to address the workforce's needs related to CYSHCN and their families. OCCYSHN partners with UCEDD and LEND

to educate pre-service students and community service providers. OCCYSHN also collaborates with UCEDD and OODH on shared priorities, such as health care transition for YSHCN.

One of OCCYSHN's primary foci is to enhance the LPHA workforce through strategy 12.2 of OCCYSHN's state action plan. This strategy builds the LPHA workforce's cross-systems communication and coordination skills. Many LPHAs invite their partners to participate in TA activities, which provides an opportunity for spreading the interdisciplinary skill building to other systems.

III.E.2.b.ii. Family Partnership

MCAH Family Partnership

Oregon's MCAH 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 in 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:

- Oregon's work on the AMCHP-led Social Determinants of Health CoIIN is focused on ensuring that the voice and needs of traditionally under-represented families are elevated in policy and program decisions related to caregiving in the first year of life. This year the CoIIN team contracted with StoryCenter to deliver a 3-day digital storytelling workshop. This workshop developed Title V staff capacity in digital storytelling, while at the same time guiding 6 participants through a 3-day process to create digital stories reflecting their lived experience with seeking childcare. The next step for the CoIIN will be to partner with the storytellers to find ways to use their stories to reach policy makers.
- Oregon's 2020 MCAH Title V Needs Assessment has a strong family/community partnership component, including 8 contracts with organizations that work with under-represented communities to ensure that the voices of those families and communities are heard in the upcoming needs assessment.
- Local Title V programs are administered through local health departments and tribes in each county in Oregon, and all have unique approaches to engage families/consumers to 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.
- State level Title V staff partner with a wide range of community agencies, as well as local public health agencies and tribes to ensure family and consumer voice informs program and policy decisions. and community programs such as the Healthy Birth Initiative Community Action Network that help ensure consumer voice in our program planning and implementation.
- Oregon Early Hearing Detection and Intervention program (EHDI) engages families of infants with hearing loss in all aspects of the program, including:
  - Contracting with Oregon Hands & Voices to provide informational and emotional support to families of infants newly diagnosed with hearing loss;
  - Actively recruiting parent members for the legislatively mandated EHDI Advisory Committee;
  - Surveying parents about their experiences, system successes and program opportunities for improvement.
  - Soliciting parent review of parent/caregiver communications

- The Adolescent and School Health (A&SH) Unit has a focus on engaging youth in the development and implementation of their policies and programs. This is achieved through youth participatory action research curriculum implemented through SBHC youth advisory councils across the state.
- The Public Health Division also 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 Task Force, the Youth Sexual Health Partnership, and the Marijuana Communications Committee.

OCCYSHN Family Partnership

OCCYSHN ensures family partnership through a robust Family Involvement Program (FIP), which includes a Manager, ORF2FHIC Project Coordinator, Resource Specialist, and 5 Parent Partners (PP). The FIP Manager serves as the Principal Investigator for the ORF2FHIC grant, and supervises the training of PPs on health care financing, systems advocacy, medical home, transition, screening, and other topics impacting CYSHCN. ORF2FHIC supports families in navigating health care and community service systems, and informs them about key resources. PPs model advocacy skills and present options for solving care and service system challenges. In addition, FIP holds listening sessions around the state where families communicate their experiences, concerns, and questions. These experiences help inform OCCYSHN's work on behalf of CYSHCN.

PPs create content for the ORF2FHIC website and tip sheets for families. FIP seeks partnerships with professionals to create plain-language materials for families. For example, PPs, EMTs and ER personnel jointly developed an ER planning guide for families of CYSHCN. In addition, FIP partners with a Latina cultural broker who is closely connected to the CYSHCN community. The cultural broker and ORF2FHIC bilingual PP translates materials into Spanish. To support non-English-speaking families of CYSHCN, interpretation services are hired, as needed, through a variety of community-based services (such as the Immigration and Refugee Community Organization language line).

PPs and affiliated parent leaders provide family leadership in the community and within OCCYSHN. They serve on committees, boards, and workgroups, OHA Rules Advisory Committees, CCO Consumer Advisory Councils, State Interagency Coordinating Council, Medicaid Advisory Committee, Early Learning Council, and the Emergency Medical Services for Children Advisory Board. The FIP Manager is a member of the block grant development and review team, and an AMCHP delegate.

FIP identifies family members of CYSCHN to speak at events and trainings, and to give technical assistance to professional stakeholders. For example, PPs review materials for family-appropriateness and provide feedback on policy issues. FIP contributes to workforce development by coaching health care providers on recruiting, hiring, and supervising PPs.

FIP is integrated into all OCCYSHN efforts, and presents at S&W regional meetings and web-based trainings. It contributes to A&E efforts (including the Needs Assessment) and other OCCYSHN activities.

III.E.2.b.iii. States Systems Development Initiative and Other MCH Data Capacity Efforts

The Oregon State Systems Development Initiative (SSDI) program develops, enhances, and expands Oregon's Title V Maternal and Child Health (MCAH) data capacity for the Title V Needs Assessment and performance measure reporting in the Title V MCAH Block Grant program. The program facilitates informed decision-making and resource allocation that support effective, efficient and quality programming for women, infants, children and youth, including children and youth with special health care needs. The Oregon SSDI program has three central goals: (1) Build and expand Oregon MCAH data capacity to support the Title V MCAH Block Grant program activities and contribute to data-driven decision making in MCAH programs, including assessment, planning, implementation and evaluation. (2) Advance the development and utilization of linked information systems between key MCAH datasets in the state. (3) Support program evaluation activities around the National Performance Measures (NPM) that contribute to building the evidence base for the Title V MCAH Block Grant program.

The development and deployment of a web-based database was a SSDI project undertaken to support the annual Title V MCAH Block Grant data collection and reporting. The database project not only streamlined submission of local plans and outcomes but enabled better continuity of information and eliminated previous issues with document version control. It also greatly reduced staff effort and timeline for even simple queries and reporting and structured the information in a way that will allow for adaption to new or different data points as performance measures and strategies change over time. Recent updates to this system included standardizing the strategies and measures for each of the state-defined priority areas. This change made reporting more consistent to aid both the submission and review of the reports as well as continued movement towards a set of comparable metrics as county and tribal needs shift and new needs emerge.

In prior fiscal years, Oregon's SSDI program supported efforts to obtain access, and make available, the minimum and core data sets. As a result of these efforts, all 24 of the Minimum/National Dataset (M/NDS) indicators, all of the eight Core/National Dataset (C/NDS) indicators, and all of the 13 Core/State Dataset (C/SDS) indicators were found to be obtainable through various sources. Efforts have been made to promote the availability of the minimum and core datasets within MCH through meetings and discussions with assessment and evaluation teams. Many of these indicators are utilized, as needed, for the Title V Needs Assessment and various reporting activities; in many cases, this has led to data sharing activities between programs.

The M/CDS work was also leveraged over the course of FY15 and FY16 as a platform to address standards and harmonization of data elements across MCH program data collection and reporting systems, including systems for Early Hearing Detection and Intervention, Oral Health, Birth Anomalies Surveillance, Oregon MothersCare, and public health nurse home visiting programs. This work was also beneficial when working with internal partners' datasets such as Immunizations, Vital Statistics, Hospital Discharge, and Medicaid datasets.

Another key accomplishment of the SSDI program was the identification and gathering of key stakeholders for the work to migrate and support Title V data collection on a new home visiting database, Tracking Home visiting Effectiveness in Oregon (THEO). The old database will begin sunsetting in the next funding year, but it is known that many local agencies leverage the system for data collection and reporting on Title V-related measures. This stakeholder group will be critical in establishing state-level needs as well as coordinating with local partners in the upcoming migration work to maintain data collection efforts.

III.E.2.b.iv. Health Care Delivery System

Overview of Health Reform in Oregon

Oregon's health system transformation is guided by the Triple Aim of better health, better care, and lower costs, and has been underway since 2011. The Oregon Health Authority, within which the MCAH 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, integration of physical, behavioral and oral health, coordination of services for children and youth with special health care needs, as well as enrollment in insurance coverage through the Oregon ONE Eligibility portal.

Oregon's Medicaid Expansion

Oregon is one of 33 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. More than 375,000 people have enrolled in OHP as a part of Medicaid Expansion.

Oregon's 1115 Medicaid Demonstration for transformation of the Oregon Health Plan was approved in 2012 and renewed in 2017. Through the demonstration, Oregon is accountable for bending the cost curve for Medicaid while improving access and quality of care for Medicaid clients. The most recent quarterly report (3/31/19) details progress on strategies to achieve demonstration goals including: Lever 1 - Improving care coordination at all points in the system, especially for those with multiple or complex conditions, with an emphasis on primary care through Patient-Centered Primary Care Homes. Lever 2 - Implementing value-based payment models to focus on value and pay for improved outcomes. Lever 3 - Integrating physical, behavioral, and oral health care structurally and in the model of care. Lever 4 - Increased efficiency in providing care through administrative simplification and a more effective model of care that incorporates community-based and public health resources. Lever 5 - Implementation of health-related services aimed at improving care delivery, enrollee health, and lowering costs. Lever 6 - Testing, accelerating and spreading effective delivery system and payment innovations through peer-to-peer learning, the spread of best practices, and innovation through the Oregon Health Authority's Transformation Center.

Oregon's Health Insurance Exchange

Oregon's expansion of Medicaid and the amount of enrollment outreach has allowed us to have one of the highest rates of health insurance enrollment in the US. Currently, 95% of Oregonians, and 98% of children have access to health coverage. More than 1.1 million people are now insured through OHP or private insurance plans through the Oregon Marketplace. A shared portal for Enrollment is at: https://healthcare.oregon.gov/Pages/index.aspx

Coordinated Care model

Coordinated Care Organizations (CCOs) are at the center of Oregon's health system transformation. Sixteen CCOs were established since 2012, and one closed leaving fifteen operating. 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 measured and shared publicly. In addition, each CCO has a community advisory council (with at least 51% of membership being OHP members or family members), a transformation plan, and a community health improvement plan which extends impacts beyond the OHP population. Local Title V agencies are active partners with their CCOs in assessment, community prevention, and MCAH service delivery. The newly revised CCO incentive metrics demonstrate the increasing

commitment to focus on early childhood, with the addition of incentive metrics related to postpartum care, oral health, and children's BMI. Work is actively underway to create additional measures for the metrics database to track work on social determinants of health and health aspects of kindergarten readiness, among other important MCAH indicators.

Since 2012 Oregon's Medicaid reforms and the CCO model have saved taxpayers an estimated $2.2 billion. CCOs are also making progress on quality. The latest metrics report shows improvements in several areas including: effective contraceptive use, follow-up after hospitalization for mental illness, and in applying dental sealants for kids. The next five-year CCO contract will start in January of 2020 (CCO 2.0). Governor Kate Brown has asked the Oregon Health Policy Board, which oversees OHA's work, to make improvements in four areas: sustainable cost growth, value-based payments that pay for performance, social determinants of health and equity, and the behavioral health system.

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 partners with the OHA Public Health Division to support transformation efforts across health and early learning so all of Oregon's young children are healthy and ready to learn. The Transformation Center is charged with testing innovative approaches to improving health and lowering costs, and Title V at both the state and local levels are key partners in these efforts.

Title V MOU with Medicaid

In addition to the broader Medicaid and health systems transformation work described above, Title V works to ensure access and coordinate systems of care for MCAH 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.

Over the last year, MCAH, OCCYSHN, and Medicaid have begun implementation of the new Title V Medicaid MOU (see Section IV). The three partners agencies have begun meeting quarterly and collaborating on legislative and policy agendas, as well as other topics of shared interest. Topics discussed to date include coding for perinatal depression screening, EPSDT, and MCH workforce capacity.

Other Health System reforms impacting MCAH

Several key pieces of legislation are currently being considered by the Oregon Legislative Assembly including:

- Universally offered home visiting
- Expansion of School Based Health Clinics
- Increased funding and support for Public Health Modernization
- Paid Family Leave

More information will be available on each of these after the conclusion of the 2019 legislative session.

Health Care Delivery for CYSHCN

OCCYSHN, in partnership with the ORF2FHIC, provides training on both public and private insurance to its PPs. Topics include protections, appeals and systems navigation. PPs help families navigate insurance systems. ORF2FHIC resources include tip sheets, appeal and grievance tool-kits, and web-based materials from the Oregon Insurance Division Consumer and Business Services.

OCCYSHN collaborates and consults with several CCOs about systems and services development for CYSHCN,

focusing on community-based health teams. Payers, including CCOs, are crucial partners for OCCYSHN's cross-systems strategies. An internal OCCYSHN workgroup has been examining alternative payment methods (APM) and value-based purchasing (VBP) as potential infrastructure supports for cross-systems care coordination and health care transition. The workgroup connected with Got Transition during the October 2017 MCHB TA meeting and received feedback. The workgroup reached out to CCOs and integrated its work into Oregon's CMC CoIIN Project with the Catalyst Center.

III.E.2.c State Action Plan Narrative by Domain

Women/Maternal Health

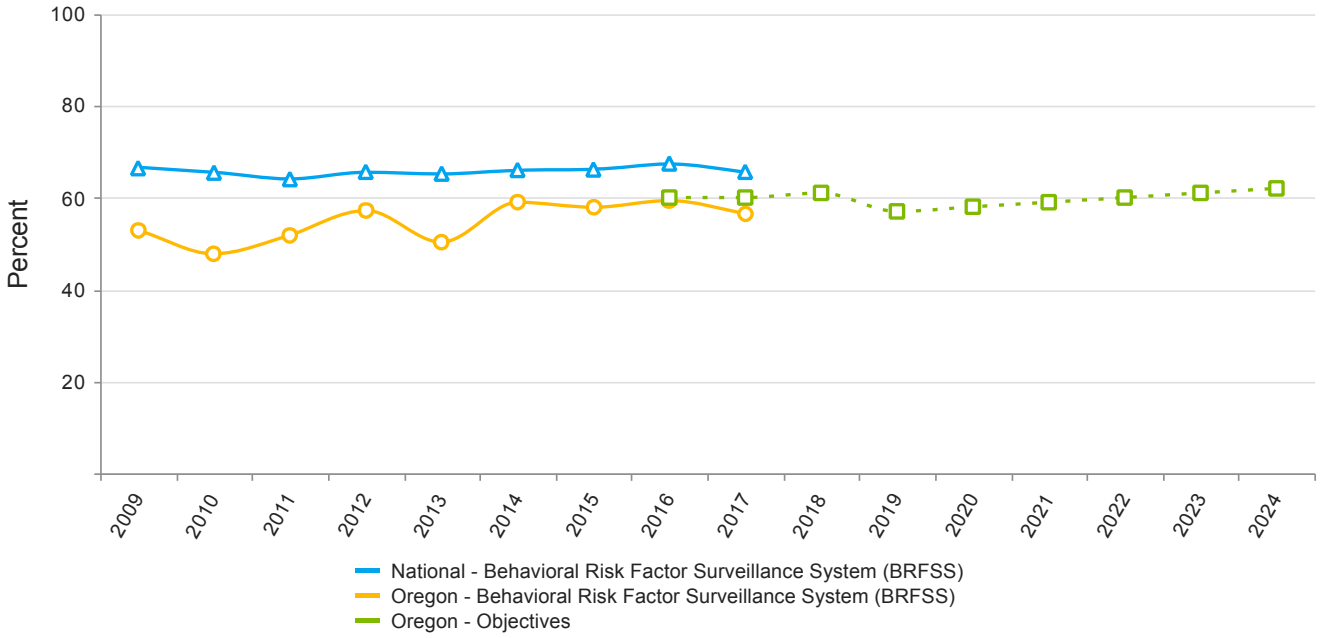
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID-2015	130.2	NPM 1 NPM 14.1
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS	Data Not Available or Not Reportable	NPM 1 NPM 14.1
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2017	6.8 %	NPM 1 NPM 14.1
NOM 5 - Percent of preterm births (<37 weeks)	NVSS-2017	8.3 %	NPM 1 NPM 14.1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2017	22.5 %	NPM 1 NPM 14.1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2016	5.0	NPM 1 NPM 14.1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2016	4.7	NPM 1 NPM 14.1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2016	3.3	NPM 1 NPM 14.1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2016	1.4	NPM 1 NPM 14.1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2016	158.1	NPM 1 NPM 14.1
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2016	74.7	NPM 14.1
NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy	PRAMS-2015	11.6 %	NPM 1
NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births	SID-2016	6.3	NPM 1
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	NSCH-2016_2017	13.8 %	NPM 13.1
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2016_2017	90.9 %	NPM 13.1 NPM 14.1

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2017	15.0	NPM 1
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth	PRAMS-2015	9.7 %	NPM 1

National Performance Measures

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year
Indicators and Annual Objectives



Federally Available Data			
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)			
	2016	**2017**	**2018**
Annual Objective	60	60	61
Annual Indicator	58.0	59.2	56.5
Numerator	394,235	409,007	391,780
Denominator	680,107	691,064	693,242
Data Source	BRFSS	BRFSS	BRFSS
Data Source Year	2015	2016	2017

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	57.0	58.0	59.0	60.0	61.0	62.0

Evidence-Based or –Informed Strategy Measures

ESM 1.2 - Number of women reached using traditional and social marketing campaigns such as CDC Show Your Love brochures, social media including Facebook and Twitter, attendance at health fairs and community meetings, and public service announcements.

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		500	600
Annual Indicator	0	0	0
Numerator			
Denominator			
Data Source	Log of brochures distributed, social media views/l	Unable to track this year	Unable to track this year
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Provisional	Provisional

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	700.0	800.0	900.0	1,000.0	1,000.0	1,000.0

ESM 1.3 - Percent of local health departments receiving technical assistance to support implementation of the well woman care priority area.

Measure Status:	Active

State Provided Data		
	2017	2018
Annual Objective	100	100
Annual Indicator	100	100
Numerator	11	9
Denominator	11	9
Data Source	Minutes from TA trainings and phone calls	Minutes from TA trainings and phone calls
Data Source Year	2017	2018
Provisional or Final ?	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	100.0	100.0	100.0	100.0	100.0	100.0

ESM 1.4 - Number of public health programs routinely screening women of reproductive age for their pregnancy intention.

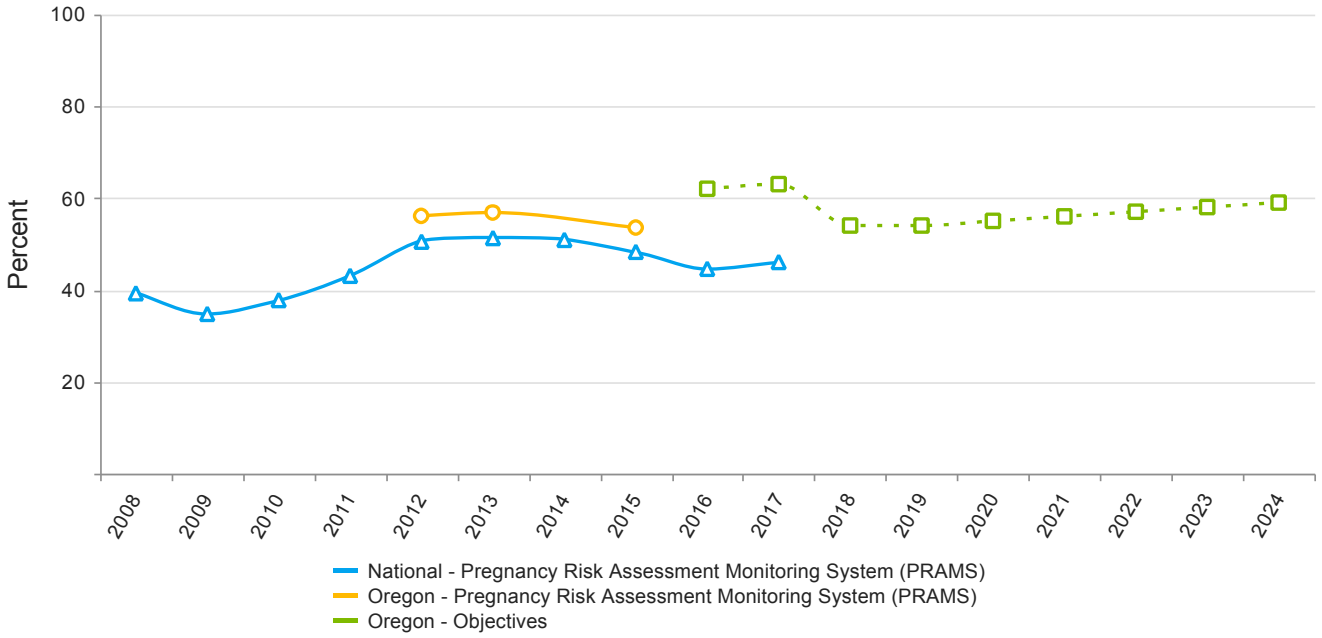
Measure Status:	Inactive - Completed

State Provided Data		
	2017	2018
Annual Objective	15	17
Annual Indicator	16	38
Numerator		
Denominator		
Data Source	Local grantee reports	Local grantee reports
Data Source Year	2017	2018
Provisional or Final ?	Final	Final

ESM 1.5 - Number of state and local partners engaged to improve access to and quality of well-woman care and reproductive health services.

Measure Status:					Active
Annual Objectives					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	15.0	15.0	15.0	15.0	15.0

NPM 13.1 - Percent of women who had a preventive dental visit during pregnancy
Indicators and Annual Objectives



Federally Available Data			
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)			
	2016	**2017**	**2018**
Annual Objective	62	63	54
Annual Indicator	57.0	53.5	53.5
Numerator	24,297	22,955	22,955
Denominator	42,656	42,925	42,925
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2013	2015	2015

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	54.0	55.0	56.0	57.0	58.0	59.0

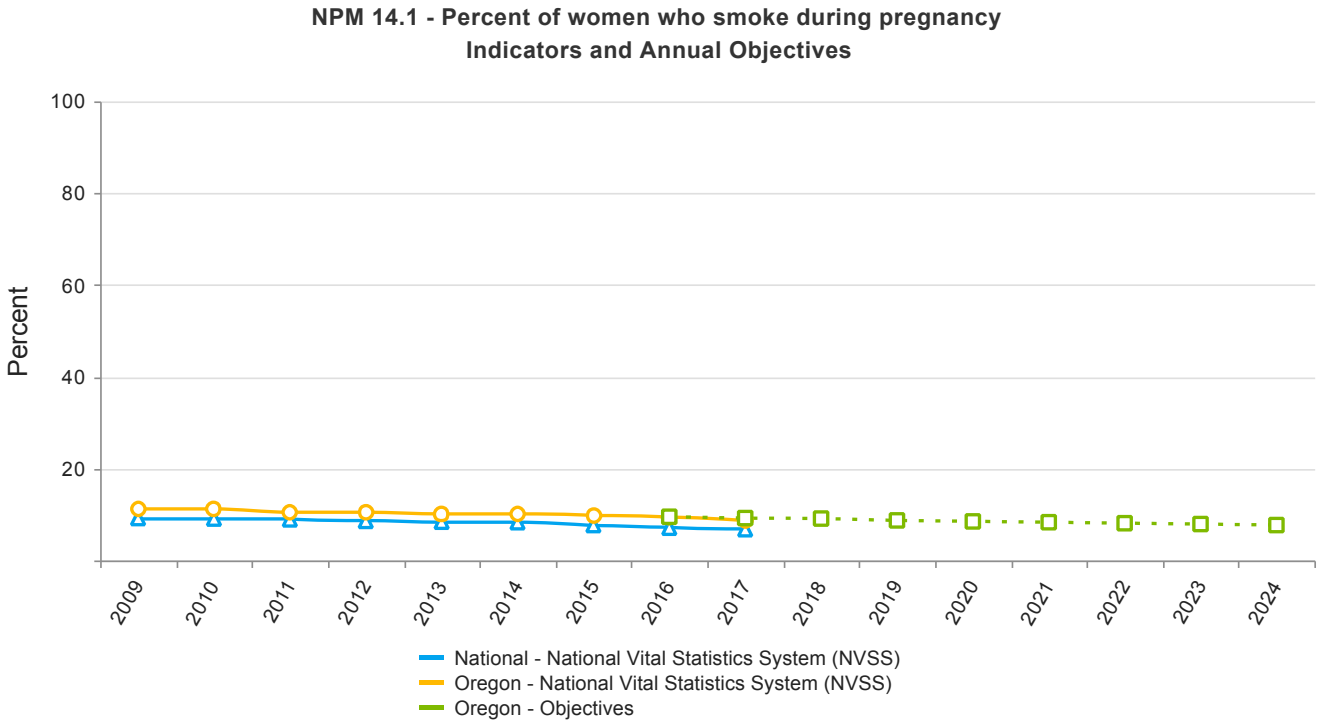
Evidence-Based or –Informed Strategy Measures

ESM 13.1.1 - Number of materials developed on the common risk factors and associations between chronic diseases and poor oral health such as cavities and periodontal disease.

Measure Status:	Inactive - Completed		
State Provided Data			
	2016	**2017**	**2018**
Annual Objective		6	4
Annual Indicator	3	3	4
Numerator			
Denominator			
Data Source	Log of materials produced	Log of materials produced	Log of materials produced
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

ESM 13.1.2 - Number of data sets in the Oregon Oral Health Surveillance System (OOHSS) that can be analyzed for oral health disparities

Measure Status:				Active		
Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	7.0	7.0	7.0	7.0	7.0	7.0



Federally Available Data			
Data Source: National Vital Statistics System (NVSS)			
	2016	**2017**	**2018**
Annual Objective	9.6	9.3	9.2
Annual Indicator	9.9	9.5	8.9
Numerator	4,517	4,326	3,880
Denominator	45,489	45,405	43,455
Data Source	NVSS	NVSS	NVSS
Data Source Year	2015	2016	2017

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	8.8	8.6	8.4	8.2	8.0	7.8

Evidence-Based or –Informed Strategy Measures

ESM 14.1.1 - Percent of local Title V grantees who have selected smoking as a priority area who are implementing the 5A's with their clients.

Measure Status:	Active

State Provided Data		
	2017	2018
Annual Objective	75	75
Annual Indicator	50	100
Numerator	5	10
Denominator	10	10
Data Source	Local grantee reports	Local grantee reports
Data Source Year	2017	2018
Provisional or Final ?	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	75.0	75.0	75.0	75.0	75.0	75.0

ESM 14.1.2 - Percent of local Title V grantees who have selected smoking as a priority area who have at least two technical assistance contacts.

Measure Status:	Active

State Provided Data		
	2017	2018
Annual Objective	80	80
Annual Indicator	90.9	100
Numerator	10	10
Denominator	11	10
Data Source	Log of technical assistance provided	Log of technical assistance provided
Data Source Year	2017	2018
Provisional or Final ?	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	80.0	80.0	80.0	80.0	80.0	80.0

State Action Plan Table

State Action Plan Table (Oregon) - Women/Maternal Health - Entry 1

Priority Need

High quality, culturally responsive preconception, prenatal and inter-conception services.

NPM

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Objectives

By Oct 1, 2020 increase the percent of women with a past year preventive medical visit from 56.5% to 58.0%, through improved accessibility, quality, and utilization.

Strategies

Provide TA to local grantees on well woman care strategy/measure selection, Title V plan development, and strategies/measure implementation.

Provide case-management to improve utilization of well-woman care.

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

Provide education/training on preconception/interconception health for providers.

Support access to well-woman care through Family Planning Clinics.

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

Provide outreach for insurance enrollment and referral to services

Research/assessment to identify barriers to well woman care

ESMs	Status
ESM 1.1 - Number of women who have been surveyed or who have participated in focus groups to identify barriers to well women care.	Inactive
ESM 1.2 - Number of women reached using traditional and social marketing campaigns such as CDC Show Your Love brochures, social media including Facebook and Twitter, attendance at health fairs and community meetings, and public service announcements.	Active
ESM 1.3 - Percent of local health departments receiving technical assistance to support implementation of the well woman care priority area.	Active
ESM 1.4 - Number of public health programs routinely screening women of reproductive age for their pregnancy intention.	Inactive
ESM 1.5 - Number of state and local partners engaged to improve access to and quality of well-woman care and reproductive health services.	Active

NOMs
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations
NOM 3 - Maternal mortality rate per 100,000 live births
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)
NOM 5 - Percent of preterm births (<37 weeks)
NOM 6 - Percent of early term births (37, 38 weeks)
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths
NOM 9.1 - Infant mortality rate per 1,000 live births
NOM 9.2 - Neonatal mortality rate per 1,000 live births
NOM 9.3 - Post neonatal mortality rate per 1,000 live births
NOM 9.4 - Preterm-related mortality rate per 100,000 live births
NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy
NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

State Action Plan Table (Oregon) - Women/Maternal Health - Entry 2

Priority Need

Improved oral health for pregnant women and children.

NPM

NPM 13.1 - Percent of women who had a preventive dental visit during pregnancy

Objectives

By October 1, 2020 increase the percentage of women who had a dental visit during pregnancy from 53.5% to 55%.

Strategies

Provide oral health preventive services or education and referral/case management services through Oregon's Home Visiting System.

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

Educate pregnant women, parents/caregivers of children, and children 0-17 about oral health and the importance of dental visits.

Integrate oral health into state Maternal and Child Health, Health Promotion, and Chronic Disease Prevention programs.

Increase oral health surveillance in Oregon

ESMs	Status
ESM 13.1.1 - Number of materials developed on the common risk factors and associations between chronic diseases and poor oral health such as cavities and periodontal disease.	Inactive
ESM 13.1.2 - Number of data sets in the Oregon Oral Health Surveillance System (OOHSS) that can be analyzed for oral health disparities	Active

NOMs

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

State Action Plan Table (Oregon) - Women/Maternal Health - Entry 3

Priority Need

Reduced tobacco use and exposure among pregnant women and children.

NPM

NPM 14.1 - Percent of women who smoke during pregnancy

Objectives

By October 1, 2020 decrease the percent of pregnant women who smoke during pregnancy from 8.9% to 8.6%.

Strategies

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

5As Intervention and Quit Line Referral (or other customized Evidence-Informed Program) within MCH Programs including Home Visiting, Oregon MothersCare, Family Planning, and WIC (if applicable)

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

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

ESMs	Status
ESM 14.1.1 - Percent of local Title V grantees who have selected smoking as a priority area who are implementing the 5A's with their clients.	Active
ESM 14.1.2 - Percent of local Title V grantees who have selected smoking as a priority area who have at least two technical assistance contacts.	Active

NOMs

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

NOM 3 - Maternal mortality rate per 100,000 live births

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

NOM 5 - Percent of preterm births (<37 weeks)

NOM 6 - Percent of early term births (37, 38 weeks)

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.2 - Neonatal mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

2018 Report: Well-Woman Care

National Performance measure (#1):

Percent of women with a past year preventive visit.

Interpretation of state performance measure data:

Oregon's rate of women attending an annual well-woman visit continues to remain below the national average. There has been a slight decrease in the percent of women attending an annual well-visit between 2014 and 2017, from 59.1% to 56.5% respectively.

Strategies and Activities

Strategy: Case-management to improve utilization of well-woman care.

ESM 1.4: Number of public health programs routinely screening women of reproductive age for their pregnancy intention.

Progress on ESM

All Babies First! and Nurse Family Partnership Home Visiting Programs in Oregon (N=38) have standards which include screening clients for pregnancy intention.

Accomplishments

Program guidance for the public health MCH Nurse Home Visiting Babies First! program was updated so that there is more focus on pregnancy intention screening, reproductive health planning and supporting access to appropriate well-woman and pre/interconception care among clients.

Crook, Deschutes, Jefferson, Lincoln, Marion, and the North Central Local Public Health Authorities provided case-management activities through the public health MCH Nurse Home Visiting programs. They implemented the One Key Question within the protocols for the home visitors and used the question as a starting point to assist women in accessing appropriate clinical preventive services.

The Klamath and Warm Springs Tribes worked to build a program which supports women throughout pregnancy and the post-partum period. The programs provided case management and incentives. They also included goals around prenatal and postpartum visit attendance as well as facilitating connections to ongoing clinical care.

Challenges & emerging issues

The ownership of the One Key Question (OKQ) moved from the Oregon Foundation for Reproductive Health to the National Power to Decide Organization. The move came with increased training costs and requirements for using the OKQ model which has proved to be a barrier for local programs. There have also been challenges around how to include the use of the OKQ in electronic medical records. Home visitors have expressed an interest in training so that they are more confident in their ability to have reproductive health conversations in a culturally competent way.

Scheduling practices within the Indian Health Services system has created challenges for women in accessing postpartum care appointments. Case managers have been working with scheduling staff to streamline this process.

Strategy: Use traditional and social marketing to educate the population and promote well woman care.

ESM 1.2: Number of women reached using traditional and social marketing campaigns such as CDC Show Your Love brochures, social media including Facebook and Twitter, attendance at health fairs and community meetings, and public service announcements.

Progress on ESMs

Local grantees have had difficulty tracking the number reached through social media due to a lack of staff time and skill in evaluating the effectiveness of outreach campaigns.

Accomplishments

State Title V staff worked with communications staff from the Oregon Health Authority to build our social media presence and have supported local grantees through technical assistance and collaboration.

Marion County worked to build their social media presence locally with messages aimed at women of reproductive age. Marion County has also worked to promote Text4baby as a way of reaching women in their community.

Challenges and emerging issues

The expertise and time needed to build effective marketing campaigns has been a challenge for both state staff and local grantees. With changes at the national level to the Text4baby program, we no longer have support for outreach materials or access to data. Due to these changes, we will not continue promotion of Text4baby. At the state and local-level we have had difficulty tracking this strategy.

Strategy: Provide education/training on preconception/interconception health for providers.

Accomplishments

- The Oregon Preventive Reproductive Health Advisory Committee (includes Title V staff) developed and disseminated Oregon guidance for the provision of high-quality contraception services.
- State Title V staff worked on quality improvement activities around the implementation of the One Key Question in public health programs.
- Oregon guidance on prescribing opioids for perinatal women was developed by the Pregnancy and Opioids Workgroup (convened by Title V staff). The guidelines were presented at the Oregon Opioid Conference (May 2018) and the Annual meeting of the Oregon Perinatal Collaborative (September 2018). State Title V staff have been disseminating the guidelines to clinicians caring for women of reproductive age.
- North Central Public Health District provided training to community partners including early learning providers through organized trainings and established community meetings.

Challenges and emerging issues

Building meaningful partnerships with clinical partners at the state and local level can be a challenge because clinicians and health systems have not prioritized efforts around well-woman care in the same way that our MCH program has. It has also been difficult to sustain work around the implementation of guidelines that have been

developed by workgroups.

Strategy: Provide access to well-woman care through Family Planning Clinics.

Accomplishments

- In collaboration with state Reproductive Health staff, Title V staff presented a training webinar on Oregon's Reproductive Health Equity Act for Title V grantees (December 2017).
- Union County, Marion County and the North Central District implemented use of the One Key Question within Family Planning Clinics.

Challenges and emerging issues

Some local grantees have moved to a model of providing less direct clinical services making it more challenging to provide care through Family Planning Clinics. Rules for family planning clinics limit the ability of providers to offer a comprehensive well woman care.

Strategy: Use of the postpartum health care visit to increase utilization of well-woman visits.

Accomplishments

Title V staff worked with the Metrics and Scoring Committee of the Oregon Health Authority to include postpartum care visit attendance as an incentive metric for Oregon's Coordinated Care Organizations.

State Title V staff developed a proposal to implement a universally-offered postpartum home visiting program in Oregon. The postpartum home visit will provide an opportunity to assess plans for postpartum well woman care, educate and refer women to appropriate services.

Challenges and emerging issues

The current metric for postpartum visit attendance does not address the quality of visits and focuses the visit on a specific timeframe that may not be appropriate for all women**.**

Strategy: Research/assessment to identify barriers to having a usual primary care provider or PCPCH and receiving well-woman care.

ESM 1.1: Number of women who have been surveyed or who have participated in focus groups to identify barriers to well women care.

Progress on ESM

47 women participated in listening sessions August-November 2017. This ESM has now been retired.

Accomplishments

- Eight key informant interviews were conducted August-September 2017.
- Five listening sessions were conducted August-November 2017.

- Analysis of the key information interviews was completed, themes were documented and recommendations developed.
- Findings from the listening sessions and key informant interviews were presented to Title V Grantees December 2017.
- Findings from the listening sessions were presented at Public Health Grand Rounds March of 2018.
- A Report on the listening sessions and key informant interviews was published May 2018.
- Findings from the listening sessions and key informant interviews were presented at the Annual MCH Epidemiology/CityMatch Conference September of 2018.
- State Title V staff provided subject matter expertise to inform legislation that established Oregon's Maternal and Morbidity Review Committee.
- Oregon HB 4133 passed establishing a Maternal and Mortality Review Committee. The Committee will consider the social determinants of health as well as access to preventive care in reviewing cases and developing recommendations.

Challenges and emerging issues

Rising rates of maternal morbidity and mortality as well as significant and persistent disparities by race are emerging issues in Oregon, as in other states. The formation of Oregon Maternal and Morbidity Review Committee will bring together new partners and focused work to improve women's health and decrease health disparities. The current method of case finding in Oregon may have undercounted actual deaths by as much as one-third. Staff from the OHA Maternal and Child Health Section and the Center for Health Statistics (CHS) have worked together on a detailed method for finding deaths of women that occurred during or within one year of the end of pregnancy, regardless of the cause of death (these are termed "pregnancy-associated deaths"). This enhanced case-finding method will allow us to better understand maternal morbidity and mortality in Oregon. The reviews will allow us to characterize and intervene in maternal mortality and morbidity. These interventions aim to connect with efforts to identify upstream root causes of morbidity, including social determinants of health, to effectively develop and implement prioritized strategies for primary, secondary, and tertiary prevention.

Challenges in formation of the committee to date have revolved around getting a diverse and complete roster of committee members approved and appointed through our Governor's office in a timely manner as well as challenges associated with using the authorization, installation and implementation of MMRIA (a CDC data system).

Strategy: Provide technical assistance to local grantees to support implementation of the well woman care priority area.

Accomplishments

We have convened a learning collaborative with every other month meetings for local grantees and our Healthy Start partners to share learnings and resources around well woman care.

ESM 1.3: Percent of local health departments receiving technical assistance to support implementation of the well woman care priority area.

Progress on ESMs

100% of local grantees (health departments and tribes, N=9) received technical assistance.

2018 Report: Oral Health (Women)

National Performance measure (#13):

Percent of women who had a dental visit during pregnancy.

Interpretation of state performance measure data:

The percent of women who had a dental visit has been consistently higher in Oregon than the national average since 2012. The state has mirrored the national decrease in this outcome between 2012 and 2015, with Oregon dropping from 56.1% to 53.5% over that time frame.

Strategies and Activities

Strategy: Integrate oral health into State Maternal and Child Health (MCH), Health Promotion, and Chronic Disease Prevention Programs.

Accomplishments

- Developed monthly oral health messages that were posted on the MCH and Public Health Division's Twitter and Facebook accounts.
- Drafted a fact sheet that focuses on the impact of diabetes and gestational diabetes and the risk of developing periodontal disease.
- The Oral Health Unit presented posters and exhibited at the Oregon Rural Health Conference in October 2017, Oregon Oral Health Coalition's (OrOHC) Fall Conference in November 2017, and the WIC Statewide Meeting in May 2018. The posters utilized described the link between oral health and chronic diseases and how oral health can be integrated into chronic disease systems of care. Oral health educational materials were disseminated at the conference.

Challenges and emerging issues

The Oral Health Unit intended to collaborate with the Health Promotion and Chronic Disease Prevention Section's Sustainable Relationships for Community Health (SRCH) grant initiative but did not have enough capacity to establish this relationship. Obtaining funding outside Title V is necessary to support SRCH grantees, and no grant opportunities were available during the grant period. The Oral Health Unit did not have existing capacity to develop materials and provide training for SRCH grantees.

ESM 13.1.1: Number of materials developed on the common risk factors and associations between chronic diseases and poor oral health such as cavities and periodontal disease.

Progress on ESMs

ESM 13.1.1: Three brochures and one fact sheet were developed.

Strategy: Provide technical assistance to local health agencies and tribes working on strategies to promote dental visits for pregnant women and children.

Accomplishments

- Nine grantees – seven local health agencies and two tribes – were provided with individualized technical assistance throughout the grant year.
- The Oral Health Unit collaborated with the Oregon Oral Health Coalition to promote the Maternity: Teeth for Two training program with four grantees. The Maternity: Teeth for Two curriculum informs pregnant women and medical professionals, such as public health nurses, on the importance of oral health during pregnancy. It trains health professionals on how to integrate oral health education and referrals into primary and prenatal care.

ESM 13.2.1: Number of school oral health programs and Title V local grantees provided with technical assistance to enhance the quality of oral health services and increase oral health visits.

Progress on ESMs

ESM 13.2.1: Nine Title V local grantees were provided with technical assistance to promote dental visits for pregnant women.

Strategy: Provide oral health services, education and referral/case management services through Oregon's Home Visiting System.

Accomplishments

- Coquille Indian Tribe and Jackson, Marion and Tillamook Counties provided oral health education and referrals for dental care in their home visiting programs (Babies First! and Maternity Case Management).
- Washington County provided oral health education and referrals and had their nurse home visitors apply fluoride varnish when applicable.
- Marion and Tillamook Counties provided First Tooth and Maternity: Teeth for Two trainings for staff.

Strategy: Educate pregnant women, parents/caregivers of children, and children 0-17 about oral health.

Accomplishments

- Crook County partnered with a dental hygienist from Advantage Dental to provide oral health screenings and fluoride varnish to pregnant women in the WIC Program.
- Douglas County collaborated with the Douglas County Oral Health Coalition to develop a messaging plan around the importance of oral health prevention for parents/caregivers.
- Klamath County provided the Maternity: Teeth for Two training for staff and assisted in establishing a local Oral Health Coalition in their area.
- Cow Creek Band of Umpqua Tribe of Indians provided pregnant women with an incentive of an electric toothbrush after seeing the dentist at least once during pregnancy.

Strategy: Promote community water fluoridation.

Accomplishments

- Klamath County developed educational materials promoting the safety of community water fluoridation.

2018 Report: Smoking (Women)

National Performance measure (#14):

A) Percent of women who smoke during pregnancy;

Interpretation of national performance measure data:

The rate of smoking during pregnancy has steadily decreased in Oregon, from 11.3% in 2010 to 8.9% in 2017. This has mirrored a steady decline nationally, although Oregon values in this performance measure are consistently higher than the national average.

Strategies and Activities

Strategy: Provide technical assistance to local health agencies and tribes working on strategies to decrease tobacco use among pregnant women and children's exposure.

Accomplishments

Technical assistance has been provided to local MCAH Programs implementing the Smoking Priority. Two webinars were conducted to share work, successes and challenges. Email communications were maintained, with materials and articles provided to local grantees. The MCAH Program also maintained collaboration with staff from the Public Health Division's Tobacco Prevention and Education Program (TPEP) in order to encourage collaboration at the local level between TPEP grantees and MCAH Program grantees.

In order for the MCH Section to more effectively disseminate materials to Title V Programs, work began on developing a web-based "shopping" experience (Shopify) for our partners. This streamlined ordering and delivery process ensured that local programs had the necessary materials to supplement their work. This allowed Oregon MothersCare Programs throughout the State (funded by Title V funds) to obtain and easily distribute Oregon Quitline information to pregnant women.

In addition to print materials, the MCAH Program worked with TPEP and the OHA Health Transformation Center (HTC) to develop tobacco cessation training modules for providers. The HTC contracted with Optum, the organization that runs the Oregon Tobacco Quit Line to develop the training modules, including a separate module for pregnant women. MCAH Title V funding was used to pay for the module development about pregnant women,

costing $4000. Our office provided oversight around the development, and invited our local MCAH Smoking Priority programs to provide input. Content of the entire training included best practice interventions – the "2As and an R", how to refer, and resources. (see Supporting Document 5 for Tobacco Cessation Training, Pregnancy module)

Upon development, links were sent to all Smoking Priority and Oregon MothersCare staff/coordinators throughout Oregon. The finalized link can be seen at: https://tcrc.rapidlearner.com/p/3462253711/story_html5.html

The Title V-funded MCAH Program, Oregon MothersCare (OMC - a patient navigation program for pregnant women), is conducted at the local level by Smoking Priority county programs as well as those who have not chosen the Smoking Priority. Some Smoking Priority Counties have incorporated OMC into their Title V work plans. However, all OMC Programs are required to provide screening and intervention for their pregnant clients who smoke. Thus throughout Oregon, 1000 pregnant women who smoked received an intervention and referral to the Oregon Quitline in 2017 and 2018 (data is only available in calendar years).

Since 2015, Tobacco has been a priority within the Oregon Public Health Division. A Tobacco State Health Improvement Plan (SHIP) was developed, and collaborative efforts within many sections (including the MCAH Title V Program) were made with successes seen. The purpose of Oregon's State Health Improvement Plan (SHIP) is to identify population-wide priorities and strategies for improving the health of people in Oregon. The SHIP serves as the basis for taking collective action on key health issues in Oregon. The Tobacco priority includes a measure for smoking prevalence among Oregon mothers and uses the Oregon birth certificate statistical files as the database. According to birth certificates in Oregon, women who have just given birth report lowering their smoking rates from 11 percent in 2012 to 8 percent in 2018. This aligns with 2017 Oregon PRAMS data which shows 7.5 percent of pregnant women reporting smoking in the last three months of their pregnancy. However Oregon PRAMS from 2011 – 2017 shows a drop in women smoking 3 months prior to pregnancy from 23.2 percent to 17.7 percent. Oregon considers smoking just prior to knowledge of pregnancy a proxy for smoking in the first trimester of pregnancy.

The MCH Section has been at the table for the duration of the development and implementation of the Tobacco SHIP priority. This past year, the Tobacco SHIP priority and Alcohol and Drug SHIP priority combined their work, meeting together to better address addiction and health issues.

Beginning January 1st, 2018 a new Oregon law took effect, which raised the legal age of purchase for tobacco and vaping products in Oregon from 18 to 21 years. As a result, a significant decrease in youth (ages 13 – 17) and young adults (ages 18 – 20) who started using tobacco has occurred. Initiation of tobacco use fell from 34% to 28% for youth between 13-17, and from 23% to 18% for young adults. For more information, go to https://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/TOBACCOPREVENTION/Documents/Oregon-Tobacco-21-Impact-Evaluation-Report.pdf

Challenges and emerging issues

For 2020 – 2024, Oregon's SHIP priorities have moved to a social determinants focus. While Tobacco is not specifically called out as its own priority, there are opportunities for tobacco strategies to be addressed. Tobacco and substance abuse are included in the new Behavioral Health Priority. The priority will be addressed by a subcommittee that will use their experience, expertise, and capacity to create a SHIP that identifies evidence based and innovative strategies for policy, system and environmental changes.

ESM 14.1.2: Percent of local Title V grantees who have selected smoking as a priority area who have at least two technical assistance contacts.

Progress on ESMs
ESM 14.1.2: 100 percent of all local Title V grantees with the Smoking Priority received at least two technical assistance contacts throughout the Title V period.

Strategy: 5As Intervention within MCAH Programs including Home Visiting, Oregon MothersCare, Family Planning, and WIC.

Accomplishments
In Clackamas County, 16 of 19 women who smoke were assessed using the 5As assessment. For some, the assessment was done more than once. During pregnancy, women are more motivated and willing to decrease or quit smoking. We know this is a good time to use the 5 As and offer Quit line services. We have been successful and celebrate decreases with an emphasis of quitting in 3rd trimester.

In Marion County, 96 percent of their Maternity Case Management clients who smoked received the 5As intervention. In addition, all nurses in the Reproductive Health Program were trained in the 5 A's and instructed to address it with all smokers. Twenty women out of the 1963 seen in the Reproductive Health program were identified as smokers.

Challenges and emerging issues
Due to the limited amounts of funding for the smoking priority, counties have chosen to incorporate their work within other MCAH Programs that currently exist, rather than conducting specific stand-alone interventions aimed at cessation for pregnant women. They have been encouraged to expand use of interventions beyond their specific MCH clients which could result in greater numbers receiving interventions.

ESM 14.1.1: Percent of local Title V grantees who have selected smoking as a priority area who are implementing the 5A's with their clients.

Progress on ESMs
ESM 14.1.1: 100% of counties that selected the smoking priority have implemented 5A's among their clients.

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

Accomplishments
One out of three (33 percent) prenatal care providers were trained in the Healthy Futures intervention; Yamhill County staff trained one prenatal practice out of the three that existed at that time in the county. Since then, the other two prenatal practices have left the county. However, the remaining provider is now conducting tobacco screening for their patients.

Challenges and emerging issues
The MCH Program has a focus on home visiting and is therefore not able to see all pregnant women who smoke, not all women receive referrals to providers and may miss getting interventions. In addition, because of the proximity to the Portland Metro Area, Yamhill County pregnant women may see providers in other counties and miss receiving the benefits of the trained Yamhill Provider.

Strategy: Collaborate with the Oregon Quit Line program to improve outreach and quit rates for pregnant and postpartum women.

Accomplishments

Through their work on improving outreach and quit rates, our local grantees have found that direct, warm referrals work better than just providing clients with the Quit Line number.

Our Home Visiting program has begun collaboration with our organization's TPEP coordinator, providing us with opportunities to benefit from Oregon Quit Line program resources.

Challenges and emerging issues

This particular strategy has been integrated with the strategy around the 5As. It was difficult for individual counties to collaborate with a statewide entity to increase outreach and quit rates for discreet areas. Obtaining data became difficult to conduct.

Collaboration between MCH Programs and Tobacco Prevention Programs has historically been a challenge because of the differing funding requirements. MCH Programs continue to be encouraged to work with their tobacco prevention and education program colleagues.

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

Accomplishments

Information about tobacco cessation insurance benefits was provided to Columbia County clients who were being offered Oregon Health Plan enrollment assistance. 96 percent (26 out of 27) of all eligible clients seen were provided this information.

Challenges and emerging issues

In choosing to work on priorities, counties do so for a year, achieve their goal, and rather than continuing to integrate successful practice into their work, will drop that work (as has been done in Columbia County) to pursue another priority.

2020 Plan: Well-Woman Care

National Performance measure (#1):

Percent of women with a past year preventative visit.

Related state priority need:

High quality, culturally responsive preconception, prenatal and inter-conception services.

Planned strategies, ESMs, and activities for October 2019 – September 2020

A logic model containing the full menu of Oregon's local level well woman care strategies, sample activities and measures can be found in Supporting Document #4. The logic model represents all the evidence based/informed strategies that Oregon's Title V grantees may work on during the 2016-2020 Title V grant cycle. The plan that follows details strategies, activities and measures selected for implementation during the 2020 grant year at both the state and local levels. A table outlining which local grantees are implementing different well woman care strategies is included in Supporting Document 4.

Strategy: Case-management to improve utilization of well-woman care.

Activities – State Level

- Provide technical assistance and quality improvement activities to support Oregon's Home Visiting programs.

Strategy: Use traditional and social marketing to educate the population and promote well woman care.

ESM 1.2: Number of women reached using traditional and social marketing campaigns.

Activities – State Level

- State Title V staff will explore social media campaigns and/or platform that specifically targets women of reproductive age.

Activities – Local Level

- Crook, Malheur, Marion will be working to build their social media presence and will participate in community events to promote awareness around well woman care.

Strategy: Provide education/training on preconception/interconception health for providers.

Activities – State Level

- In Partnership with the Oregon Perinatal Collaborative, explore opportunities to provide education and training to clinical providers.

Activities – Local Level

- Douglas County will be working to provide education/training for public health staff as well as clinical providers in their community.

Strategy: Provide access to well-woman care through Family Planning Clinics.

ESM 1.5: Number of state and local partners engaged to improve access to and quality of well-woman care and reproductive health services.

Activities – State Level

- Explore opportunities to promote well woman care through collaboration with state Family Planning program.

Activities – Local Level

- Baker, Washington and Union Counties will be working to provide access through Family Planning Clinics by screening and referring for care, offering care within their clinical systems and partnering with community organizations that provide clinical care.

Strategy: Use of the postpartum health care visit to increase utilization of well-woman visits.

Activities – State Level

- Provide guidance and technical assistance to Coordinate Care Organizations around the postpartum incentive metric.

Activities – Local Level

- The Warm Springs Tribe will be working to modify scheduling practices within their clinic to increase access to postpartum care for women in their community.

Strategy: Research/assessment to identify barriers to having a usual primary care provider or PCPCH and receiving well-woman care.

Activities – State Level

- Participation in the development and implementation of Oregon's Maternal Mortality and Morbidity Review Committee. Review of deaths will include review of whether women had been able to access preventive care. Recommendations coming from the Committee may include recommendations to decrease barriers for women so that they can receive preventive care and enter pregnancy healthier.

Strategy: Provide technical assistance to local grantees to support implementation of the well woman care priority area.

ESM 1.3: Percent of local health departments receiving technical assistance to support implementation of the well woman care priority area.

Activities – State Level

- Continue to plan and convene Learning Collaborative webinars for local grantees.

Critical partnerships

- Oregon Perinatal Collaborative
- Grantees (Local Public Health Authorities and Tribes)
- Oregon's Family Planning Program
- Healthy Start (Healthy Birth Initiative in Multnomah County and the Health Care Coalition of Southern Oregon)
- Oregon Preventive Reproductive Health Advisory Committee
- Coordinated Care Organizations

2020 Plan: Oral Health (Women)

National Performance measure (#13):

Percent of women who had a dental visit during pregnancy

Related state priority need:

Improved oral health for pregnant women and children.

Planned strategies, ESMs, and activities for October 2019 – September 2020

A logic model containing the full menu of Oregon's local level oral health strategies, sample activities and measures can be found in Supporting Document #4. The logic model represents all the evidence based/informed strategies that Oregon's Title V grantees may work on during the 2016-2020 Title V grant cycle. The plan that follows details strategies, activities and measures selected for implementation during the 2020 grant year at both the state and local levels.

Strategy: Increase awareness and engagement within the dental community of oral cancer and HPV.

ESM 13.2.3: Number of oral health providers provided training on oral cancer and HPV.

Activities – State Level

- Develop oral health messages, fact sheets and educational materials for dental providers to share with

parents/guardians on oral cancer and HPV.

Strategy: Provide technical assistance to school oral health programs and Title V grantees.

ESM 13.2.1: Number of school oral health programs and Title V local grantees provided with technical assistance to enhance the quality of oral health services and increase oral health visits.

Activities – State Level

- Collaborate with state and local Title V staff to identify technical assistance needs – Ongoing.
- Identify forums for technical assistance (e.g. webinars, learning collaborative, conference calls) – August 2019.
- Develop and conduct a webinar for Title V grantees on developing oral health education materials and health literacy standards – Spring 2020.
- Identify and develop resources and materials for dissemination to Title V grantees – Ongoing. Materials may include an adolescent oral health poster, guide to dental referrals, tribal specific materials, and a quarterly newsletter for school oral health programs.
- Promote state and local oral health strategies and activities within the Public Health Division and other oral health partner networks – Ongoing.

Strategy: Increase oral health surveillance in Oregon.

ESM 13.1.2: Number of data sets in the Oregon Oral Health Surveillance System (OOHSS) that can be analyzed for oral health disparities.

Activities – State Level

- Increase the number of data points within the Oregon Oral Health Surveillance System (OOHSS) that can be analyzed by race, ethnicity, language, and disability (REALD) – Winter 2018.
- Compile and analyze REALD data collected as part of the statewide OHA School Dental Sealant Program to identify oral health disparities – Winter & Spring 2020.
- Develop a strategic plan to implement REALD in all data sources within the OOHSS – Spring & Summer 2019.

Strategy: Provide oral health preventive services or education and referral/case management services through Oregon's Home Visiting System.

Activities – Local Level

- Jefferson, Lake, Linn, Malheur, Morrow and Wheeler Counties will provide oral health education and referrals for dental care during home visits. They will also collaborate with the Oregon Oral Health Coalition to provide the Maternity Teeth for Two training for nurse home visiting and WIC staff.

Strategy: Educate pregnant women, parents/caregivers of children, and children 0-17 about oral health and the importance of dental visits.

Activities – Local Level

- Benton County will implement a plan to provide all clients with culturally appropriate oral health education and incentivize pregnant and postpartum women to visit the dentist by providing an electric toothbrush after a dental appointment.
- Clackamas County is integrating oral health across systems to ensure women, children, youth, and families receive screenings, referrals, and access to and utilization of preventative oral health services.
- Columbia County will provide oral health education to pregnant women in their home visiting and WIC programs.
- Cow Creek Band of Umpqua Tribe of Indians will provide pregnant women with an incentive of an electric toothbrush after seeing the dentist at least once during pregnancy.
- Hood River will provide oral health education in their WIC program and collaborate with Advantage Dental to provide monthly oral health screenings and preventive services for pregnant women.
- Josephine County will collaborate with Siskiyou Dental to provide oral health education and fluoride varnish to low-income families participating in their public health programs.
- Klamath County will collaborate with the Klamath Basin Oral Health Coalition and Cascade Health Alliance CCO to expedite dental services for pregnant women.
- Klamath Tribes will provide pregnant women with a diaper bag that includes a spin toothbrush and oral health education after seeing the dentist at least once during pregnancy.
- Polk County will incorporate oral health education and referral services into their Oregon MothersCare and home visiting programs, as well as reach out to local dental providers to ensure pregnant women have access to dental care.

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

Activities – Local Level

- Tillamook County will collaborate with primary care providers and other clinical staff within the Community Health Center (CHCO) to address oral health issues during prenatal visits.

Critical Partnerships:

- Oregon home visiting programs (MCM, Babies First!, NFP, CaCoon)
- Oregon MothersCare Program
- Health Promotion and Chronic Disease Prevention Section
- State WIC Program
- Oregon Oral Health Coalition (OrOHC)
- Coordinated Care Organizations (CCOs)
- Dental Care Organizations (DCOs)

2020 Plan: Smoking (Women)

National Performance measure (#14):

Percent of women who smoke during pregnancy.

Related state priority need:

Reduced tobacco use and exposure among pregnant women and children.

Planned strategies, ESMs, and activities for October 2019 – September 2020

A logic model containing the full menu of Oregon's local level smoking strategies, sample activities and measures can be found in Supporting Document #4. The logic model represents all the evidence based/informed strategies that Oregon's Title V grantees may work on during the 2016-2020 Title V grant cycle. The plan that follows details strategies, activities and measures selected for implementation during the 2020 grant year at both the state and local levels.

Strategy: Provide technical assistance to local health agencies and tribes working on strategies to decrease tobacco use among pregnant women and children's exposure.

ESM 14.1.2: Percent of local Title V grantees who have selected smoking as a priority area who have at least two technical assistance contacts.

Activities – State Level

- Twice yearly webinars with all counties and tribes that have identified smoking as a priority to share successes, challenges, and to provide a learning collaborative opportunity.
- Provide regular email communication updates to all smoking priority counties and tribes which may include research articles, tool kits, policy updates, and other resources.
- Participation in the Public Health Division's Behavioral Health State Health Improvement Plan.
- Provide necessary print, electronic, and training materials to counties and tribes to increase knowledge around tobacco coverage benefits and the Oregon Quitline.

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

Activities – State level

- Serve as the MCAH staff liaison to the Alcohol and other Drug Prevention Services Unit of the Center for Prevention and Health Promotion.
- Liaison with Tobacco Prevention and Education Program within the Health Promotion and Chronic Disease Preventions (HPCDP) Section of the Public Health Division
- Participate in the work of the State Health division's State Health Improvement Plan - Behavioral health priority.
- Partner with the adolescent health unit to identify and develop opportunities for tobacco prevention for youth.
- Promote the linkage between ACEs prevention and tobacco prevention in state agency work groups and policy settings.

Strategy: 5As Intervention within MCAH Programs including Home Visiting, Oregon MothersCare, Family Planning, and WIC.

ESM 14.1.1: Percent of local Title V grantees who have selected smoking as a priority area who are implementing the 5A's with their clients.

Activities – Local Level

Lane, Coquille Tribal Nation, will conduct one or more of the following activities:

- Conduct the 5As intervention with each client on Babies First! and NFP caseloads who smokes
- Organize training opportunities for Direct Care Staff on American Indian and Alaska Native (AI/AN) Quit Line and Cessation Program for Northwest Tribes.

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

Activities - Local Level

Coquille Tribal Nation will conduct the following activity:

- Collaborate with OHA HPCDP, Northwest Portland Area Indian Health Board, and other Tribal TPEP Coordinators to gain best practices screening and intervention expertise.

Yamhill County will conduct the following activities:

- Enroll tobacco smoking pregnant women into a modified Quitting Tobacco in Pregnancy program called Healthy Futures.
- Work with prenatal practices in the county to identify candidates for the Healthy Futures program.

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

Activities – State Level

- Work with OHP and CCOs across the state to develop and disseminate information about tobacco cessation benefits for pregnant women in Medicaid.

Activities - Local Level

Lane County will do one the following activity:

- Provide all clients enrolled in MCH services or at an Oregon Mother's Care appointment information on tobacco cessation benefits

Critical partnerships

- Local Title V Grantees: Columbia, Lane, Tillamook, Yamhill, Wheeler, Coquille Indian Tribe, Confederated Tribes of the Umatilla Indian Reservation
- Oregon Public Health Division, Health Promotion and Chronic Disease Prevention Program, Tobacco

Prevention and Education Program
- Oregon Health Authority, Health Transformation Office
- Local County Health Department Tobacco Prevention and Education Program Grantees
- Coordinated Care Organizations
- American College of Obstetricians and Gynecologists
- Oregon Midwifery Council
- Oregon MothersCare Program
- Oregon Quitline
- 211Info Resource and Referral
- Oregon Health Plan

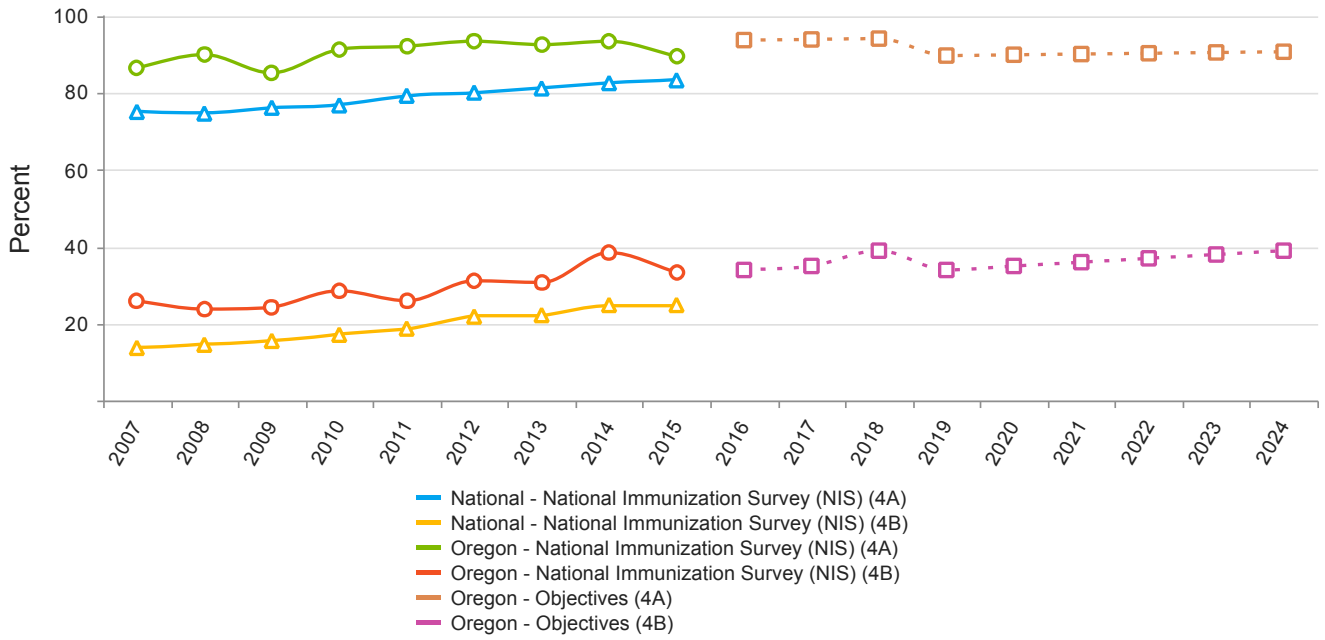
Perinatal/Infant Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2016	4.7	NPM 4
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2016	1.4	NPM 4
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2016	74.7	NPM 4

National Performance Measures

NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months Indicators and Annual Objectives



NPM 4A - Percent of infants who are ever breastfed

Federally Available Data			
Data Source: National Immunization Survey (NIS)			
	2016	**2017**	**2018**
Annual Objective	93.6	93.8	94
Annual Indicator	92.5	93.2	89.4
Numerator	37,456	44,505	38,219
Denominator	40,509	47,759	42,729
Data Source	NIS	NIS	NIS
Data Source Year	2013	2014	2015

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	89.6	89.8	90.0	90.2	90.4	90.6

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

Federally Available Data			
Data Source: National Immunization Survey (NIS)			
	2016	**2017**	**2018**
Annual Objective	34	35	39
Annual Indicator	30.6	38.3	33.4
Numerator	11,501	17,140	13,911
Denominator	37,583	44,757	41,664
Data Source	NIS	NIS	NIS
Data Source Year	2013	2014	2015

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	34.0	35.0	36.0	37.0	38.0	39.0

Evidence-Based or –Informed Strategy Measures

ESM 4.1 - Number of government agencies partnered with to implement breastfeeding support policy.

Measure Status:	Inactive - Completed		
State Provided Data			
	2016	**2017**	**2018**
Annual Objective		15	15
Annual Indicator	15	15	15
Numerator			
Denominator			
Data Source	Log of all OHA/DHA offices	Log of government offices partnered with	Log of government offices partnered with
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

ESM 4.3 - Number of health care providers trained in breastfeeding support

Measure Status:	Active	
State Provided Data		
	2017	**2018**
Annual Objective		50
Annual Indicator	112	50
Numerator		
Denominator		
Data Source	Grantee annual report on strategy measures	Grantee annual report on strategy measures
Data Source Year	2017	2018
Provisional or Final ?	Final	Final

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	50.0	50.0	50.0	50.0	50.0	50.0

ESM 4.4 - Percent of local grantees who have met their target for breastfeeding education among pregnant and postpartum women

Measure Status:					Active
Annual Objectives					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	60.0	65.0	70.0	75.0	80.0

State Action Plan Table

State Action Plan Table (Oregon) - Perinatal/Infant Health - Entry 1

Priority Need

Improved maternal, infant, child, adolescent and family nutrition.

NPM

NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Objectives

By Oct 1, 2020 increase the percent of infants who are ever breastfed from 89.4% to 89.8%; and increase the percent of infants breastfed exclusively through 6 months from 33.4% to 35.0%.

Strategies

Provide TA to local grantees on: breastfeeding strategy/measure selection, Title V plan and measure development, and implementation of strategies to promote breastfeeding.

Increase workforce support for breastfeeding through training and access to high quality services.

Increase access to workplace breastfeeding support.

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

Fill unmet needs for peer support of breastfeeding.

Educate pregnant women about breastfeeding.

Increase support for breastfeeding in child care settings through policy, training, and workforce development

ESMs	Status
ESM 4.1 - Number of government agencies partnered with to implement breastfeeding support policy.	Inactive
ESM 4.2 - Number of hits to state intranet website with policy on breastfeeding in the workplace.	Inactive
ESM 4.3 - Number of health care providers trained in breastfeeding support	Active
ESM 4.4 - Percent of local grantees who have met their target for breastfeeding education among pregnant and postpartum women	Active

NOMs
NOM 9.1 - Infant mortality rate per 1,000 live births
NOM 9.3 - Post neonatal mortality rate per 1,000 live births
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

2018 Report: Breastfeeding

National Performance measure (#4):

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

Interpretation of national performance measure data:

1. The rate of breastfeeding initiation in Oregon has consistently surpassed the national average, although it has decreased slightly within the state, from 93.2% in 2014 to 89.4% in 2015.
2. The rate of exclusive breastfeeding through 6 months in Oregon has also consistently surpassed the national average. Although this rate has recently decreased within the state, from 38.3% in 2014 to 33.4% in 2015, there has been an overall upward trend since 2010.

Strategies and Activities

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

Accomplishments

- North Central Health District (NCHD) worked with community partners and the breastfeeding coalition to provide community presentations for providers to address partner support. One of the events was a half-day training for providers and the other training as an advanced lactation support training for home visit nurses. NCHD met their target goal and reported that a community presentation was an effective way to reach multiple providers.
- Washington County successfully partnered with the WIC program in delivery of their WIC Partner breastfeeding support class which was offered to both WIC and MCH clients and their non-nursing partners and family members. The class was promoted in the community.

Challenges and emerging issues

- NCHD's challenge was organizing both community events, finding a time for community partners to participate and getting fathers & grandmothers to engage in WIC and/or home visits so information could be provided.
- Washington County did not meet target goal of reaching 200 families; reached 96 families. Their challenge was the inability to schedule classes in the evening or weekends due to staffing structure and programs rules.

Strategy: Fill unmet needs for peer support of breastfeeding.

Accomplishments

- Baker County surveyed WIC participants about breastfeeding barriers and reasons for not breastfeeding. Survey included asking if they would attend a support group and if yes, what dates and times are best. A nursing student administered the survey to WIC clients to make sure clients did not feel pressure from WIC staff when they completed the survey. 59% of participants completed survey.

- Clatsop County administered and completed their infant feeding survey in English and Spanish to pregnant and breastfeeding women as well as key stakeholders. Survey results indicated the priority area to focus on within Title V for next year. Survey evaluation results were presented to the Clatsop County Board of Commissioners.
- Jefferson County conducted five Loving Leche (Spanish speaking) breastfeeding support groups. Due to poor attendance they shifted plans towards the end of the grant cycle and focused on individual lactation support and rebuilding the local breastfeeding coalition. They have good attendance at community outreach activities to spread the word about the breastfeeding coalition and services there.
- Multnomah County focused work on increasing participation in breastfeeding peer support groups serving the African American community. The biggest success was the collaboration with community partners and WIC staff to create a culturally inclusive & trauma-informed black breastfeeding curriculum.

Challenges and emerging issues

- Baker County didn't meet target goal and identified survey length and surveys that were mailed instead of interviewed in person were reasons for lower than expected response rate.
- Clatsop County had a 25% return rate (196/800) which is below their 38% target. One of their biggest challenges was the number of surveys being completed through the local OB & pediatric offices as increased support and encouragement needed to be provided to the staff.
- Jefferson County struggled to get attendance at Loving Leche support groups so did not hold six as originally planned and learned that a "support group" might not be what their community needed.
- Multnomah County did not increase attendance in the breastfeeding peer support groups as planned however as noted above they focused work on improving their curriculum to make it relevant.

Strategy: Education of pregnant women about breastfeeding.

Accomplishments

- Clackamas County exceeded goal and reached 97% (728 unduplicated count) of pregnant women served in multiple programs. As part of health department restructuring they were better able to align breastfeeding goals, training, referrals and expertise between WIC and Title V programs.
- Columbia County's home visiting program screened pregnant women (34 out of 48 women) for breastfeeding intention and provided breastfeeding education to pregnant women (75 out of 105).
- Grant County is very small/rural and has not had access to good lactation support in their community. The home visit nurse has increased outreach about services with a local hospital and clinic and provided breastfeeding support to six women more than once each. Four community partner meetings were held which included promotion of breastfeeding services.
- Josephine County had 20 out of 360 non-WIC clients attend breastfeeding classes which is slightly under target goal. They gained a better idea of what prenatal and postpartum clients needed for breastfeeding education.
- Yamhill County developed one-page educational handout to share with other home visiting programs in their county. Community-wide messaging was identified among different home visiting programs in the county and four agencies adopted the shared messaging.
- Warm Springs Tribe provided breastfeeding education through the childbirth education classes and local hospital with emphasis on six-month exclusive breastfeeding; exceeded their target goal and provided education to 98% (77/78) of women. A six-month club was started to provide encouragement and

mothers were given a small gift for each month they breastfed. Additionally, they developed two PSAs which were aired on the local radio station during June about benefits of breastfeeding. The PSAs featured two mothers who were interviewed about the benefits and challenges of breastfeeding

Challenges and emerging issues

- Clackamas County experienced significant change and staff reductions so did not have capacity to do a policy review as planned.
- Clatsop County reported unmet needs for peer support.
- Columbia County did not reach targets of the percentage of home visiting clients and visits but they had confidence in the quality of their breastfeeding education within the programs. They reported many challenges with their data system and data collection.
- Grant County was not able to reach a formal agreement with the local hospital to provide breastfeeding services when women were discharged. Thus the hospital did not provide notice prior to discharge about women needing services. Since only one person provided this support, many women did not get the help they needed early on which resulted in discontinuation of breastfeeding.
- Josephine County's challenges were generating interest in breastfeeding classes.
- Yamhill County spent most of their time focused on meeting their CQI initiatives around safe sleep, so less time was spent specific to breastfeeding.
- Due to staff turnover in both programs, Warm Springs Tribe was not able to carry out an activity in conjunction with WIC using a tool to learn why mothers are not exclusively breastfeeding for six months, and then providing follow-up education with the RD or IBCLC. Due to staff turnover use of the tool was discontinued.

ESM 4.4: Percent of local grantees who have met their target for breastfeeding education among pregnant and postpartum women.

Progress on ESM:

This ESM is new and won't be reported on until next year.

Strategy: Increase workforce support for breastfeeding through training and access to high quality services.

Accomplishments

State Title V staff have shared breastfeeding training opportunities with grantees. State Title V staff have monitored coverage of lactation services by Medicaid and CCOs.

Local grantees

- Baker County - 11 Babies First and Cacoon home visit nurses were trained in breastfeeding training through online resources and through their WIC breastfeeding specialist.
- Benton County – 18 nursing staff received in-depth training on a variety of breastfeeding topics. This increased interest among staff to pursue IBCLC.
- Clackamas County updated their resource list and FAQs for providers to use when interacting with their breastfeeding patients. It was sent to providers in their county who serve pregnant and breastfeeding women. The breastfeeding website was updated. The home visit team was able to case conference and collaborate with providers more effectively and could share available breastfeeding support services.

- Columbia County has no birthing facility in their county. Monthly discussions with providers led to development of a community-wide provider survey in conjunction with WIC to be carried out next fiscal year.
- Crook County is rural and did not have adequate breastfeeding support available in their county. They formalized an agreement with Deschutes County WIC to offer breastfeeding education and support groups to Crook County WIC clients. St. Charles Medical Center is working on providing support group/classes for Crook County but has not yet finished the process.
- Douglas County – 9 out of 12 staff received intensive breastfeeding training.
- Hood River County has hired new staff who have completed Breastfeeding Level 1 and Level 2 training. They started a regional breastfeeding coalition. They have worked in collaboration with Providence to support new moms and babies as well as other community members.
- Jackson County met their goal of ten home visit staff attending Breastfeeding Champions training.
- Jefferson County continued to do outreach about services by nurse home visitors. They began meeting with the breastfeeding coalition members quarterly and have seen increased number of referrals from St. Charles Madras lactation services. They also offer Health Families Screening to women at the hospital post-partum at which time the Perinatal Care Coordinator offers information about lactation support availability at public health & offers information on nurse home visiting. Their Perinatal Care Coordinator offers breastfeeding information at prenatal visits which average 10/month.
- Yamhill County supported staff to attend regional breastfeeding training. Sign-in tracking was not available so they could not report how many staff trained, but they estimate three.

Challenges and emerging issues

State Title V staff experienced challenges with facilitating the “Breastfeeding Champions” training because it is dependent on local agency capacity to sponsor the training. The local agencies were not able to sponsor the training during this grant cycle.

Local grantees

- Baker County - unable to train medical providers in the community as they could not find a breastfeeding specialist to travel to Baker County due to its rural location.
- Benton County – none reported.
- Clackamas County - following up with providers was time consuming and challenging. General outreach was not successful as providers are well-guarded.
- Columbia County used an already established provider group meeting to have discussions about breastfeeding support in the community. There was limited agenda time to have collaborative breastfeeding discussions in that setting.
- Crook County is small and rural where staffing and training resources are barriers. Finding a training close enough for two of the three MCH staff to attend for three days in a row at the same time was challenging.
- Douglas County – training program chosen was a few days in-person training with work to be done outside of the training which was not made clear ahead of the training, so staff did not have enough time to do the additional required reading and education needed.
- Hood River County experienced staffing shortages so were not able to host regional Breastfeeding Champion training, or have partners already trained to receive their training certification.
- Jackson County – none reported.
- Jefferson County was unable to capture many lactation appointments so reported measure is inaccurate.
- Linn County had challenges with documentation in their data system. Their goal was to ask 100% of women about breastfeeding plans. Documentation in ORCHIDS supports that 79% were asked but felt

that was underreported. They also were unable to report exact number staff trained as noted above.

ESM 4.3: Number of health care providers trained in breastfeeding support.

Progress on ESM
51 providers received breastfeeding education

Strategy: Increase access to workplace breastfeeding support.

Accomplishments
State Title V staff completed implementation guidance of the Workplace Breastfeeding Support policy. Draft tools were shared with OHA policy team. Technical assistance about workplace support was provided to local grantees upon request.

Coos County developed a workplace support toolkit specific to their community.
http://www.co.coos.or.us/Portals/0/Public%20Health/Toolkit-%20Breastfeeding%20Friendly%20Workplace%20Toolkit.pdf?ver=2018-06-13-114831-350
They held a workshop about implementing toolkit. Three businesses championed and implemented the toolkit in their workplace.

Challenges and emerging issues
Oregon Public Health Division and programs implementing workplace support policy have not had capacity to further the dissemination of tools or evaluate guidance and implementation of the policy. For ESM, unable to obtain website data as another agency manages this and web platform has changed.

At the local level, Coos County planned on presenting the toolkit to the Chamber of Commerce but there were no slots available for current year; will plan to do in future year.

ESM: 4.1: Number of agencies partnered with to implement breastfeeding support policy.

Progress on ESMs
ESM 4.1: 15 government agencies were partnered with to implement workplace breastfeeding support policy.

Strategy: Increase support of breastfeeding at child care settings through policy, training and workforce development.

Accomplishments
Josephine County circulated a letter for pregnant women to give to employers that states the legal and health reasons to support breastfeeding women in the workplace.

Challenges and emerging issues
Josephine County was unable to accomplish this strategy due to termination of the Healthy Start staff support. The loss of the nurse along with a reduction in overall staffing levels reduced capacity to reach out and engage with partner agencies within the community.

ESM: 4.1: Number of agencies partnered with to implement breastfeeding support policy.

Progress on ESM
4.1 the number of state partners involved remains the same.

Strategy: Develop policy brief and logic model to support implementation of evidence-informed state and local strategies for addressing breastfeeding and impact on maternal, child and family health.

Accomplishments
State Title V staff finalized a brief and breastfeeding logic model in November 2017. Staff made this brief available online and printed copies were shared with grantees and stakeholders. This logic model helped grantees understand the role of strategies and activities more clearly within the larger outcome of improving health of women and children.

Challenges and emerging issues – none to report at this time.

Strategy: Provide technical assistance to local health agencies working on strategies to promote breastfeeding.

Accomplishments
The breastfeeding NPM is the most frequently selected with 17 grantees working on at least one of the identified evidence-informed strategies. Each grantee created a plan of activities and measures tailored to their community's needs. The most frequently selected strategies (#3-5) among the counties target education and training of women and health care providers and provide professional lactation support. Due to this need, state Title V staff provided technical assistance to grantees when requested and as new resources became available. Our breastfeeding webpage was periodically updated to increase access to new resources.

Challenges and Issues
Due to scope of work in breastfeeding around the state, it is difficult to roll up data. State Title V staff has been working on this issue so at least some data can be quantified and reported on over the next year.

2020 Plan: Breastfeeding

National Performance measure (#4):

A) Percent of infants who are ever breastfed.
B) Percent of infants breastfed exclusively through 6 months.

Related state priority need:

Improved maternal, infant child, adolescent and family nutrition.

Planned strategies, ESMs, and activities for October 2019 – September 2020

A logic model containing the full menu of Oregon's local level breastfeeding strategies, sample activities and measures can be found in Supporting Document #4. The logic model represents all the evidence based/informed strategies that Oregon's Title V grantees may work on during the 2016-2020 Title V grant cycle. The plan that follows details strategies, activities and measures selected for implementation during the 2020 grant year at both the state and local levels. A table outlining which local grantees are implementing different well woman care strategies is included in Supporting Document 4.

Strategy: Increase the number of fathers, non-nursing partner and family members, especially grandmothers, who learn about the importance of breastfeeding

Activities – State Level

- Coos county is implementing activities that reach family and other support people about breastfeeding. These activities include finalizing promotional videos and breastfeeding pocket guide that were initiated in 2018, and then promotion of videos and pocket guide via social media and movie theater advertising.

Strategy: Fill unmet needs for peer support of breastfeeding.

Activities – Local Level

- Clackamas, Clatsop, Columbia, Multnomah and Yamhill counties and Cow Creek tribe are implementing activities that increase peer support of breastfeeding.

Strategy: Educate pregnant women about breastfeeding.

ESM 4.4: Percent of local grantees who have met their target for breastfeeding education among pregnant and postpartum women

Activities – Local Level

- Clackamas, Clatsop, Columbia, Deschutes, Lincoln, Polk, Tillamook, Umatilla and Washington counties and Warm Springs tribe are implementing activities that increase peer support of breastfeeding.

Strategy: Increase workforce support for breastfeeding through training and access to high quality services.

ESM 4.3: Number of health care providers trained in breastfeeding support

Activities – State Level

- Promote breastfeeding training opportunities to increase minimum competencies for lactation care with public health partners.

Activities – Local Level

- Crook, Deschutes, Douglas and Grant counties are supporting breastfeeding training for local public health staff.

Strategy: Increase access to workplace breastfeeding support.

Activities – State Level

- Continue to monitor and provide TA for agency-wide Workplace Breastfeeding Support policy and guidance.

Activities – Local Level

- Coos county will present employer toolkit to Chamber of Commerce and sponsor an employer workshop to increase access to workplace support.

Strategy: Increase support of breastfeeding at child care settings through policy, training and workforce development.

Activities – Local Level

- Clackamas and Josephine counties are implementing activities to increase child care breastfeeding support.

Strategy: Provide technical assistance to local health agencies and tribes working on strategies to promote breastfeeding.

Activities – State Level

- The breastfeeding NPM is selected by 17 grantees working on at least one of the identified evidence-informed strategies. Each grantee has a plan of activities and measures tailored to their community's needs. The most frequently selected strategy among the grantees target education of pregnant women.
- Collaborate with PHD staff including WIC to identify local health agency TA needs.
- Identify or develop resources and articles about breastfeeding strategies for dissemination to local grantees.

Critical partnerships

- WIC Program
- Health Promotion and Chronic Disease Prevention Program
- OHA and DHS Divisions
- OHA Health Systems, and Policy and Analytics Division
- Oregon Medical Assistance Program
- CCO Innovator Agents
- Oregon Department of Education, Child Nutrition Programs
- SNAP-Ed
- Nutrition Council of Oregon

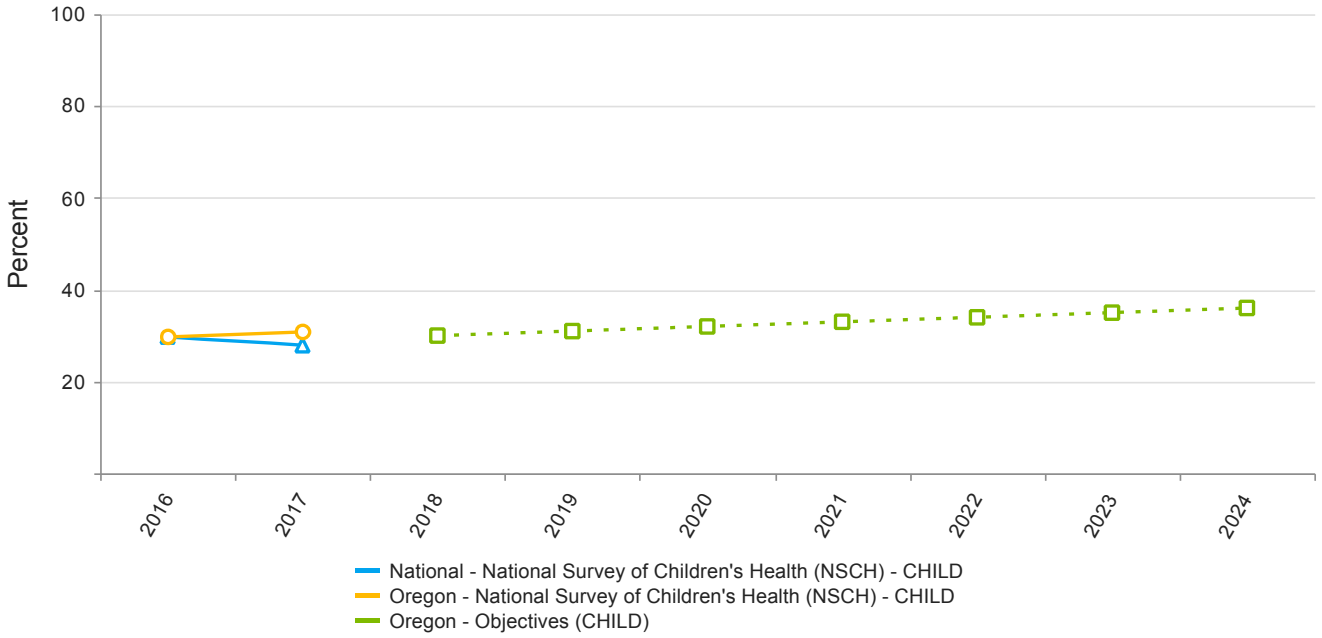
Child Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID-2015	130.2	NPM 14.2
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS	Data Not Available or Not Reportable	NPM 14.2
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2017	6.8 %	NPM 14.2
NOM 5 - Percent of preterm births (<37 weeks)	NVSS-2017	8.3 %	NPM 14.2
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2017	22.5 %	NPM 14.2
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2016	5.0	NPM 14.2
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2016	4.7	NPM 14.2
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2016	3.3	NPM 14.2
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2016	1.4	NPM 14.2
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2016	158.1	NPM 14.2
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2016	74.7	NPM 14.2
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	NSCH-2016_2017	13.8 %	NPM 13.2
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2016_2017	90.9 %	NPM 8.1 NPM 13.2 NPM 14.2
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	NSCH-2016_2017	11.4 %	NPM 8.1
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	WIC-2014	15.0 %	NPM 8.1
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	YRBSS	Data Not Available or Not Reportable	NPM 8.1

National Performance Measures

NPM 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day
Indicators and Annual Objectives



Federally Available Data			
Data Source: National Survey of Children's Health (NSCH) - CHILD			
	2016	**2017**	**2018**
Annual Objective			30
Annual Indicator		29.7	30.9
Numerator		88,810	91,445
Denominator		298,807	296,257
Data Source		NSCH-CHILD	NSCH-CHILD
Data Source Year		2016	2016_2017

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	31.0	32.0	33.0	34.0	35.0	36.0

Evidence-Based or –Informed Strategy Measures

ESM 8.1.3 - Percent of local grantees supported/provided with technical assistance to work on developing school wellness policies or safe routes to school, among those that selected the child physical activity priority area.

Measure Status:	Active

State Provided Data		
	2017	2018
Annual Objective	100	100
Annual Indicator	100	100
Numerator	5	5
Denominator	5	5
Data Source	Log of technical assistance provided	Log of technical assistance provided
Data Source Year	2017	2018
Provisional or Final ?	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	100.0	100.0	100.0	100.0	100.0	100.0

ESM 8.1.6 - Number of state early care and education systems addressed or influenced by Title V physical activity efforts during the grant year (CDC ECE Spectrum of Opportunities)

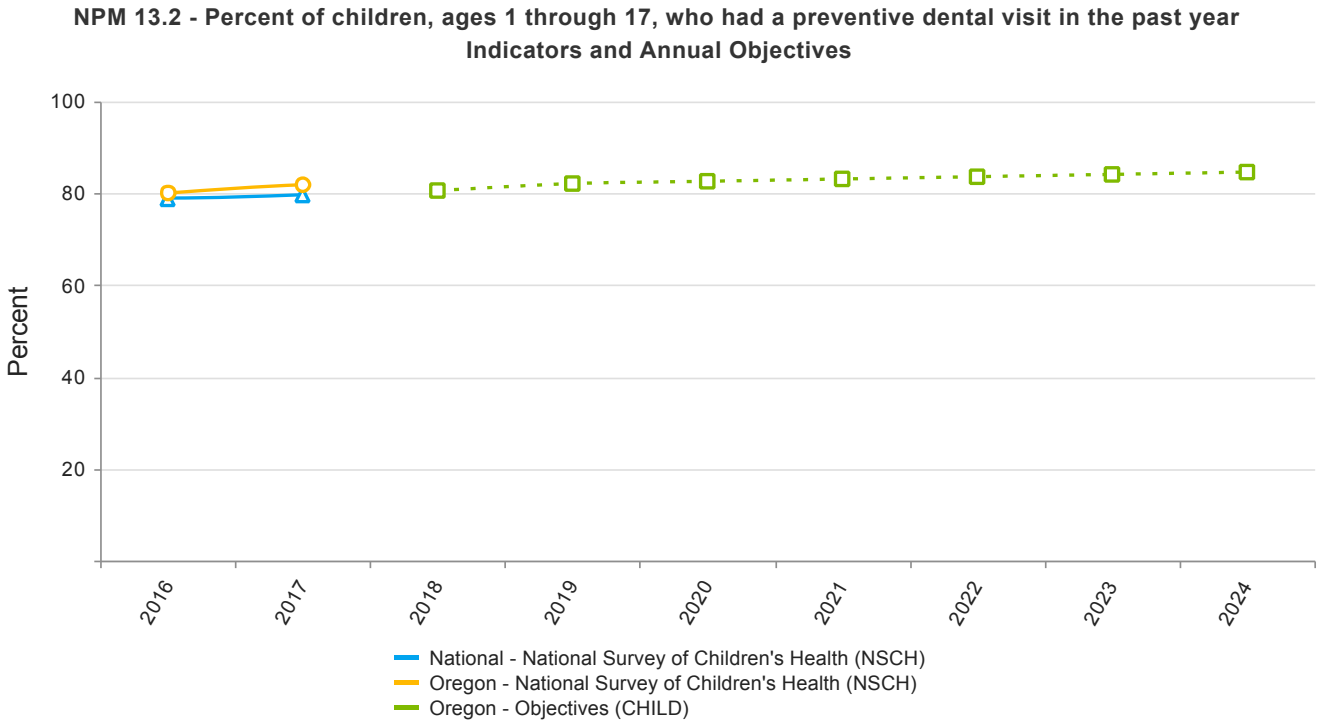
Measure Status:	Active

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	3.0	3.0	5.0	5.0	5.0	5.0

ESM 8.1.7 - Number of school districts who have participated in focus groups to explore challenges and opportunities to implement physical activity before, during and after school

Measure Status:	Active

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	3.0	3.0	3.0	3.0	3.0	3.0



NPM 13.2 - Child Health

Federally Available Data			
Data Source: National Survey of Children's Health (NSCH)			
	2016	**2017**	**2018**
Annual Objective			80.5
Annual Indicator		80.1	81.8
Numerator		647,060	662,516
Denominator		808,103	810,225
Data Source		NSCH	NSCH
Data Source Year		2016	2016_2017

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	82.0	82.5	83.0	83.5	84.0	84.5

Evidence-Based or –Informed Strategy Measures

ESM 13.2.1 - Number of school oral health programs and Title V local grantees provided with technical assistance to enhance the quality of oral health services and increase oral health visits.

Measure Status:	Active

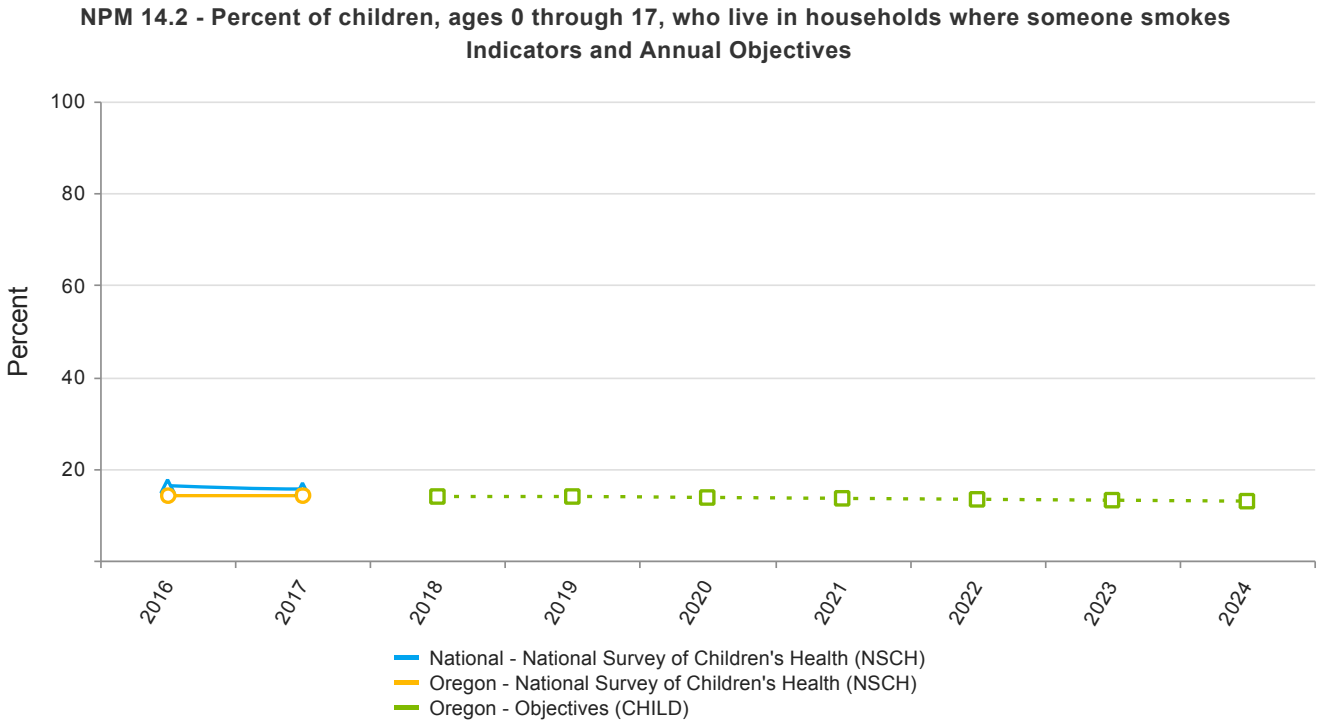
State Provided Data		
	2017	2018
Annual Objective	30	30
Annual Indicator	28	30
Numerator		
Denominator		
Data Source	Log of technical assistance provided	Log of technical assistance provided
Data Source Year	2017	2018
Provisional or Final ?	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	20.0	20.0	20.0	20.0	20.0	20.0

ESM 13.2.3 - Number of oral health providers provided training on oral cancer and HPV.

Measure Status:	Active

Annual Objectives					
	2020	2021	2022	2023	2024
Annual Objective	100.0	100.0	100.0	100.0	100.0



NPM 14.2 - Child Health

Federally Available Data			
Data Source: National Survey of Children's Health (NSCH)			
	2016	**2017**	**2018**
Annual Objective			14
Annual Indicator		14.2	14.3
Numerator		118,807	121,667
Denominator		838,336	849,982
Data Source		NSCH	NSCH
Data Source Year		2016	2016_2017

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	14.0	13.8	13.6	13.4	13.2	13.0

Evidence-Based or –Informed Strategy Measures

ESM 14.2.1 - Number of local and state regulatory agencies worked with, contacted, or engaged in smoke free childcare project.

Measure Status:	Inactive - Completed		
State Provided Data			
	2016	**2017**	**2018**
Annual Objective		3	2
Annual Indicator	1	2	1
Numerator			
Denominator			
Data Source	Log of of local and state regulatory agencies part	Log of of local and state regulatory agencies	Log of of local and state regulatory agencies part
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

ESM 14.2.3 - Number of proposed smoking related licensing rule changes submitted to the Department of Education/Early Learning Division/Office of Child Care.

Measure Status:	Inactive - Completed	
State Provided Data		
	2017	**2018**
Annual Objective	4	3
Annual Indicator	4	4
Numerator		
Denominator		
Data Source	Records of proposed changes	Records of proposed changes
Data Source Year	2017	2018
Provisional or Final ?	Final	Final

ESM 14.2.4 - Percent of proposed smoking related licensing rule changes adopted into rule in at least one of five types of child care settings.

Measure Status:	Inactive - Completed	
State Provided Data		
	2017	**2018**
Annual Objective	50	33
Annual Indicator	25	25
Numerator		
Denominator		
Data Source	DOE/ELD/Office of Child Care	DOE/ELD/Office of Child Care
Data Source Year	2017	2018
Provisional or Final ?	Final	Final

ESM 14.2.5 - Number of external partners engaged in developing a policy agenda to decrease youth exposure to tobacco.

Measure Status:				Active	
Annual Objectives					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	5.0	5.0	5.0	5.0	5.0

State Action Plan Table

State Action Plan Table (Oregon) - Child Health - Entry 1

Priority Need

Physical activity throughout the lifespan.

NPM

NPM 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Objectives

By Oct 1, 2020 increase the percent of children and adolescents age 6-17 who are physically active at least 60 minutes per day from 30.9% to 32%, by creating the context to support physical activity.

Strategies

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

Support physical activity before, during and after school.

Provide TA to local health agencies working on strategies to promote physical activity (PA before, during, and after school; safe and active transportation, PA in childcare setting, community campaigns and clinical partnerships).

Increase safe and active transportation options

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

Improve the physical environment for physical activity

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

ESMs	Status
ESM 8.1.1 - Number of trainings for childcare providers which promote physical activity identified and added to a list.	Inactive
ESM 8.1.2 - Number of trainings which promote physical activity approved and offered to childcare providers.	Inactive
ESM 8.1.3 - Percent of local grantees supported/provided with technical assistance to work on developing school wellness policies or safe routes to school, among those that selected the child physical activity priority area.	Active
ESM 8.1.4 - Number of proposed physical activity related licensing rule changes submitted to the Department of Education/Early Learning Division/Office of Child Care.	Inactive
ESM 8.1.5 - Percent of proposed physical activity related licensing rule changes adopted into rule in at least one of five types of child care settings.	Inactive
ESM 8.1.6 - Number of state early care and education systems addressed or influenced by Title V physical activity efforts during the grant year (CDC ECE Spectrum of Opportunities)	Active
ESM 8.1.7 - Number of school districts who have participated in focus groups to explore challenges and opportunities to implement physical activity before, during and after school	Active

NOMs
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

State Action Plan Table (Oregon) - Child Health - Entry 2

Priority Need

Improved oral health for pregnant women and children.

NPM

NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Objectives

By October 1, 2020 increase the percentage of children ages 1 through 17 who had a preventive dental visit in the past year from 81.8% to 82.5%.

Strategies

Provide oral health preventive services or education and referral/case management services through Oregon's Home Visiting System.

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

Incorporate oral health preventive services for adolescents into School-based Health Centers (SBHCs) and adolescent well care visits

Educate pregnant women, parents/caregivers of children, and children 0-17 about oral health and the importance of dental visits

Integrate oral health into state MCH, Health Promotion, and Chronic Disease Programs.

Provide technical assistance to school oral health programs and Title V grantees.

Increase oral health surveillance in Oregon.

ESMs	Status
ESM 13.2.1 - Number of school oral health programs and Title V local grantees provided with technical assistance to enhance the quality of oral health services and increase oral health visits.	Active
ESM 13.2.2 - Number of first to third graders screened for the Oregon SMILE Survey and Healthy Growth Survey	Inactive
ESM 13.2.3 - Number of oral health providers provided training on oral cancer and HPV.	Active

NOMs
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

State Action Plan Table (Oregon) - Child Health - Entry 3

Priority Need

Reduced tobacco use and exposure among pregnant women and children.

NPM

NPM 14.2 - Percent of children, ages 0 through 17, who live in households where someone smokes

Objectives

By October 2020, decrease the percentage of children who live in households where someone smokes from 14.3% to 13.8%.

Strategies

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

ESMs	Status
ESM 14.2.1 - Number of local and state regulatory agencies worked with, contacted, or engaged in smoke free childcare project.	Inactive
ESM 14.2.2 - The number of child care agencies that have a signed voluntary commitment to implement a smoke free campus policy.	Inactive
ESM 14.2.3 - Number of proposed smoking related licensing rule changes submitted to the Department of Education/Early Learning Division/Office of Child Care.	Inactive
ESM 14.2.4 - Percent of proposed smoking related licensing rule changes adopted into rule in at least one of five types of child care settings.	Inactive
ESM 14.2.5 - Number of external partners engaged in developing a policy agenda to decrease youth exposure to tobacco.	Active

NOMs

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

NOM 3 - Maternal mortality rate per 100,000 live births

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

NOM 5 - Percent of preterm births (<37 weeks)

NOM 6 - Percent of early term births (37, 38 weeks)

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.2 - Neonatal mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

2018 Report: Physical Activity for Children

National Performance measure (#8):

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

Interpretation of national performance measure data:

The percent of children ages 6 through 11 who are physically active for at least 60 minutes per day has increased slightly, when comparing data from 2016 to combined years of data from 2016 and 2017 (29.7% vs. 30.9%). 2017 data cannot be compared independently within Oregon due to small sample size. In 2016, Oregon's outcome for this performance measure was not statistically significantly different to the national average.

Strategies and Activities

Strategy: Support physical activity in child care settings through policy, training and workforce development.

Accomplishments

- Coordinated public health response during open comments period to proposed state child care health and safety rule revision process to promote alignment with national standards and evidence based best practices in Winter/Spring 2018. Continued to monitor rules process and provide technical assistance, policy review and support as needed.
- Reviewed and provided comments and recommendations to strengthen the Early Learning Division's proposed Child Care Development Block Grant Plan in Spring 2018.
- Developed key messages for PHD leadership and media inquiries related to the release of the Centers for Disease Control and Prevention (CDC) Early Care and Education (ECE) State Indicator Report.
- Provided technical assistance and support to local Title V partners, including compiling model physical activity policies for child care settings.
- Partnered with the PHD Health Promotion and Chronic Disease Prevention Program for the CDC 1807 Notice of Funding Opportunity.
    - Drafted a physical activity and early care and education work plan that included 8 activities that aligned with Oregon's Title V priority work.
    - Developed proposal for contractor to revise Neighborhood Navigators, an existing K-8 grade Safe Routes to School curriculum, for the preschool/early childhood period and settings. Embedded small funding in 1807 grant application to support adaptation, pilot testing, revision, development of a kit of training tools, and a train the trainer of staff from Oregon's Child Care Resource and Referral programs for statewide implementation and use in child care settings. Ultimately, this curriculum adaptation would have promoted active and safe transportation for children in early childhood settings.
    - Convened early learning partners to frame a scope of work for CDC 1807 grant application related to assessing pre-service and professional development needs for child care providers related to physical activity and health.
    - Oregon was not awarded the grant.
- Polk County provided bilingual training, technical assistance and coaching to child care providers in local community to support increased physical activity for children in early childhood settings.

Challenges and emerging issues

There are two primary challenges related to advancing physical activity in child care settings: the limits to state level capacity to perform the work plan, and the difficulty of influencing and manifesting change in the sphere of early learning and education. The Early Learning Division is laser focused on internal priorities, such as child care quality, addressing sleep related deaths in care, academic readiness of children, issues of equity and supporting child care providers in the field. Prioritizing physical activity and health for children and staff are values held by our ELD partners, but for which there is limited buy-in among many other competing priorities. As a result, we continue to see little improvement in the number of healthy weight practices for physical activity implemented into state rules.

ESMs:

- **ESM 8.1.4:** Number of proposed physical activity related licensing rule changes submitted to the Department of Education/Early Learning Division/Office of Child Care
- **ESM 8.1.5:** Percent of proposed physical activity related licensing rule changes adopted into rule in at least one of five types of child care settings.

Progress on ESMs

- **ESM 8.1.4:** 9 proposed physical activity related licensing rule changes submitted to the Department of Education/Early Learning Division/Office of Child Care
- **ESM 8.1.5:** 44% (4 out of 9) proposed physical activity related licensing rule changes adopted into rule in at least one of five types of child care settings.

Strategy: Support physical activity before, during and after school.

Accomplishments

- Co-lead Children's Healthy Weight CoIIN through the Association of State Public Health Nutritionists (ASPHN) in partnership with the Oregon Department of Education, Safe Routes to School National Partnership, and the Multnomah Education Service District. The project team meets monthly to advance our two project components, both focused on understanding and addressing the challenges to meeting the state's physical education and activity law (Senate Bill 4):

    1. Studying and describing the process to align supplemental instructional materials (SIM) for physical education/activity with state education standards. Teachers need supplemental instructional materials to implement physical education and activity before, during and after school. Lessons must be reviewed to align with the state academic content standards. The team documented the process and created a flowsheet to help encourage further development of instructional materials for use in classrooms. This review can inform state policy and guidance, and ultimately make more instructional materials available for use in schools.

    2. Engaging school principals to learn about opportunities and barriers to physical activity before, during, and after school. The team conducted focus group sessions with three different districts in three counties.

- Participated in monthly Wellness in School Environments (WISE) coalition meetings.
- Provided technical assistance and support to local Title V partners to strengthen and improve school and

district wellness policies.

- Participated with other PHD colleagues (1305 funded staff, Title V, WIC) in monthly meetings and coordinated efforts of State Health Improvement Plan Obesity team.
- Klamath County participated in community outreach events, presented to school districts on Recess before Lunch initiative, participated with Blue Zones Partnership, supported growth of walking school bus.
- Marion County developed and supported expansion of Safe Routes to School in neighborhoods, presentations and outreach to schools and districts.
- Polk County collaborated with community wide 5-2-1-0 campaign, promoted via social media.
- Umatilla County advanced the "Year of Wellness" campaign, promoted physical activity through events and social media.
- Wheeler County expanded yoga program started in rural schools, provided information about physical activity to providers and families at annual Health Fair.

Challenges and emerging issues

Despite Oregon's investment in physical education and activity for children, demonstrated by passage of legislation in 2017 that sets intermediate benchmarks to ramp up PE minutes to 150 minutes for K-5 grade students and 225 minutes for middle school students, as well as updated academic content standards, there are real and perceived barriers to increasing physical activity before, during and after school. Many of these are structural barriers, such as physical space, scheduling challenges, difficulty integrating more physical activity into an already short instructional day, lack of prepared teachers, and more.

Through the Healthy Weight CoIIN project, our team has identified a potential gap in the research, teacher preparation, and training related to students with behavioral issues and dysregulation due to trauma, adversity and mental health issues being equitably served with physical education and activity. These children and youth may be unable to participate in physical education and activity due to their own traumatic experiences and can disrupt learning and participation for other students. Teachers need training and support to engage these students in appropriate and responsive ways that do not retraumatize, nor sideline students, but instead support equitable access. The team has been searching for an expert in inclusive physical activity/education and behavioral health who could provide training, technical assistance and consultation in Oregon. We have uncovered numerous national and state experts in adaptive physical activity for children with physical disabilities, but no one focused on the intersection of behavioral health and trauma vis a vis physical activity. Currently, we are talking with several professors and researchers at universities in Oregon to help define the question and strategize steps forward to address the gap.

ESM 8.1.3: Percent of local grantees supported/provided with technical assistance to work on developing school wellness policies or safe routes to school, among those that selected the child physical activity priority area.

Progress on ESMs

ESM 8.1.3: 100% of local grantees were supported with technical assistance to work on developing school wellness policies or safe routes to school, among those that selected the child physical activity priority area.

Strategy: Increase safe and active transportation options.

Accomplishments

- Provided technical assistance and support to local Title V local partners for enhanced participation and expansion of Safe Routes To School (SRTS) initiative in communities for safe and active transportation

options for all ages.

- Noted in earlier strategy: Developed proposal for contractor to revise Neighborhood Navigators, an existing K-8 grade Safe Routes to School curriculum, for the preschool/early childhood period and settings. Embedded small funding in 1807 grant application to support adaptation, pilot testing, revision, development of a kit of training tools, and a train the trainer of staff from Oregon's Child Care Resource and Referral programs for statewide implementation and use in child care settings. Ultimately, this curriculum adaptation would have promoted active and safe transportation for children in early childhood settings.
- Klamath County participated in community outreach events, presented to school districts on Recess before Lunch initiative, participated with Blue Zones Partnership, supported growth of walking school bus.
- Marion County developed and supported expansion of Safe Routes to School in neighborhoods, presentations and outreach to schools and districts.
- Umatilla County advanced the "Year of Wellness" campaign, promoted physical activity through events and social media.

Challenges and emerging issues
Nothing to report.

Strategy: Provide technical assistance to local health agencies working on strategies to promote physical activity.

Accomplishments

- Supported local public health partners in using model policies, training and coaching strategies with child care in their communities (Polk Co. Public Health).
- Provided technical assistance to local public health partners to encourage local school districts to strengthen and improve school and district wellness policies for health (Klamath, Marion, Polk, Umatilla, Wheeler Co Public Health).
- Provided technical assistance to local public health partners to encourage participation and expansion of Safe Routes To School (SRTS) initiative in communities for safe and active transportation options for all ages (Klamath, Marion, Umatilla Co. Public Health).
- Finalized logic model and work plan tools. Provided technical assistance to align local public health partners on a more defined strategy and measure package.

Challenges and emerging issues
Nothing to report.

ESM 8.1.3: Number of local grantees supported/provided with technical assistance to work on developing school wellness policies or safe routes to school.

Progress on ESMs
ESM 8.1.3: 100% of local grantees were supported with technical assistance to work on developing school wellness policies or safe routes to school, among those that selected the child physical activity priority area.

2018 Report: Oral Health (Children)

National Performance measure (#13):

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

Interpretation of state performance measure data:

There has been a small increase in the percent of Oregon children ages 1 to 17 years who had a preventive dental visit in the last year, when comparing the 2016 rate of 80.1% to the combined 2016 and 2017 rate of 81.8%. 2017 data cannot be examined independently in Oregon due to small sample size. In 2016, the outcome of this performance measure was slightly better in Oregon than nationally, with a national average of 78.7%.

Strategies and Activities

Strategy: Integrate oral health into State Maternal, Child, and Adolescent Health (MCAH), Health Promotion, and Chronic Disease Prevention Programs.

Accomplishments

- Developed monthly oral health messages that were posted on the MCH and Public Health Division's Twitter and Facebook accounts.
- Developed and posted bi-weekly oral health messages on Facebook and Twitter to promote Children's Dental Health Month in February 2018. Topics included oral hygiene techniques, access to dental care, dental sealants, fluoride, mouth guards, etc. A resource table was staffed for the entire month in the lobby of the Public Health Division.
- Finalized and distributed the brochure titled, "Keeping Your Child's Mouth Healthy", for school-age children. Oral health topics it covers include describing what a cavity is; visiting the dentist regularly; good nutrition habits; wearing a sports guard; fluoride; fluoride varnish; dental sealants; and oral hygiene techniques for brushing and flossing. It has been translated into seven different languages and is posted on both websites for the Oral Health Unit and Oregon Department of Education.
- Developed a draft brochure titled, "Keep Your Child's Smile Healthy with Fluoride", for parents/guardians explaining the various modalities of fluoride. The next step is to test the draft brochure with pregnant women and families participating in the WIC program.
- Collaborated with the state Immunization Program to develop the brochure titled, "Oral Cancer and HPV: Protect Your Family" that can be used by dental providers to promote the HPV vaccine for adolescents with parents/caregivers.
- Participated on the planning committee for the 2018 Statewide HPV Summit, sponsored by the American Cancer Society and state Immunization Program. We engaged the dental community to attend the event and have two presentations specifically on oropharyngeal cancer and HPV.

Challenges and emerging issues

The Oral Health Unit intended to collaborate with the Health Promotion and Chronic Disease Prevention Section's Sustainable Relationships for Community Health (SRCH) grant initiative but did not have enough capacity to establish this relationship. Obtaining funding outside Title V is necessary to support SRCH grantees, and no grant

opportunities were available during the grant period. The Oral Health Unit did not have existing capacity to develop materials and provide training for SRCH grantees.

ESM 13.1.1: Number of materials developed on the common risk factors and associations between chronic diseases and poor oral health such as cavities and periodontal disease.

Progress on ESMs
ESM 13.1.1: Three brochures and one fact sheet were developed.

Strategy: Provide technical assistance to local health agencies and tribes working on strategies to promote dental visits for pregnant women and children.

Accomplishments

- Nine grantees – seven local health agencies and two tribes – were provided with individualized technical assistance throughout the grant year.
- The Oral Health Unit conducted a clinical training for school dental sealant programs on August 17, 2018 that included sessions on trauma informed practices, health equity and health literacy.
- Site visits were conducted with 21 school dental sealant programs to ensure they were meeting certification requirements. One of the requirements specifies that programs must refer children for further treatment if needed.
- The Oral Health Unit collaborated with the Oregon Oral Health Coalition to promote the First Tooth training program with grantees. First Tooth trains medical providers, such as public health nurses, to deliver oral health preventive services (oral health screenings, fluoride varnish, anticipatory guidance, and referral/case management services) within their existing practice for infants and toddlers 0 to 5 years old.

ESM 13.2.1: Number of school oral health programs and Title V local grantees provided with technical assistance to enhance the quality of oral health services and increase oral health visits.

Progress on ESMs
ESM 13.2.1: Technical assistance was provided to 21 school dental sealant programs.

Strategy: Conduct oral health assessment and surveillance that is disseminated and utilized by partners and the general public.

Accomplishments

- Contracted with 13 dental hygienists to screen children in 1st-3rd grades for dental conditions, height, and weight.
- Conducted a refresher calibration training session for contracted hygienists on August 24, 2017.
- Finished collecting data for the 2017 Oregon Smile and Healthy Growth Survey from 135 school surveyed over two school years (2016-17 and 2017-18).
- Compiled data to be analyzed and published in 2019.

Challenges and emerging issues

It was challenging getting schools to agree to participate in the survey. The Oral Health Program Unit spent two school years collecting data (2016-17 and 2017-18 school years) instead of one school year. School Administrators would prefer having programs come into their schools that provide actual oral health services to their students versus just surveillance. Without additional funding to provide incentives for schools to participate, it will most likely require two school years to collect data for the next Smile & Healthy Growth Survey in 2022.

ESM 13.2.2: Number of first to third graders screened for the Oregon SMILE Survey and Healthy Growth Survey.

Progress on ESMs
ESM 13.2.2: A total of 8,024 students in grades 1-3 were screened for the Oregon Smile & Healthy Growth Survey.

Grade	Absent	Opt-out	Screened	Total students
1st	225	307	2732	3264
2nd	210	246	2554	3010
3rd	227	258	2723	3208
Total	**662**	**813**	**8024**	**9499**

An estimate must have been provided for last year's grant report (8,200). It is unknown how many children were screened during each school year, as we only have aggregate numbers.

Strategy: Provide oral health services, education and referral/case management services through Oregon's Home Visiting System.

Accomplishments

- Washington County not only provided oral health education and referrals but also had their nurse home visitors apply fluoride varnish when applicable.

Strategy: Educate pregnant women, parents/caregivers of children, and children 0-17 about oral health.

Accomplishments

- Crook County partnered with a dental hygienist from Advantage Dental to provide oral health screenings and fluoride varnish to children in the WIC Program.
- Cow Creek Band of Umpqua Tribe of Indians provided birthday kits for children that included oral health education materials.

2018 Report: Smoking (Children)

National Performance measure (#14):

B) Percent of children who live in households where someone smokes.

Interpretation of national performance measure data:

The percent of Oregon children who live in households where someone smokes has not changed statistically significantly, when comparing the 2016 outcome of 14.2% to the combined 2016 and 2017 outcome of 14.3%. Oregon data from 2017 cannot be examined independently sue to small sample size. In 2016, the outcome of this performance measure was slightly lower than the national average of 16.2%.

Strategies and Activities

Strategy: Provide technical assistance to local health agencies and tribes working on strategies to decrease tobacco use among pregnant women and children's exposure.

Accomplishments

Technical assistance has been provided to local MCAH Programs implementing the Smoking Priority. Two webinars were conducted to share work, successes and challenges. Email communications were maintained, with materials and articles provided to local grantees. The MCAH Program also maintained collaboration with staff from the Public Health Division's Tobacco Prevention and Education Program (TPEP) in order to encourage collaboration at the local level between TPEP grantees and MCAH Program grantees.

The MCH Section has been at the table for the duration of the development and implementation of the Tobacco SHIP. This past year, the Tobacco SHIP and Alcohol and Drug SHIP combined their work, meeting together to better address addiction and health issues.

Beginning January 1st, 2018 a new Oregon law took effect, which raised the legal age of purchase for tobacco and vaping products in Oregon from 18 to 21 years. As a result of that law, a significant decrease in youth (ages 13 – 17) and young adults (ages 18 – 20) who started using tobacco has occurred. Initiation of tobacco use fell from 34% to 28% for youth between 13-17, and fell from 23% to 18% for young adults. For more information, go to https://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/TOBACCOPREVENTION/Documents/Oregon-Tobacco-21-Impact-Evaluation-Report.pdf

Challenges and emerging issues

For 2020 – 2024, Oregon's SHIP Priorities have moved to a more social determinants focus. While Tobacco is not specifically called out as its own priority, there are opportunities for tobacco strategies to be addressed. Tobacco and substance abuse are included in the new Behavioral Health Priority. The priority will be addressed by a subcommittee that will use their experience, expertise, and capacity to create a SHIP priority that identifies evidence based and innovative strategies for policy, system and environmental changes.

ESM 14.1.2: Percent of local Title V grantees who have selected smoking as a priority area who have at least two technical assistance contacts.

Progress on ESMs

ESM 14.1.2: 100 percent of all local Title V grantees with the Smoking Priority had received at least two technical assistance contacts throughout the Title V period.

Strategy: Collaborate w/CCOs, DCOs, and medical and early childhood/education providers to implement tobacco-related policies and build screening and intervention processes into their work practices, including workforce training.

Accomplishments

Infants and children in child care centers experienced a big win when the Oregon Office of Child Care amended its rules for Certified Child Care Centers and broadened smoke free zones to include the entire premises of child care centers, including playgrounds, parking lots, and any other structure on the property. Our program made recommendations for changes in the Oregon Administrative Rules (OARs) to make child care spaces safer for children. Included in these rule recommendations were more stringent restrictions around the use of tobacco by staff and visitors. While not all recommendations were adopted, they did adopt into their safety rules the banning of all tobacco use on the premises of Certified Child Care Centers.

Challenges and emerging issues

Our MCH Section provided the Oregon Office of Child Care with a list of recommendations regarding tobacco use in and around Certified Child Care Centers, Certified Family Child Care Homes, and Registered Family Child Care Homes. They included:

- *For those Certified Child Care Centers (Family Child Care Homes, or Registered Family Child Care Homes) fronting on a public sidewalk, no person shall smoke any smoking instrument, including inhalant delivery systems, within 25 feet of a window or door*
- *No person adult shall bring or wear clothing that smells of tobacco smoke onto the center premises, indoors and outdoors, where children are present.*
- *The provider shall provide the parent with written information at registration that tobacco use occurs in the home outside of business hours, and will include information about the risks of third-hand smoke. The provider will visibly post signage indicating that third hand smoke may be present in the home.*

The above recommendations for rule changes were not adopted, but our office will continue to make these recommendations and raise the conversations as those opportunities arise.

ESM 14.2.1: Number of local and state regulatory agencies worked with, contacted, or engaged in smoke free childcare project.
ESM 14.2.3: Number of proposed smoking related licensing rule changes submitted to the Department of Education/Early Learning Division/Office of Child Care.
ESM 14.2.4: Percent of proposed smoking related licensing rule changes adopted into rule in at least one of five types of child care settings.

Progress on ESMs

ESM 14.2.1: One state regulatory agency, the Office of Child Care, was engaged in smoke free childcare project.
ESM 14.2.3: Four proposed smoking related licensing rule changes were submitted to the Department of Education/Early Learning Division/Office of Child Care.
ESM 14.2.4: 25 percent (one out of four) of proposed smoking related licensing rule changes were adopted into rule in at least one of five types of child care settings.

2020 Plan: Physical Activity for Children

National Performance measure (#8):

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

Related state priority need:

Physical activity throughout the lifespan.

Planned strategies, ESMs, and activities for October 2019 – September 2020

A logic model containing the full menu of Oregon's local level physical activity strategies, sample activities and measures can be found in Supporting Document #4. The logic model represents all the evidence based/informed strategies that Oregon's Title V grantees may work on during the 2016-2020 Title V grant cycle. The plan that follows details strategies, activities and measures selected for implementation during the 2020 grant year at both the state and local levels. A table outlining which local grantees are implementing different well woman care strategies is included in Supporting Document 4.

Strategy: Support physical activity in child care settings through policy, training and workforce development

ESM 8.1.6: Number of state early care and education systems addressed or influenced by Title V physical activity efforts during the grant year (CDC ECE Spectrum of Opportunities)

Activities – State Level

- Complete updated scan of current landscape for physical activity standards in state systems identified in CDC ECE State Indicator Report.
- Draft Oregon companion to the CDC ECE State Indicator Report. Align with Raise Up Oregon Early Learning Plan and Early Learning Division (ELD) priorities - quality child care, equity, academic readiness, and provider support.
- Convene local Title V partners for cross-grantee sharing of information, support and technical assistance in core physical activity strategy areas. Provide or facilitate access to technical assistance as needed.

Strategy: Support physical activity before, during and after school

ESM 8.1.3: Percent of local grantees supported/provided with technical assistance to work on developing school wellness policies or safe routes to school, among those that selected the child physical activity priority area.

ESM 8.1.7: Number of school districts who have participated in focus groups to explore challenges and opportunities to implement physical activity before, during and after school

Activities – State Level

- Continue to co-facilitate the Oregon Healthy Weight CollN team in partnership with Department of

Education, Safe Routes to School National Partnership, and the Multnomah Educational Service District.

- Participate in Oregon Healthy Schools Advisory Committee. Attend bimonthly meetings.
- Participate in monthly Wellness in School Environment (WISE) meetings.
- Convene and advance multisector conversations related to teacher training and technical assistance to support students experiencing dysregulation due to trauma, adversity and mental health issues in equitable access to physical education and activity.
- Convene local Title V partners for cross-grantee sharing of information, support and technical assistance in core physical activity strategy areas. Provide or facilitate access to technical assistance as needed.
- Five local Title V grantees (Confederated Tribes of the Umatilla Indian Reservation, the Coquille Tribe, Jefferson County, Marion County and Wheeler County) will conduct activities related to physical activity before, during and after school.

Critical partnerships

- OHA/PHD/Health Promotion Chronic Disease Prevention Program
- Oregon Department of Education, Office of Student Services
- Local grantees: Marion county, Coquille tribe, Umatilla tribe, Jefferson county, Wheeler county
- Oregon Department of Education, Early Learning Division
- Western Oregon University, Teaching Research Institute
- Child Care Resource and Referral Network
- Oregon Center for Career Development, Portland State University
- Wellness in School Environments (WISE) members
- Oregon ASK
- Oregon Healthy Schools Advisory Committee members

2020 Plan: Oral Health (Children)

National Performance measure (#13):

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

Related state priority need:

Improved oral health for pregnant women and children.

Planned strategies, ESMs, and activities for October 2019 – September 2020

A logic model containing the full menu of Oregon's local level oral health strategies, sample activities and measures can be found in Supporting Document #4. The logic model represents all the evidence based/informed strategies that Oregon's Title V grantees may work on during the 2016-2020 Title V grant cycle. The plan that follows details strategies, activities and measures selected for implementation during the 2020 grant year at both the state and local levels. A table outlining which local grantees are implementing different well woman care strategies is included

in Supporting Document 4.

Strategy: Increase awareness and engagement within the dental community of oral cancer and HPV.

ESM 13.2.3: Number of oral health providers provided training on oral cancer and HPV.

Activities – State Level

- Develop oral health messages, fact sheets and educational materials for dental providers to share with adolescents on oral cancer and HPV.
- Finalize an adolescent oral health poster that can be posted in School-based Health Centers that includes messages around preventing cancer with the HPV vaccine.
- Conduct "You are the Key" webinar trainings to dental professionals. Dr. Bruce Austin, Statewide Dental Director or another dentist will present the training since a dentist must provide it.
- Develop a webpage on the Oral Health Unit's website for oral cancer and HPV. The website will include information on House Bill 2022 (dentists administering vaccines), oral cancer resources, recordings of webinar trainings, etc.
- Participate on the PHD HPV Committee. Oral cancer and increasing dental engagement has been identified as a priority for the next two years. Activities include developing shared messaging around the HPV vaccine, educational materials and resources for key stakeholders.
- Collaborate with the State Immunization Program and American Cancer Society on the 2020 Statewide HPV Summit.

Strategy: Provide technical assistance to school oral health programs and Title V grantees.

ESM 13.2.1: Number of school oral health programs and Title V local grantees provided with technical assistance to enhance the quality of oral health services and increase oral health visits.

Activities – State Level

- Collaborate with state and local Title V staff to identify technical assistance needs – Ongoing.
- Identify forums for technical assistance (e.g. webinars, learning collaborative, conference calls) – August 2019.
- Develop and conduct a webinar for Title V grantees and school oral health programs on developing oral health education materials and health literacy standards – Spring 2020.
- Develop and conduct a webinar for school oral health programs on adverse childhood experiences (ACEs) and trauma informed care practices – Spring 2020.
- Identify and develop resources and materials for dissemination to local Title V grantees and school oral health programs – Ongoing.
- Promote state and local oral health strategies and activities within the Public Health Division and other oral health partner networks – Ongoing.

Strategy: Increase oral health surveillance in Oregon.

ESM 13.1.2: Number of data sets in the Oregon Oral Health Surveillance System (OOHSS) that can be

analyzed for oral health disparities.

Activities – State Level

- Increase the number of data points within the Oregon Oral Health Surveillance System (OOHSS) that can be analyzed by race, ethnicity, language, and disability (REALD) – Winter 2018.
- Compile and analyze REALD data collected as part of the statewide OHA School Dental Sealant Program to identify oral health disparities – Winter & Spring 2020.
- Develop a strategic plan to implement REALD in all data sources within the OOHSS – Spring & Summer 2019.

Strategy: Provide oral health preventive services or education and referral/case management services through Oregon's Home Visiting System.

Activities – Local Level

- Jackson County will implement early childhood preventive services (e.g. oral screenings and fluoride varnish) in their home visiting program.

Strategy: Educate pregnant women, parents/caregivers of children, and children 0-17 about oral health and the importance of dental visits.

Activities – Local Level

- Clackamas County is integrating oral health across systems to ensure women, children, youth, and families receive screenings, referrals, and access to and utilization of preventative oral health services.
- Columbia County will provide oral health education to children in their home visiting and WIC programs.
- Cow Creek Band of Umpqua Tribe of Indians will provide tribal children with a dental care kit after they visit the dentist for their first cleaning of the year.
- Hood River will provide oral health education in their WIC program and collaborate with Advantage Dental to provide monthly oral health screenings and preventive services for children.
- Josephine County will collaborate with Siskiyou Dental to provide oral health education and fluoride varnish to at-risk youth participating in their public health programs.
- Morrow County will collaborate with Advantage Dental to provide oral health education in the schools and assist with getting parent permission as needed for follow-up dental care.
- Polk County will reach out to local dental providers to ensure children have access to dental care.

Critical Partnerships:

- Oregon home visiting programs (MCM, Babies First!, NFP, CaCoon)
- Oregon MothersCare Program
- Health Promotion and Chronic Disease Prevention Section
- State WIC Program
- Oregon Oral Health Coalition (OrOHC)
- Coordinated Care Organizations (CCOs)
- Dental Care Organizations (DCOs)

2020 Plan: Smoking (Children)

National Performance measure (#14):

Percent of children who live in households where someone smokes**.**

Related state priority need:

Reduced tobacco use and exposure among pregnant women and children.

Planned strategies, ESMs, and activities for October 2019 – September 2020

A logic model containing the full menu of Oregon's local level smoking strategies, sample activities and measures can be found in Supporting Document #4. The logic model represents all the evidence based/informed strategies that Oregon's Title V grantees may work on during the 2016-2020 Title V grant cycle. The plan that follows details strategies, activities and measures selected for implementation during the 2020 grant year at both the state and local levels. A table outlining which local grantees are implementing different well woman care strategies is included in Supporting Document 4.

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

ESM 14.2.5: Number of external partners engaged in developing a policy agenda to decrease youth exposure to tobacco.

Activities – State level

- Act as MCH Section liaison to the Alcohol and other Drug Prevention Services Unit of the Center for Prevention and Health Promotion.
- Liaison with Tobacco Prevention and Education Program within the Chronic Disease Section of the Public Health Division
- Participate in the work of the State Health division's Behavioral Health State Health Improvement Plan.
- Partner with the adolescent health unit to identify and develop opportunities for tobacco prevention for adolescents.
- Promote the linkage between ACEs prevention and tobacco prevention in state agency work groups and policy settings.
- Explore partnerships to expand protections for children from second and third hand smoke exposure in home childcare settings.

Strategy: Provide technical assistance to local health agencies and tribes working on strategies to decrease tobacco use among pregnant women and children's exposure.

ESM 14.1.2: Percent of local Title V grantees who have selected smoking as a priority area who have at least two technical assistance contacts.

Activities – State Level

- Twice yearly webinars with all counties and tribes that have identified smoking as a priority to share successes, challenges, and to provide a learning collaborative opportunity.
- Provide regular email communication updates to all smoking priority counties and tribes which may include research articles, tool kits, policy updates, and other resources.
- Participation in the Public Health Division's Behavioral Health State Health Improvement Plan.
- Provide necessary print, electronic, and training materials to counties and tribes to increase knowledge around tobacco cessation benefits and the Oregon Quitline.

Critical partnerships

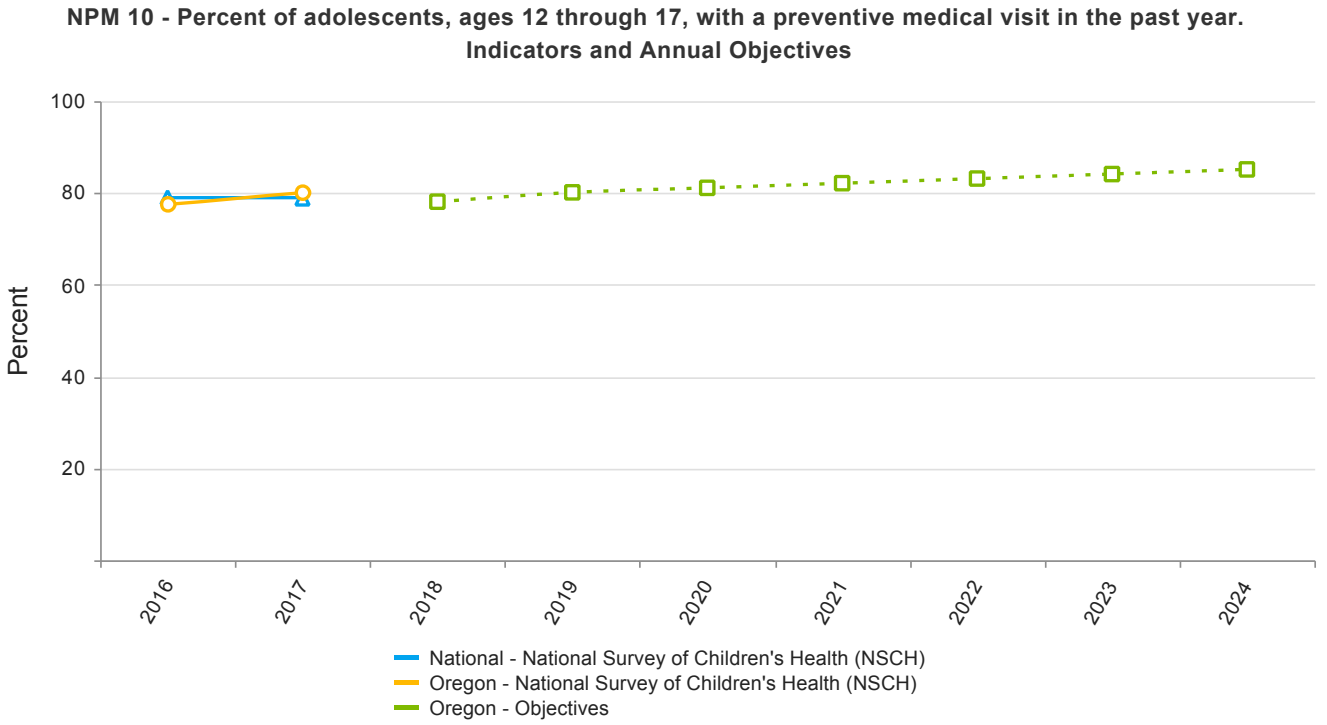
- Local Title V Grantees: Columbia, Lane, Tillamook, Yamhill, Wheeler, Coquille Indian Tribe, Confederated Tribes of the Umatilla Indian Reservation
- Oregon Public Health Division, Health Promotion and Chronic Disease Prevention Program, Tobacco Prevention and Education Program
- Oregon Health Authority, Health Transformation Office
- Local County Health Department Tobacco Prevention and Education Program Grantees
- Coordinated Care Organizations
- American College of Obstetricians and Gynecologists
- Oregon Midwifery Council
- Oregon MothersCare Program
- Oregon Quitline
- 211Info Resource and Referral
- Oregon Health Plan
- Oregon Office of Childcare
- Oregon Early Learning Division

Adolescent Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS-2017	32.3	NPM 10
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS-2015_2017	9.2	NPM 10
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2015_2017	13.8	NPM 10
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2016_2017	61.8 %	NPM 10
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2016_2017	90.9 %	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	NSCH-2016_2017	11.4 %	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	WIC-2014	15.0 %	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	YRBSS	Data Not Available or Not Reportable	NPM 10
NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza	NIS-2017_2018	54.0 %	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NIS-2017	71.2 %	NPM 10
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS-2017	86.3 %	NPM 10
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine	NIS-2017	77.0 %	NPM 10
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2017	15.0	NPM 10

National Performance Measures



Federally Available Data			
Data Source: National Survey of Children's Health (NSCH)			
	2016	**2017**	**2018**
Annual Objective			78
Annual Indicator		77.4	79.9
Numerator		227,178	230,520
Denominator		293,358	288,666
Data Source		NSCH	NSCH
Data Source Year		2016	2016_2017

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	80.0	81.0	82.0	83.0	84.0	85.0

Evidence-Based or –Informed Strategy Measures

ESM 10.1 - Number of health professionals trained on adolescent well visits.

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective			
Annual Indicator	161	282	575
Numerator			
Denominator			
Data Source	Attendance sheets	Attendance sheets	Attendance sheets
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	200.0	200.0	200.0	200.0	200.0	200.0

ESM 10.2 - The number of health professionals trained and informed to promote the practice of going beyond the sports physical

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective			100
Annual Indicator	0	1,137	168
Numerator			
Denominator			
Data Source	State tracking	State tracking	State tracking
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	100.0	100.0	100.0	100.0	100.0	100.0

State Action Plan Table

State Action Plan Table (Oregon) - Adolescent Health - Entry 1

Priority Need

High quality, confidential, preventive health services for adolescents

NPM

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

Objectives

By Oct 1, 2020 increase the percentage of adolescents age 12-17 with a preventive medical visit in the last year, from 79.9% to 81%.

Strategies

Increase outreach to key populations in community.

Promote policies and practices to make health care more youth-friendly. Including engaging youth as peer health educators.

Promote youth engagement activities in health classes and school based health center Youth Advisory Councils to increase youth resilience and youth voice in local decision making for school health.

Promote practice of going beyond sports physicals to wellness exams.

Strengthen health care privacy and confidentiality policies and practices.

Develop and strengthen partnerships with public and private entities invested in adolescent health.

Investigate barriers to adolescent well visits.

ESMs	Status
ESM 10.1 - Number of health professionals trained on adolescent well visits.	Active
ESM 10.2 - The number of health professionals trained and informed to promote the practice of going beyond the sports physical	Active

NOMs

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

2018 Report: Adolescent Well Care

National Performance measure (#10):

Percent of adolescents with a preventive medical visit in the last year.

Interpretation of national performance measure data:

The National Performance Measure (NPM 10) percent of adolescents with a preventative medical visit in the last year has been steadily increasing since 2003 (according to the National Survey of Children's Health). While 2017 data is not comparable to 2012 – the rates of adolescents with a well-visit is at a state high of 79.9 percent of those aged 12-17. State level data (Oregon Health Teens and Medicaid data) echo improvements in preventative care for adolescents. We believe that Medicaid Coordinated Care Organizations' emphasis on the well-visit in combination with partnerships between Medicaid, Title V, and Oregon Pediatrics Society have increased knowledge of the well-visit among providers and have provided more promotion of these services. Moreover, the Affordable Care Act ensures access to the well-visit by mandating insurance coverage for this preventive care without cost sharing.

Strategies and Activities

Strategy: Promote policies and practices to make youth health care more youth friendly.

Report

- Educated health professionals with data on measures of health and well-being from Oregon Health Teens Survey, and tied data to the importance of the adolescent well-visit and programs that support youth resiliency such as youth participatory action research. After the release of the 2017 Oregon Healthy Teens data, we updated the Snapshot of Adolescent Health, a multi-domain data presentation for providers, educators, and other health professionals to help them understand all aspects of adolescent health. The Snapshot highlights policy and socioeconomic context for trends in health outcomes and highlights the need for preventative services in addressing and screening for health issues which youth face. Domains include substance use, mental health, physical health/activity, access to clinical services, reproductive health, and social determinants of health. The Snapshot can be tailored to the audience's needs, but always presents data on adolescent well-visits and promotes its use as an intervention in improving the presented outcomes. Presented the Snapshot to 20 audiences (about 250 attendees total) across the state of Oregon in the 2017-18 grant cycle.
- Through the Snapshot, we created data visuals that highlight disparities in adolescent health and access to clinical services. The Snapshot clearly shows health and access disparities for Native American and LBGTQ+ youth and as part of outreach. We used the data points to promote the need for culturally competent and youth friendly care for these populations.
- Presented data to health care providers and insurers on the importance of resilience building and positive youth development on youth health outcomes – relating those concepts back to the adolescent well-visit. In June of 2018, made a presentation to 265 health professionals associated with Oregon Medicaid's Coordinated Care Organizations on the importance of positive youth development and resilience.
- Over the summer of 2018, sat on a workgroup with Oregon's school administrators, principals and teachers for policy discussions related to school-based health services, with an emphasis on access to

mental health services. Provided information to 60 school administrators on school-based health centers (SBHCs), qualified mental health providers at SBHCs, the adolescent well-visit, and how those strategies provide screenings and interventions for youth at school. Helped to formulate policy ideas that promote access to school-based services in schools.

- Over the summer of 2018, began a process of youth engagement to improve school health surveys. Held focus groups, key informant interviews and surveys with youth to better understand how they feel about their health and how the State should tailor the content and process of youth health surveys to better capture those feelings. Based on qualitative data from youth, we presented recommendations to survey steering committee for changes to the survey content and process. One key piece that came out was that youth want to be asked about resources and assets in their lives that help them make healthy decisions, and this included access to clinical services like the well-visit.
- Supported and educated providers on confidentiality laws relevant to minors, particularly HB 2758. Information material on HB 2758 (allows for patients enrolled in a private health insurance policy to request confidential communications) distributed to health care providers via email in response to inquiries about the law.
- Promoted adolescent well-visits using social media messages. The Oregon Health Authority uses Twitter and Facebook to promote messages around the Oregon State Health Improvement Plan (SHIP). We took this as an opportunity to:

    1. frame adolescent health issues within the context of SHIP priorities areas and
    2. promote the well-visit as a viable way to meet SHIP goals. The Adolescent and School Health Program submits two social media messages per month, with many of those messages promoting the well-visit.

Accomplishments

When updating and promoting the Snapshot of Adolescent Health**, t**he data showed important trends with respect to mental health, resilience, and sexual health. It was used by audience members in legislative testimony, reporting, and other presentations. The Snapshot was presented to 20 audiences across the state of Oregon in the 2017-18 grant cycle. Audience members often refer other groups to see the presentation – creating new partnerships in promoting the well-visit and adolescent health.

Our engagement with youth driven organizations on youth health surveys has created partnerships that can be used to improve youth outreach and youth friendly policy and clinical practice. It has also improved our survey process and helped us consider ways to make health surveys more youth friendly.

Challenges and emerging issues

Integrating school-based health services into schools has been difficult in some communities due to a lack of providers and various funding streams/financial constraints for school-based health. This has created access issues for the well visit and mental health screenings.

ESM 10.1: Number of health professionals trained on adolescent well-visits.

Progress on ESMs

ESM 10.1: For the 2018 reporting year, the Oregon Title V program reached 575 professionals working on youth health with presentations on positive youth development, confidentiality and privacy, and population health data for youth

Strategy: Promote practice of going beyond sports physicals. (State and local Level).

Report

- In October of 2017, state staff held a panel discussion for Oregon's school-based health center coordinators on different ways sites are transforming sports physicals into adolescent well-visit. Three sites which have modified workflows, practice, and policy to increase the number of student athletes getting adolescent well-visits were highlighted. These examples acted as models for other school-based health centers working on the same issue. Overall, 68 health professionals received the information.
- Oregon School Activities Association (OSAA), Public Health Division, Transformation Center, Health System partners continued to distribute joint adolescent well-visit and PPE comparison document to School-Based Health Centers, athletic departments, CCOs, and local partners. In Summer of 2018, distributed 100 copies of the document to health professionals at the National School Based Health Alliance conference.
- State Title V staff supported Harney, Jefferson, and Lake Health Departments as they work to promote the adolescent well-visit over the sports physical. Provided well-visit/sports physical document to these sites and help Lake and Harney County prepare and shift the focus of health fair events that were traditionally geared towards sports physicals.
- Lake County shifted the focus of health fair events that were traditionally geared towards sports physicals. 150 youth participated in the fair and they rotated youth through stations that included other preventive services like immunizations.
- Jefferson County worked with local healthcare providers to "phase out" sports physicals and incorporate well-visits as part of routine care. 100% of sports physicals done in the Jefferson County SBHC now include a full well-visit. However, some other community providers continue to only do sports physicals.
- Harney County partnered with schools, the local hospital system and clinics to try to encourage families to get well-visit for their youth, including at the school. They also promoted the well-visit through media and newspaper through 15 media releases.

Accomplishments

The biggest accomplishment of the year was the panel discussion for SBHC coordinators, because it gave sites best practice and practical methods for implementing policy and work flows to improve adolescent well-visits through the sports physical.

Challenges and emerging issues

Coordinated Care Organizations can still count a sports physical as an adolescent well visit for incentive metrics. The sports physical is still entrenched in some local adolescent practices. While CCOs have been a great partner in trying to get their providers to do well-visits instead of sports physicals, providers can still meet their metrics by doing sports physicals. Removing sports physicals from the adolescent well-visit metric will take a state policy change involving many partners. Several communities still prefer the sports physical to the well visit – one reason being that Athletic Departments use the screening as a revenue source. There is some parent resistance to the well-visit and the more comprehensive screenings that are included.

ESM 10.2: The number of health professionals trained and informed to promote the practice of going beyond the sports physical.

Progress on ESMs

ESM 10.2: For the 2018 reporting year, the Oregon Title V program reached 168 health professionals with training and information about the differences and comparative strengths between the adolescent well-visit and the sports physical, and how to use the Oregon Sports Pre-Participation Examination (PPE) either to complete or refer for an adolescent well-visit.

Strategy: Increase outreach to key populations in the community.

Report

- Coos County created a sizeable amount of promotional materials and distributed them through county fairs and community partners. Radio and Facebook messages were also posted regarding the importance of adolescent well-visits.
- Morrow County connected with community partners – CCO, FQHC, Schools, and others – to promote adolescent well-visit and offered several events to increase referrals for the adolescent well-visit. They were able to generate 250 referrals through these events.

Accomplishments

Morrow County had a list of well-established regional partners which contributed to 3-month campaign with at least three major events. This helped increase the number of referrals (250 referrals of the grant period) for well-visits.

Challenges and emerging issues

Local level documentation of data has been a challenge. It has been difficult to assess what outcomes events drives and referrals are having.

Strategy: Leverage SBHC to conduct broader outreach within school and community.

Report

- Jefferson County leveraged youth to inform students and families of the importance of the adolescent well-visit. As a result, Madras High School School-Based Health Center (in Jefferson County) had doubled monthly visits (15 per month) in the second year of operation. Community awareness of the clinic and the services provided also increased. Additionally, there was an overall increase in the awareness of the importance of the mental/behavioral health components of the well-visit.

Accomplishments

Jefferson leveraged youth word of mouth to increase utilization, which could further their youth engagement in other issues (youth friendliness of clinic space, etc).

Challenges and emerging issues

There were issues with referrals between SBHCs and other community providers when well-visit screenings revealed the need for other care.

Strategy: Raise awareness of the importance of adolescent well-care.

Report

Morrow County staff created targeted messages which were delivered to students and families through monthly

school-based robo calls, social media, organization websites, community promotoras/outreach workers and print media. Youth were also identified by utilizing a patient roster or student athlete list to contact and schedule those in need of a well care exam.

Accomplishments

Morrow County reports that sports physicals “have essentially been replaced with adolescent well care exams.” Partners have “committed to a community benefit payment policy that once insurance has been billed, there is no out of pocket cost to the individual. Quality measures are reviewed on a monthly basis and quality improvement plans are initiated if quality goals are not met. The intent going forward is to spread the broader message about the value of accessing age appropriated well care visits for everyone, which will present its own unique set of challenges.”

Challenges and emerging issues

N/A

2020 Plan: Adolescent Well Care

National Performance measure (#10):

Percent of adolescents with a preventative medical visit in the last year.

Related state priority need:

High quality, confidential, preventive health services for adolescents.

Planned strategies, ESMs, and activities for October 2019 – September 2020

A logic model containing the full menu of Oregon's local level adolescent well-visit strategies, sample activities and measures can be found in Supporting Document #4. The logic model represents all the evidence based/informed strategies that Oregon's Title V grantees may work on during the 2016-2020 Title V grant cycle. The plan that follows details strategies, activities and measures selected for implementation during the 2020 grant year at both the state and local levels. A table outlining which local grantees are implementing different well woman care strategies is included in Supporting Document 4.

Strategy: Promote policies and practices to make youth health programs more youth friendly and youth informed.

ESM 10.1: Number of health professionals trained on adolescent well-visits, i.e. number of health professionals who attend trainings or informational presentations on the promotion of youth friendly services (through trainings on positive youth development, confidentiality and privacy, and population health data on youth.)

Activities – State Level

- Update the Adolescent Snapshot with data on positive youth development, adverse childhood experiences, and other measures of health and well-being from 2019 Oregon Health Teens Survey and tie data to the importance of the adolescent well-visit and programs that support youth resiliency such as youth participatory action research. Continue to use data presentations to highlight the importance of evidence-based well-visits in screening and providing strengths-based anticipatory guidance. Target: one presentation per month for a total of 12 presentations starting October 2019.
- Distribute an updated adolescent well-visit guidance document to Oregon Medicaid's Coordinated Care Organizations. Include examples of best practice from across the state to improve the quality and youth friendliness of services.
- Work with educators and the Oregon Department of Education to ensure that school districts and schools have the data, resources, and personnel they need to promote, refer, and/or deliver adolescent preventive care (including mental and reproductive health care). Ongoing throughout the grant cycle.
- Create a stakeholder advisory committee for the Oregon Adolescent and School Health Unit (including Title V Adolescent Health priority area). Use Title V Needs Assessment to identify members for said advisory committee by September 2020.
- Continue to gather information from youth and educators to inform youth health surveys, make them more relevant, and to improve surveillance of adolescent health issues--ongoing throughout grant period

- Support the seven local public health authorities (North Central Public Health District and Clackamas, Curry, Harney, Marion, Morrow, and Umatilla County) that selected Adolescent Well-Visit as their priority measure for coming year--ongoing throughout grant period.
- Promote adolescent well-visits using social media messages--ongoing throughout the grant period.

Strategy: Promote youth engagement activities in health classes and School Based Health Center Youth Advisory Councils to increase youth resilience and youth voice in local decision making for school health.

Activities – State Level

- Evaluate effectiveness of the Youth Participatory Action Research (YPAR), a youth engagement strategy in which youth lead an action-oriented research project. Oregon has five counties who are supporting youth advisory councils to do YPAR. Continue to provide technical assistance to these sites throughout the grant period.
- Encourage, promote, and provide technical assistance for the proliferation of youth advisory councils, including the seven local public health authorities. Ongoing throughout grant period.

Strategy: Promote practice of going beyond sports physicals. (State and local Level)

ESM 10.2: Train and inform health professionals to promote the practice of going beyond sports physical (Oregon Sports Pre-Participation Examination or PPE) and to complete or refer an adolescent well-visit.

Activities – State Level

- Oregon School Activities Association (OSAA), Public Health Division, Transformation Center, Health System partners will continue to distribute joint adolescent well-visit and PPE comparison document to School-Based Health Centers, athletic departments, CCOs, and local partners. Ongoing throughout grant period.
- Support five counties as they work to promote the adolescent well-visit over the sports physical. Provide well-visit/sports physical document. Ongoing throughout grant period.
- Strategize with health systems partners about changes to the adolescent well-visit metric – removing sports physical codes from that metric definition for purpose of incentives. Ongoing throughout grant period.

Activities – Local Level

- Curry County will continue to offer sports physicals at the local school-based health center and then attempt to convert them to well-visits. Ongoing throughout the grant period.
- Harney County will partner with schools to provide four full days of adolescent wellness exams in August prior to school and fall sports starting – helping to catch athletes as they try to fulfill the sports physical requirement.
- Marion County will explore partnering with local school districts to develop messaging that can be shared with families at school sponsored events during Fall of 2019.
- Morrow County will continue to support change in community norms to obtain adolescent well-visits on a yearly basis, and to eliminate sports physicals in all county healthcare clinics regardless if the child is playing sports. The county will continue an advisory council aimed at providing community education to parents and caregivers. Ongoing throughout the grant period.
- Umatilla County will meet with school district staff to promote the well-visit in place of sports physicals. They will work with school staff to schedule well-visits before the deadline that athletes must complete sports visits. They will develop a well-visit campaign at the middle and high school in the spring of 2020

and they will develop policies to try to institutionalize the well-visit.

Strategy: Investigate barriers to adolescent well-visits.

Activities – Local Level

- Curry County will conduct 2-3 student lead focus groups and distribute a survey throughout the school year to better understand the challenges facing children. They will utilize their local youth advisory council and engage other student groups in other cities to work with students to understand their needs and barriers. Ongoing throughout the grant period.

Strategy: Increase outreach to key populations in community. This could include raising awareness of importance of well care and leveraging SBHCS to conduct outreach.

Activities – Local Level

- Clackamas County will develop and implement a marketing plan to promote adolescent well-visits at their local SBHC. The marketing plan will leverage sports physicals and school immunization law requirements. Ongoing throughout the grant period.
- Harney County will work with community members to try to improve adolescent wellness exam rates in the Paiute tribe and among adolescents coming to the local health department for family planning visits, WIC, STD screening, and immunizations. Harney County will also do some education among junior high and high school health classes. Ongoing throughout the grant period.

Strategy: Strengthen health care privacy and confidentiality policies and practices.

Activities – Local Level

- Morrow County will continue to promote collaboration between the county's primary care clinics in implementing policies that protect adolescents' ability to self-consent to care and to eliminate barriers (like privacy) to health care services. This is the next step as they developed an access and consent policy in a previous grant year. Ongoing throughout the grant period.

Strategy: Develop and strengthen partnerships with public and private entities invested in adolescent health.

Activities – Local Level

- Marion County will explore surveying provider offices to assess if there is a difference in completing a well-visit among adolescents with private versus Medicaid insurance. The county will also survey families to investigate reasons for non-completion.
- North Central Public Health District will convene local partners (including youth-serving orgs, CCO's, community providers and school districts) to address access and education barriers for the well-visit and reproductive health.

Critical partnerships:

- Oregon Health Authority – Transformation Center
- Coordinated Care Organizations
- School-Based Health Centers
- Oregon School Nurses Association
- Oregon School-Based Health Alliance
- Oregon Health Authority – Reproductive Health Program
- Oregon Pediatric Society
- Oregon Pediatric Improvement Partnership
- Confederation of Oregon School Administrators
- Oregon Department of Education
- Oregon school districts
- Oregon Student Voice

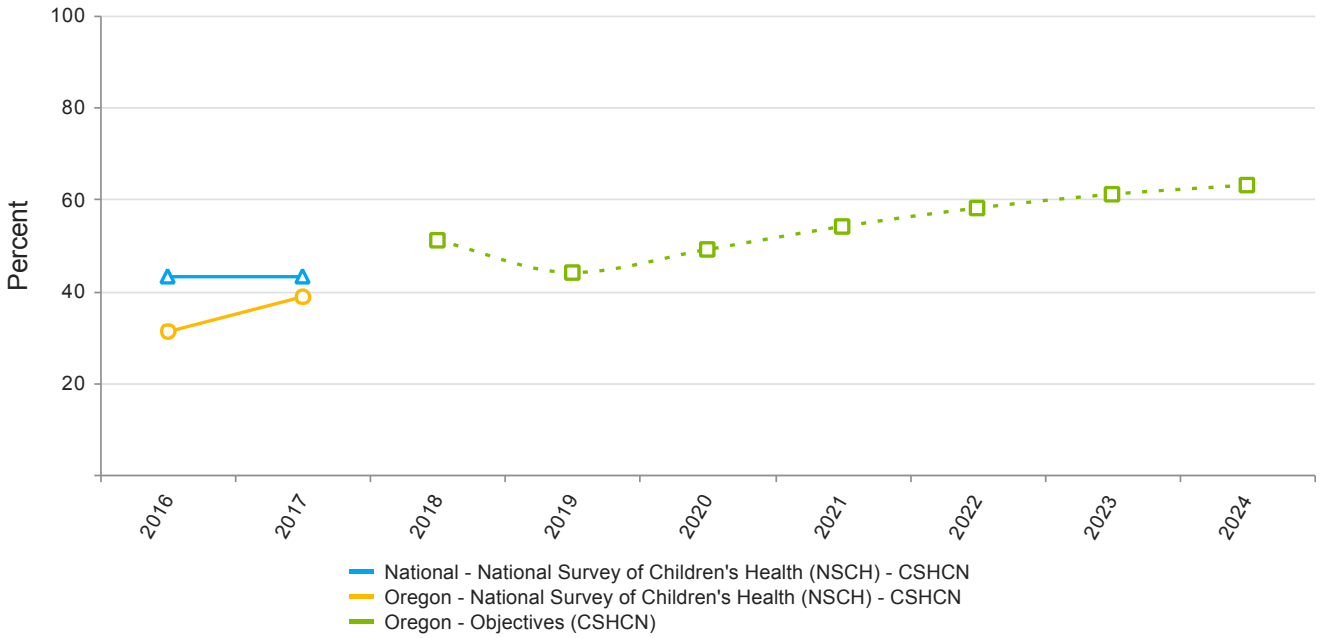
Children with Special Health Care Needs

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2016_2017	15.7 %	NPM 11 NPM 12
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2016_2017	61.8 %	NPM 11
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2016_2017	90.9 %	NPM 11
NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year	NSCH-2016_2017	3.3 %	NPM 11

National Performance Measures

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home
Indicators and Annual Objectives



NPM 11 - Children with Special Health Care Needs

Federally Available Data			
Data Source: National Survey of Children's Health (NSCH) - CSHCN			
	2016	**2017**	**2018**
Annual Objective			51
Annual Indicator		31.3	38.6
Numerator		49,675	61,991
Denominator		158,652	160,752
Data Source		NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	44.0	49.0	54.0	58.0	61.0	63.0

Evidence-Based or –Informed Strategy Measures

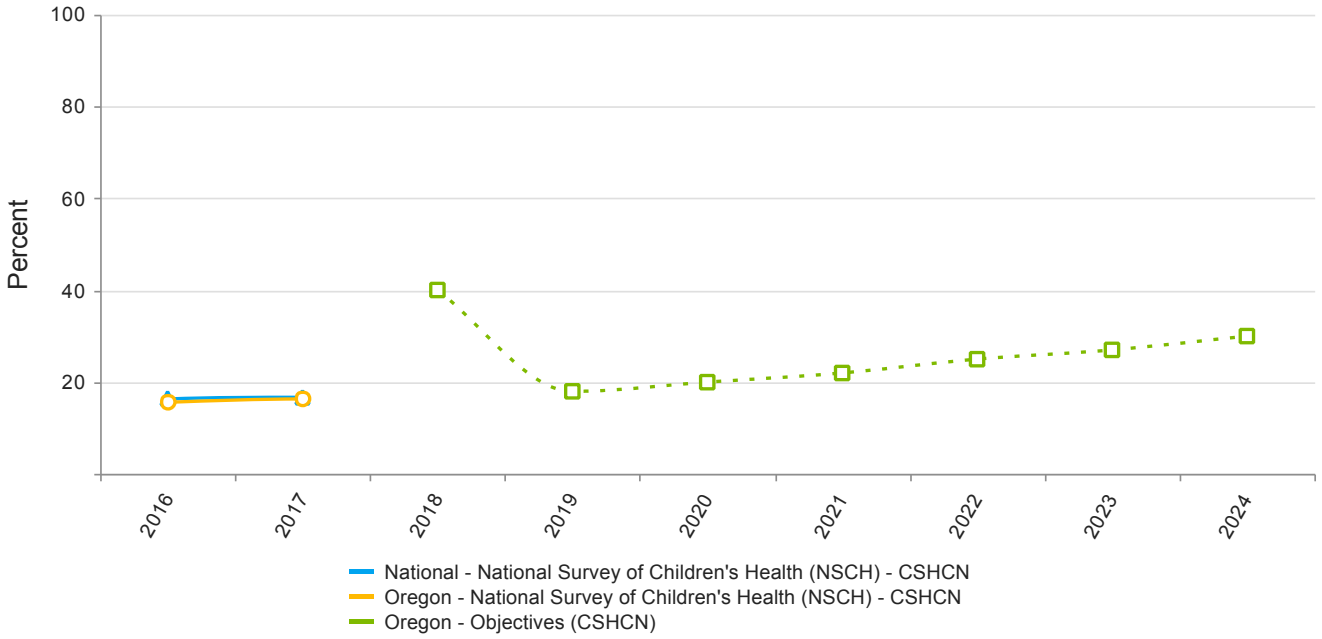
ESM 11.1 - Number of REACH teams that created a plan by which care information for targeted CYSHCN are shared between health care providers and educators.

Measure Status:	Inactive - Replaced		
State Provided Data			
	2016	**2017**	**2018**
Annual Objective		3	4
Annual Indicator	0	1	1
Numerator			
Denominator			
Data Source	REACH teams CQI forms.	REACH teams CQI forms.	REACH teams CQI forms.
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

ESM 11.2 - Number of PACCT (Piloting ACT.md for Care Coordination Team) standing teams with consistent primary care involvement.

Measure Status:				Active	
Annual Objectives					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	2.0	5.0	5.0	5.0	5.0

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care
Indicators and Annual Objectives



NPM 12 - Children with Special Health Care Needs

Federally Available Data			
Data Source: National Survey of Children's Health (NSCH) - CSHCN			
	2016	**2017**	**2018**
Annual Objective			40
Annual Indicator		15.8	16.5
Numerator		12,536	11,986
Denominator		79,458	72,528
Data Source		NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	18.0	20.0	22.0	25.0	27.0	30.0

Evidence-Based or –Informed Strategy Measures

ESM 12.1 - Percent of SPOC initiated or re-evaluated by county public health departments contracting with OCCYSHN, that serve transition-aged youth 12 years and older.

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		10	15
Annual Indicator	0	25.5	19.3
Numerator		35	21
Denominator		137	109
Data Source	SPOC Information Form	SPOC Information Form	SPOC Information Form
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	20.0	20.0	20.0	21.0	22.0	23.0

ESM 12.2 - Percent of the SPOC that are initiated or re-evaluated for youth that address transition planning.

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		80	85
Annual Indicator	0	45.7	66.7
Numerator		16	14
Denominator		35	21
Data Source	SPOC Information Form	SPOC Information Form	SPOC Information Form
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	68.0	70.0	72.0	74.0	76.0	76.0

State Action Plan Table

State Action Plan Table (Oregon) - Children with Special Health Care Needs - Entry 1

Priority Need

High quality, family-centered, coordinated systems of care for children and youth with special health care needs.

NPM

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Objectives

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 PCPCH (medical home) by 20%.

1.3 By 06/2020, develop a 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.

Strategies

11.1. Support regional care integration by implementing a regional, team-based approach to cross systems care coordination (CSCC) based on modifying AHRQ's (2011) medical neighborhood strategy.

11.2. Improve CYSHCN family members' ability to better understand and actively participate in their child's health care decision-making by educating them about Medical Home concepts, REACH, SPOCs, HCT, and CLAS.

11.3. Improve payer and provider responsiveness to CYSHCN by providing or supporting workforce development opportunities focused on the CYSHCN population and their care needs.

11.4. Enhance local community infrastructure to implement child health teams by providing consultation and technical assistance to CCNs to become self-sustaining.

11.5. Integrate state systems of services for CYSHCN and their families through cross sector collaboration, workforce and system infrastructure development.

11.6. Conduct ongoing assessment of Oregon's CYSHCN by developing studies focused on subpopulations of CYSHCN.

11.7. Develop evidence that may show support for the benefit of care coordination for Oregon CYSHCN by designing a study to evaluate SPOC.

ESMs	Status
ESM 11.1 - Number of REACH teams that created a plan by which care information for targeted CYSHCN are shared between health care providers and educators.	Inactive
ESM 11.2 - Number of PACCT (Piloting ACT.md for Care Coordination Team) standing teams with consistent primary care involvement.	Active

NOMs
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health
NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year

State Action Plan Table (Oregon) - Children with Special Health Care Needs - Entry 2

Priority Need

High quality, family-centered, coordinated systems of care for children and youth with special health care needs.

NPM

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

Objectives

2.1 By 2020, increase percent of YSHCN receiving services necessary to transition from pediatric to adult medical care by 5%.

2.2 By 2018, increase number of 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.

Strategies

12.1. Increase the number of family members of YSHCN who are informed about HCT through community conversations and the dissemination of resources based on Got Transition materials.

12.2. Enhance cross systems care coordination for CYSHCN by building county public health workforce capacity to lead or participate in shared care planning that includes transition-aged youth.

12.3. Increase the capacity of adult providers to provide care for transitioning YSHCN by conducting professional development activities using Got Transition resources with 4 adult practices.

12.4. Increase pediatric provider awareness of transition services by incorporating HCT assessment in adolescent well visits.

ESMs	Status
ESM 12.1 - Percent of SPOC initiated or re-evaluated by county public health departments contracting with OCCYSHN, that serve transition-aged youth 12 years and older.	Active
ESM 12.2 - Percent of the SPOC that are initiated or re-evaluated for youth that address transition planning.	Active

NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

2018 Report: NPM 11 Medical Home

National Performance Measure 11: Percent of children with special health care needs having a medical home.

Report on Strategies and Activities October 2017– Sept 2018

Strategy 11.1: Support regional care integration by implementing a regional, team-based approach to cross-systems care coordination based on modifying AHRQ's (2011) medical neighborhood strategy.

OCCYSHN continued to support the regional quality improvement (QI) efforts of three Regional Approach to Child Health (REACH) teams in Central, Eastern, and Southern Oregon. Teams implemented Plan Do Study Act (PDSA) cycles to improve systems of care for CYSHCN.

OCCYSHN continued to provide support specific to the needs of each team, and helped them align REACH with public health modernization and LPHA accreditation efforts. Staff conducted an environmental scan on modernization activities before half-day REACH workshops. The scan provided information on other QI activities happening across the state that might align with REACH work, and improved OCCYSHN's technical assistance to the teams. OCCYSHN hosted group and team-specific conference calls monthly, and provided additional technical assistance as-needed. OCCYSHN monitored REACH teams' progress toward goals, and reviewed their PDSA cycles.

In spring and summer 2018, OCCYSHN facilitated half-day project planning workshops for the Southern and Central Oregon teams at their local sites. During these sessions, REACH teams reviewed data sets for information about medical and social complexity, family-centered care, and culturally and linguistically appropriate services for CYSHCN in their areas. They identified barriers, gaps, and redundancies in local systems of care. These assessments informed their aims for the next year (see Plan Section 11.1).

After they achieved their goal of establishing a policy that allows siblings of CYSHCN to travel with a parent using Medicaid-assisted transportation to medical appointments, the Eastern Oregon team indicated they would not pursue REACH in the next contract year, due to lack of capacity. They plan to strengthen their shared care planning work by developing new partnerships and infrastructure.

ESM: Number of REACH teams that created a plan by which care information for targeted CYSHCN is shared between healthcare providers and educators.

ESM PROGRESS: One team (Southern Oregon) chose to focus on this issue in 2016-17. They worked on developing a HIPAA/FERPA-compliant release of information (ROI). No teams chose to work on ROIs in 2017-2018.

Strategy 11.2: Improve CYSHCN family members' ability to better understand and actively participate in their child's health care decision-making by educating them about Medical Home concepts, REACH, SPOCs, HCT, and CLAS.

During the project year, 8 Parent Partners in 4 regions staffed the ORF2FHIC phone lines (both English and Spanish) 5 days a week. They also conducted workshops for families, and helped develop materials for families. They participated in monthly trainings on community-based services and health care finance topics, along with partner staff from Providence Swindells Center. Sixteen family events served 214 families in 7 communities. Outreach included 3 online events and 2 conferences that drew statewide audiences.

OCCYSHN trained Parent Partners on using topic-specific "conversation starters" in their phone support with families. ORF2FHIC developed these prompts to ensure Parent Partners provide peer support that addresses core MCH performance measures. Workshops and trainings focused on three key topics – Health Care Advocacy, Planning for A Healthy Transition, and Resources and More. The Family Involvement Program (Family Involvement Program) updated content to reflect policy and program changes in the state. They also revised workshop materials based on feedback from program participants. ORF2FHIC developed a packet of handouts for workshop participants that includes a note sheet/problem tracker, a referral sheet for follow up, a list of vetted Oregon family support organizations, and a list resources mentioned in the presentation. Each training event included the following specific elements: short didactic, guided discussion, activity, demonstration of the ORF2FHIC website, and short introduction to the birth anomaly resource materials.

The Family Involvement Program held its annual Parent Partner training in Portland. Topics included updates to the Oregon Health Plan and other CYSHCN systems, newborn screening, and birth anomalies programs. An OCCYSHN staff member presented on health equity and racism. The training also covered data collection requirements, and the roles and responsibilities of Parent Partners. The meeting gave OCCYSHN staff a chance to meet Parent Partners.

The Family Involvement Program collaborated with other OCCYSHN staff in shared care planning (see Strategy 12.2) and Regional Approach to Child Health team (see Strategy 11.1) development. The Family Involvement Program Manager helped plan and implement OCCYSHN Regional Meetings, where she presented to LPHA partners about the family perspective on shared care planning. She wrote a family guide to shared care planning, and with Systems and Workforce Development staff co-produced a voice-over PowerPoint training for community teams. The ORF2FHIC conducted 4 listening sessions on the topic of shared care planning (see Strategy 11.1). During these discussions families shared their experience with and perception of shared care planning. They talk about how shared care planning might help or hinder them, and which professionals they might want to include in the process. Although most parents were comfortable with shared care planning, some expressed reservations. Family Involvement Program staff compiled families' de-identified responses and shared them with OCCYSHN and public health staffs to inform program development.

Strategy 11.3: Improve payer and provider responsiveness to CYSHCN by providing or supporting workforce development opportunities focused on the CYSHCN population and their care needs.

Shared care planning (see Strategy 12.2) is essential to developing workforce responsiveness to CYSHCN needs. OCCYSHN implemented 4 workforce development activities, in addition to Strategy 12.2, detailed below.

Provider Training from the Family Involvement Program

The Family Involvement Program Manager attended all OCCYSHN Regional Meetings to facilitate a 45-minute presentation and discussion focused on engaging families in shared care planning. Sessions included family perceptions of shared care planning, gleaned from statewide listening sessions (see Strategy 11.2). Sessions also included an exploration of parent-professional partnerships, and the vital role professionals play as family allies. OCCSYHN's Family Involvement Program provided training and information to a variety of professional healthcare organizations, including LEND Training Cohort, OHSU Pediatric Cardiology, Institute on Development & Disability/Doernbecher Social Work Departments, Doernbecher Family Life Program, Emergency Medical Services for Children, and the Oregon Medicaid Advisory Committee. Family Involvement Program staff also provided feedback to OHSU Gabriel Park Family Practice about family engagement materials. Family Involvement Program staff wrote Parent Partner job description templates for community and health programs, including Salem Hospital and the Autism Identification Teams (see below). The Family Involvement Program Manager provided one-to-one technical assistance to health care providers in Coos Bay and Medford on employing peer navigators in their practices. New opportunities for partnerships arose throughout the program year, including ORF2FHIC specific outreach to social workers from 6 culturally-specific organizations in the Portland metro region.

CaCoon

OCCYSHN contracted with 33 LPHAs to implement public health nurse home visiting services in 34 of Oregon's 36 counties. CaCoon served 1,358 CYSHCN in 7,889 visits; 89% of CYSHCN served were insured through Medicaid. Transition-aged youth ≥ 12 years made up 12% of CYSHCN served by CaCoon. Technical assistance to LPHAs to facilitate their county-level work remained a key function for OCCYSHN. CaCoon orientation for new public health nurses consists of a PowerPoint-based curriculum and assessment, and participation in a 30-60 minute three-way phone call with each nurse's supervisor and OCCYSHN's Care Coordination Specialist to discuss the new nurse's knowledge of CYSHCN needs, and to plan for continuous improvement of their CaCoon practice. Through June 2018, two new nurses completed the CaCoon and shared care planning orientation. Our Care Coordination Specialist continued to connect LPHAs to OHA guidance on Targeted Case Management (TCM) billing. Additionally, OCCYSHN partnered with the OHA-MCH Nurse Team through monthly meetings that promote and support alignment across home visiting programs, which is important given overlap in the local public health nurse workforce.

Most LPHAs reported meeting most CaCoon standards in the first of their now-annual CaCoon Accountability Reports (2016-2017). When agencies reported challenges in meeting a given standard, they provided thoughtful feedback on opportunities for improvement. Challenges included: (1) time, bandwidth and experience barriers to integrating shared care planning into CaCoon practice, (2) lack of condition-specific educational opportunities, and (3) lack of experience with youth transition to adult health care. OCCSYHN conducted individual discussions with LPHAs to begin addressing each of these barriers, an effort which will continue into the next fiscal year.

Coffee Time Webinars

In partnership with OHSU's Department of Pediatrics, OCCYSHN supported distance-learning opportunities for Oregon

health care providers in the form of monthly “Coffee Time” webinars. The webinars offered continuing medical education credits for physicians. OHSU Pediatrics staff provided administrative support to market and conduct the webinars. OCCYSHN’s Medical Consultant chaired the planning committee, which identified topics and speakers. In FY18, there were 9 Coffee Time webinars. Each lasted 35 minutes and included an instructional presentation followed by questions and answers. Topics included depression screening, iron deficiency, dental issues in CYSHCN, and adverse childhood events. Presenters used case reports to demonstrate key points, provide resources, and discuss issues impacting CYSHCN and their families. Attendance ranged from 23 to 48 professionals per webinar.

ACCESS

In 2013, HRSA awarded OCCYSHN a State Implementation Grant for Improving Services for Children and Youth with Autism Spectrum Disorder (ASD). OCCYSHN’s grant effort was called *Assuring Comprehensive Care through Enhanced Service Systems for Children with Autism and Other Developmental Disabilities (ACCESS)*. The ACCESS project supported development of 8 community-based teams of educational and medical professionals who conducted comprehensive diagnostic evaluations for young children at risk for ASD. Teams included Parent Partners to provide peer support to families, and family perspective to professionals. ACCESS teams. The goal of ACCESS was to provide coordinated autism evaluation at the community level to improve early diagnosis, referral and entry to ASD services. ACCESS emphasized culturally appropriate, family centered care.

HRSA funding for ACCESS ended in December 2016. However, 6 teams continued their work with assistance from OCCYSHN staff and other OHSU faculty, in the absence of external funding. Given the teams’ efficacy in increasing access to care for children and their families, OCCYSHN provided FTE support for OHSU faculty to provide guidance and consultation to the remaining teams in 2018. OCCYSHN did a brief needs assessment survey of ACCESS teams. Staff identified (a) autism education, and (b) infrastructure for telehealth and telepractice as high priorities. OHSU’s Institute of Development and Disability (IDD) autism clinic director consulted with each ACCESS team. OCCYSHN provided grants to teams in Clatsop, Coos, and Jackson Counties to hire Parent Partners. OCCYSHN hosted two topical webinars and one 2-hour virtual workshop to provide the sustained teams with additional technical assistance. Finally, OCCYSHN began to build telehealth and telepractice infrastructure for the existing teams.

Strategy 11.4: Enhance local community infrastructure to implement child health teams by providing consultation and technical assistance to Community Connection Network teams to become self-sustaining.

Two of 9 Community Connection Network teams continued functioning as successful cross-sector communities of practice following the discontinuation of OCCYSHN funding: Coos Bay and Clatsop. Lessons learned from CCN teams provided a basis for OCCYSHN’s shared care planning strategy (see Strategy 12.2). As shared care planning developed, OCCYSHN explored ways to (a) build upon the work of sustained CCN teams, (b) support additional teams as they reestablish themselves, and (c) provide technical assistance on implementing “standing teams” for shared care planning (elaborated on in the FY2020 plan section of this report).

Strategy 11.5: Integrate state systems of services for CYSHCN and their families through cross sector collaboration, workforce and system infrastructure development.

With the conclusion of the HRSA D70 State Implementation Grant, *Enhancing Systems of Services for CYSHCN*, OCCYSHN’s efforts to integrate systems at the state level during FY18 focused primarily on continuing our collaboration with the 211 Information Center (211info). The grant provided an opportunity to formalize a partnership between OCCYSHN’s Family Involvement Program (Family Involvement Program), ORF2FHIC, and 211info. The goal of this partnership was to increase referrals to ORF2FHIC when it was likely that a caller was the parent or provider of a CYSHCN, and to ensure that 211info had appropriate information to share with CYSHCN-related callers.

211info administers a voluntary follow-up survey to callers, to collect data about whether referrals met caller’s needs. OCCYSHN and 211info collaborated on revising the survey questionnaire to measure the D70 grant’s Shared Resource aim. After the grant ended, OCCYSHN, ORF2FHIC, and 211info continued their partnership. OCCYSHN continued collecting survey data, and provided professional development to 211info staff. The ORF2FHIC Coordinator trained 211info staff on who might benefit from ORF2FHIC services and how to access those services. Additionally, the ORF2FHIC Coordinator collaborated with 211info on website modifications that improved linkages to ORF2FHIC. OCCYSHN’s Assessment and Evaluation team worked with 211info to revise the follow-up survey to capture additional information on the types of needs families had. The Assessment and Evaluation team established quarterly meetings with 211info’s Child Care Line Manager and Lead Data Analyst to review and discuss follow-up survey and referral data. Assessment and Evaluation staff also worked with 211info to collect these data from the Maternal and Child Health call line.

The D70 grant allowed OCCYSHN to establish a CYSHCN Advisory Board to (a) provide input into OCCYSHN's D70 grant, and (b) serve as a networking and information-sharing venue about state level efforts affecting Oregon CYSHCN and their families (e.g. health care and early learning systems transformations). In FY18, OCCYSHN's director solicited input from board members on the future function and structure of the group. OCCYSHN determined that going forward, the group would serve as a venue for (1) obtaining state-level partner input on Title V strategies, and (2) collaborating with state-level partners to realize *Systems Standards for CYSHCN* (AMCHP, 2014). OCCYSHN identified a core group of state-level partners with whom to initiate conversations about realizing this group's second purpose. The group will be asked to consider domains of systems standards (AMCHP, 2014; AMCHP & NASHP, 2017) as they align with OCCYSHN's block grant priorities: Medical Home, Access to Care, and Health Care Transition. The advisory group's new name is the Collaborative to Align Systems for CYSHCN (CASC).

To build capacity to lead strategic statewide planning and advocacy for CYSHCN, OCCYSHN tracked policy to align program efforts, identify threats and opportunities, and prepare for anticipated changes. OCCYSHN staff participated on policy committees, and provided public comment and presentations to inform policymakers. OCCYSHN's Director participated in Health Share's (Portland-metro area CCO) regional collaborative focused on kindergarten readiness, and sat on the Oregon Council on Developmental Disabilities. OCCYSHN's Family Involvement Program Manager served on the state Medicaid Advisory Committee and on OCDD's Sustaining Families Committee. A Parent Partner participated on the State Interagency Coordinating Council (for Early Intervention and Early Childhood Special Education). OCCYSHN's Systems and Workforce Development Manager served on the Early Hearing Detection and Intervention (EHDI) program advisory board.

OCCYSHN staff presented information on shared care planning to a Telepractice and Early Learning Hub Event hosted by the Clackamas County Education School District (ESD) in March 2018. OCCYSHN's A&E Manager provided public comment to Oregon's Health Plan Quality Metrics (HPQM) Committee to advocate for the inclusion of CYSHCN-specific metrics that align with Title V Block Grant priorities (Supporting Document 1). OCCYSHN continued to partner with the Oregon Pediatric Improvement Partnership (OPIP), whose director is a member of the HPQM Committee. OCCYSHN and OPIP staff successfully presented testimony to the HPQM to ensure that two key metrics tools, the Family Experience of Care Coordination (FECC; Mangione-Smith et al.) survey items and the Pediatric Integrated Care Survey (PICS; Antonelli et al.) were included on the menu of health plan metric options. In February 2018, OCCYSHN staff attended an intensive 3-day training hosted by a prominent Oregon health insurance organization, CareOregon. The event focused on Patient-Centered Primary Care Transformation using the Institute for Healthcare Improvement's "Coaching for Improvement" model. In addition to gaining a better understanding of primary care engagement and quality improvement and the interaction among the building blocks of primary care. The training improved OCCYSHN's ability to engage primary care in regional and local care integration efforts.

Strategy 11.6: Conduct ongoing assessment of Oregon's CYSHCN by developing studies focused on subpopulations of CYSHCN.

Ongoing assessment of Oregon's CYSHCN consisted of three primary activities, detailed below.

Children with Medical Complexity in Medical Home Practices

OCCYSHN's Assessment and Evaluation (A&E) unit collaborated with Neal Wallace, PhD, a health economist with the OHSU-PSU School of Public Health. Dr. Wallace and colleagues completed an evaluation of Oregon's Patient-Centered Primary Care Home (PCPCH) program in September, 2016. The study examined program implementation and outcomes achieved during the first four years of the program. Dr. Wallace led quantitative analyses to examine changes in service utilization and costs for patients cared for in primary care practices identified as PCPCHs compared to patients cared for in non-PCPCH primary care practices. The OCCYSHN A&E Manager (Alison Martin) collaborated with Dr. Wallace in replicating these analyses for Children with Medical Complexity using the Pediatric Medical Complexity Algorithm (Simon et al., 2014). Sara (Sally) Bachman, PhD, and Catalyst Center Principal Investigator at the time, consulted on the project.

Drs. Wallace and Martin worked together to develop the analytic plan. Dr. Wallace computed the analyses and prepared tables of results, which were discussed with Drs. Martin and Bachman. In January 2018, OCCYSHN hosted a meeting of key stakeholders to share preliminary results. Alison and Neal facilitated the meeting. Meeting participants included Sally Bachman, both the Title V and Title V CYSHCN Directors, several CYSHCN Advisory Group members (i.e., PCPCH program manager, Oregon Pediatric Improvement Partnership Director, OHA Health Policy Division Operations and Policy Analyst), and OCCYSHN's Medical Consultant. Because meeting materials were preliminary, recipients of the results signed non-disclosure agreements. Sally recommended this approach to ensure that OCCYSHN retained control over their dissemination. Sally expressed excitement about this work. She noted that these are the types of questions that Title V CYSHCN agencies should be asking, and these are issues on which Title V CYSHCN should collaborate with State Medicaid.

CYSHCN with Behavioral/Mental Health Conditions

Olivia Lindly, PhD, Kate Lally, MSW/MPH, and OCCYSHN's A&E Manager revised a manuscript summarizing the analyses using 2009-2010 NS-CSHCN data, and submitted it to the *Maternal and Child Health Journal*. The review process was disappointing. The journal took an excessive amount of time assigning a reviewer to the article. The authors did not receive feedback in FY2018.

NSCH Results

Assessment and Evaluation staff reviewed NSCH results and presented key information to OCCYSHN staff. The staff initiated planning to collect primary data from subgroups of CYSHCN and their families about which little is known (e.g., CYSHCN who are members of communities of color, CYSHCN who live in foster care, CYSHCN who experience medically complex conditions). Work began on implementing culturally responsive data collection for the 2020 needs assessment.

Strategy 11.7: Develop evidence that may show support for the benefit of care coordination for Oregon CYSHCN by designing a study to evaluate SPOC.

Assessment and Evaluation staff continued to collect and analyze formative evaluation data. Staff modified data collection instruments, disseminated results to LPHA partners, and submitted a presentation proposal about first year findings to a national conference. Assessment and Evaluation staff consulted with Jeannie McAllister, BSN, MS, MHA, about ongoing shared care planning evaluation efforts (see Strategy 12.2).

LPHAs completed a **S**hared care plan **I**nformation **F**orm (SIF) following each shared care planning meeting. SIF data describe the date, the participants, the manner in which participants participated, the facilitator, the reasons for choosing this child for shared care planning, and descriptive information about the child and family. Assessment and Evaluation staff received OHSU Institutional Review Board approval to update the SIF used during year 2 data collection to include each child's initials. Combining initials with date of birth will enable OCCYSHN to track SIF data by child over time. In response to feedback from LPHAs, OCCYSHN updated the SIF race/ethnicity question to include more comprehensive race/ethnicity categories that better reflect the complexity of both. We modified the content and timing of annual open-ended survey of LPHA staff. Finally, we included in our IRB protocol the Record of Technical Assistance (TA) form developed in 2016-2017.The form allows Systems and Workforce Development staff to track their TA to LPHAs. Family Involvement Program and Systems and Workforce Developoment staff informed modifications to all data collection instruments.

Dr. Martin and Katharine Zuckerman, MD, MPH, submitted a grant proposal to fund an outcome evaluation pilot of OCCYSHN's shared care planning work. The proposal scored well but was not awarded funds. Dr. Martin began discussions with OCCYSHN leadership about how we might begin to implement parts of the outcome evaluation design, first focusing on family outcomes. Our 2018-2019 block grant report and the current document's (2019-2020) plan will expand on this outcome evaluation.

OCCYSHN submitted a proposal to CityMatCH to share year 1 evaluation findings specific to adolescent transition. The 2018-2019 block grant report will contain those findings. Assessment and Evaluation staff shared other results during monthly TA webinars with LPHA partners. SIF results follow in Exhibits 11.7.1 through 11.7.4.

- 109 shared care plans for Oregon CYSHCN in 2017-18.
- 88 SIFs were for children birth to 12 years.
    - 58 were new shared care plans.
    - 30 were re-evaluated shared care plans.
- 21 SIFs were for young adults 12 to ≤ 21 years.
    - 10 were new shared care plans.
    - 11 were re-evaluated shared care plans.
- 98 SIFs were for CYSHCN identified as complex; that is, ≥2 condition types (medical, behavioral, developmental, social, other).
- CaCoon PHNs most often identified the child or young adult for whom a shared care plan was created.

Exhibit 11.7.1 Demographic Characteristics of Oregon CYSHCN Who Received Shared Care Planning, Year 1 (2016-2017) and 2 (2017-2018)

Child Demographics

Less than 1 year old up to 12 years

Children Year 1 (n = 102)	Children Year 2 (n = 88)
Average age: 4 years	Average age: 5 years
Reported frequency of condition types • Developmental (81%) • Social complexity (65%) • Medical (57%)	Reported frequency of condition types: • Developmental (85%) • Medical (68%) • Social complexity (58%)
Race/Ethnicity • 75% Caucasian/White • 31% Hispanic or Latino origin or descent • 7% "I don't know" • 6% American Indian/Alaska Native	Race/Ethnicity • 58% Caucasian/White • 43% Hispanic or Latino origin or descent • 13% More than 1 race
19% speak Spanish as their primary language	25% speak Spanish as their primary language

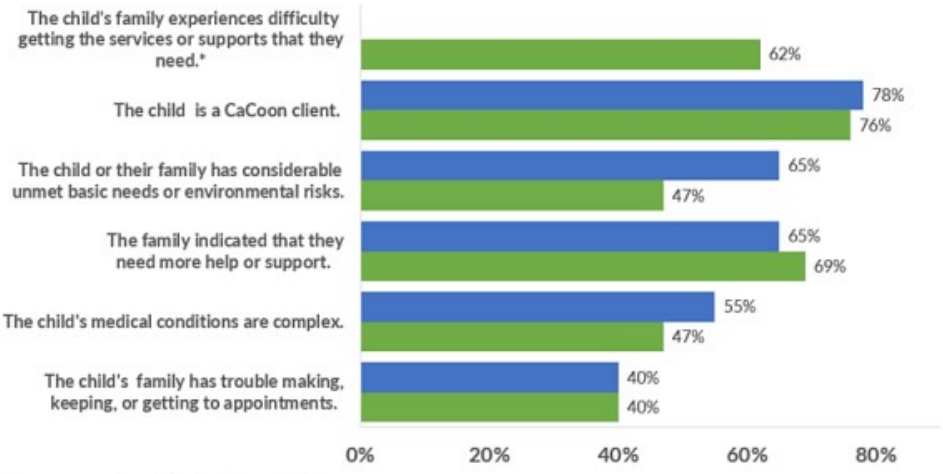
Source: 2016-17 & 2017-18 Shared Care Plan Information Forms

Young Adult Demographics

12 years old up to 21 years

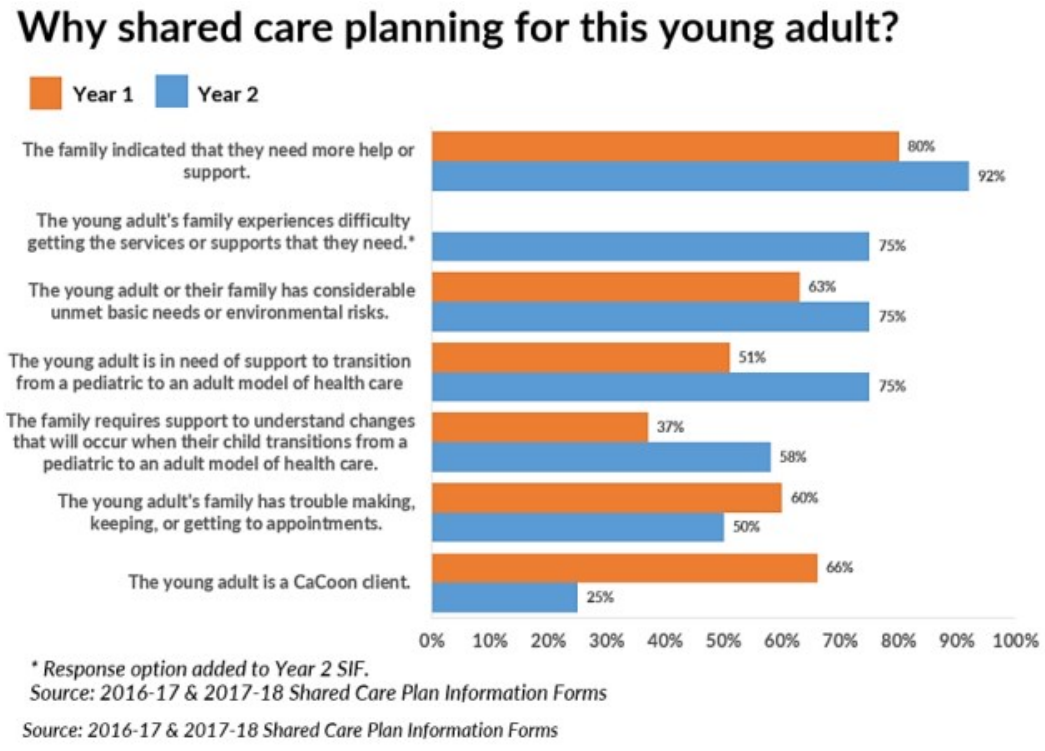
Young Adults Year 1 (n = 35)	Young Adults Year 2 (n = 21)
Average age: 15 years	Average age: 18 years
Reported frequency of condition types • Developmental (80%) • Social complexity (80%) • Behavioral/mental (69%) • Medical (69%)	Reported frequency of condition types: Behavioral/mental (90%) Social complexity (86%) Medical (62%)
Race/Ethnicity • 89% Caucasian/White • 31% Hispanic or Latino origin or descent • 6% "I don't know"	Race/Ethnicity 67% Caucasian/White 39% Hispanic or Latino origin or descent 19% More than 1 race
17% speak Spanish as their primary language	19% speak Spanish as their primary language

Source: 2016-17 & 2017-18 Shared Care Plan Information Forms



** Response option added to Year 2 SIF.*
Source: 2016-17 & 2017-18 Shared Care Plan Information Forms

Exhibit 11.7.2. Most Frequently Reported Reasons for Creating a Shared Care Plan, Year 1 (2016-2017) and 2 (2017-2018)



Source: 2016-17 & 2017-18 Shared Care Plan Information Forms

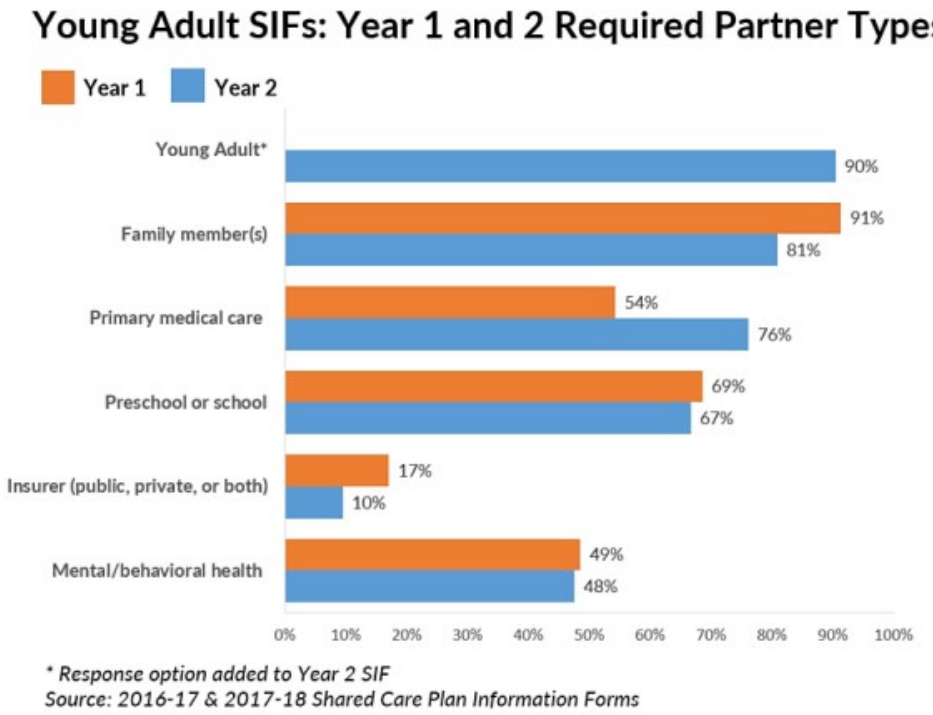
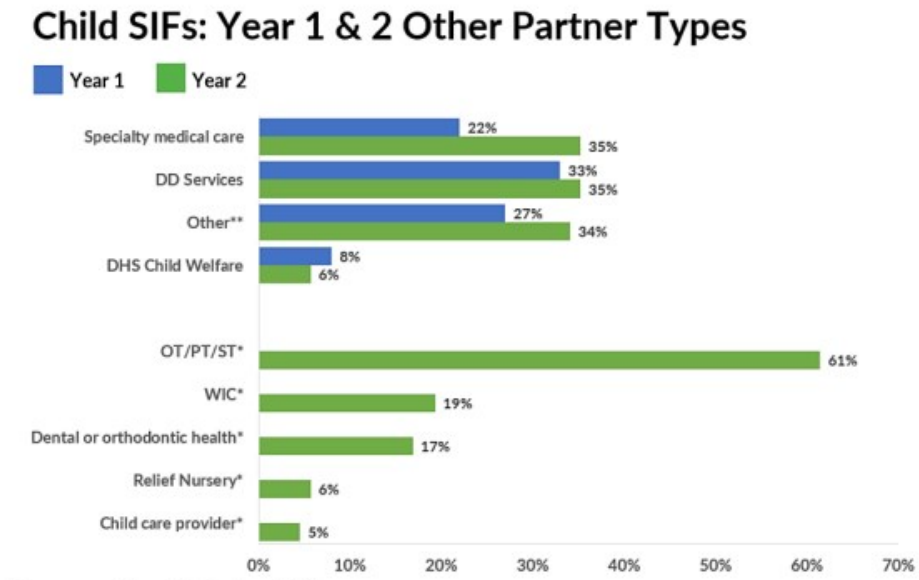
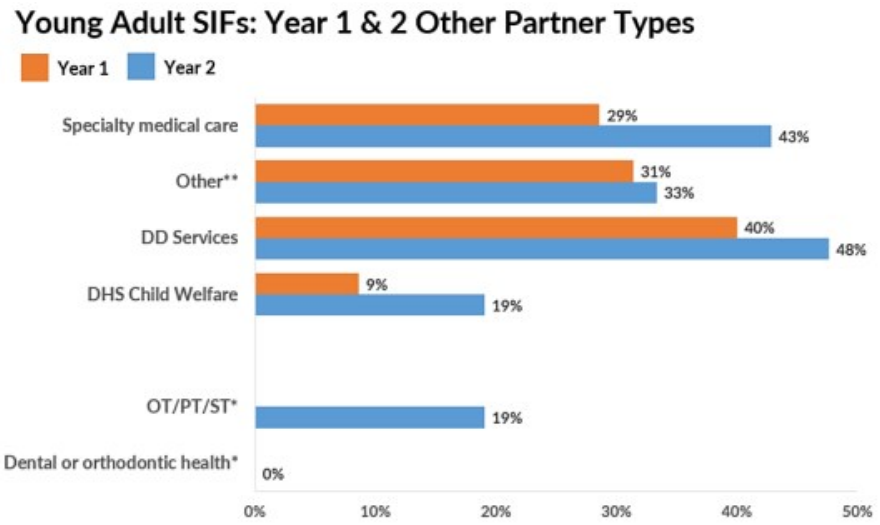


Exhibit 11.7.4. Types of Other Partners on the CYSHCN's health team, Year 1 (2016-2017) and 2 (2017-2018)



** Response options added to Year 2 SIF.*
*** Examples of Other partner types include Parent Advocate, Dietician, and Spanish Interpreter.*
Source: 2016-17 & 2017-18 Shared Care Plan Information Forms



** Response option added to Year 2 SIF.*
*** Examples of Other partner types include Family Support Specialist, Youth Mentors, and Healthy Families Home Visitor.*
Source: 2016-17 & 2017-18 Shared Care Plan Information Forms

2018 Report: NPM 12 Health Care Transition (HCT)

National Performance Measure 12: Percent of adolescents with special health care needs who received services necessary to make transitions to adult health care.

Report on Strategies and Activities October 2017 – Sept 2018

Strategy 12.1: Increase the number of family members of YSHCN who are informed about HCT through community conversations and the dissemination of resources based on Got Transition materials.

The ORF2FHIC refined its 90-minute training on health care transition (HCT) and actively promoted it among Oregon family organizations. Twenty-two families attended 3 HCT trainings in 3 communities. A cultural broker in Portland's Black community was engaged to assess the cultural appropriateness of the training materials. The cultural broker, also the parent of a young adult with special health needs, convened a group of Black parents of CYSHCN. They assessed the materials and provided input. Overall, the group gave the materials high marks. They offered suggestions about the physical layout of the materials, and the images used. Family Involvement Program staff and the cultural broker revised the materials to better serve Black parents.

The Family Involvement Program trained ORF2FHIC Parent Partners on HCT during their annual training. The Parent Partners had no lived experience with HCT, because their children were younger. The training covered the collaboration required for a successful transition, using Got Transition youth and parent readiness checklists, and minors' rights to request or refuse health care. At the request of the physician champion in a primary care medical home, Parent Partners reviewed that practice's transition "birthday letters" and offered suggestions.

ORF2FHIC collected HCT materials aimed at families, youth, and providers and shared them on the newly revamped website (https://www.ohsu.edu/oregon-family-to-family-health-information-center/resources-health-care-transition). The Family Involvement Program shared the transition pages with social workers, nurses, and other providers. Additionally, ORF2FHIC highlighted the updated page of HCT materials on its Facebook page.

Strategy 12.2: Enhance cross systems care coordination for CYSHCN by building county public health workforce capacity to lead or participate in shared care planning that includes transition-aged youth.

OCCYSHN continued to support cross-systems care coordination as an evidence-informed strategy to address the health and related needs of CYSHCN. OCCYSHN continued implementing an LPHA-led shared care planning strategy, and gave individualized TA that addressed the unique needs of each LPHA. LPHA contracts directed that shared care planning teams must minimally include representatives from the family, public health, primary care, education, mental health and a payer. Contracts continued to specify that a required number of plans be created or re-evaluated. Twenty percent of the plans were required to serve children/youth with complex needs, and 20% were required to address health care transition for a child 12 years or older. Contracts required that a specific number of SPOCs be re-evaluations of previously developed plans. Formative evaluation data collected from LPHAs helped staff offer more direct, specific and collaborative support.

OCCYSHN's care coordination home-visiting program, CaCoon, (see Strategy 11.3) remained an important foundation for shared care planning. Using our previously created crosswalk of CaCoon Standards, shared care plan "essential elements," and the *Systems Standards for CYSHCN* (AMCHP, 2014) OCCYSHN developed an enhanced understanding of how both CaCoon and shared care planning help achieve these standards. CaCoon and shared care planning align with initiatives for public health modernization and accreditation, both important drivers for LPHA change. This alignment between Title V strategies and Oregon public health modernization reinforced shared care planning as a tool for defining a new role for public health, extending care coordination beyond what primary care providers can do.

LPHA Technical Assistance

To engage LPHAs and their community partners, OCCYSHN hosted 4 OCCYSHN Regional Meetings between April and June 2017. The meetings were in Tualatin, Roseburg, La Grande, and Bend. The theme "Come to the Table for Kids with Special Health Needs." The agenda featured (a) facilitated shared learning activities, (b) listening sessions to build OCCYSHN's understanding of what works well and where the barriers are in the shared care planning and home-visiting work and establish a dialogue between OCCYSHN and our community partners, and (c) opportunities to inform and engage new shared care planning partners in each community. The Family Involvement Program (Family Involvement Program) Manager led discussions on family-centered goal setting in shared care planning, and on the updated ORF2FHIC website. OCCYSHN's Director presented on strategies for engaging primary care in shared care planning.

OCCYSHN provided monthly TA webinars for LPHAs implementing shared care planning. The webinar format encouraged cross-LPHA communication. Topics included discharge planning, assessment and evaluation, collaborating with primary care and Developmental Disability services, family and youth goal-setting, and lessons learned to date from shared care planning implementation. The webinars aimed to support shared care planning work while building an authentic learning community. Materials and highlights were emailed to participants afterwards, and shared online. To inform improvements to web-based LPHA support, OCCYSHN surveyed partners about their technological capacity. The results informed changes to our webinar platform.

OCCSYHN updated the Shared Care Planning Handbook to make it more concise, accurate, and accessible. In response to requests for TA on engaging other community partners in shared care planning, OCCYSHN developed a customizable PowerPoint presentation for LPHAs to use for outreach. This and other resources for LPHAs were posted on OCCYSHN's

shared care planning web page.

In response to LPHA concerns about a lack of local infrastructure to support shared care planning, OCCYSHN provided one-time additional funds to each contracted LPHA. The funds supported LPHAs to build partnerships, secure tools and technology, and fine-tune processes for shared care planning. OCCYSHN provided project planning templates and individual consultations on using the infrastructure funds. OCCYSHN's Director and Systems and Workforce Development Manager visited Columbia County in summer 2018 to discuss the use of the additional funds. LPHAs will report to OCCYSHN on their use of the infrastructure funds in September 2019.

Technical Assistance to OCCYSHN

In February 2018, OCCYSHN began contracting with Jeanne W. McAllister, BSN, MS, MHA, a national expert on family-centered care coordination for CYSHCN. The contract allowed OCCYSHN to continue monthly TA conference calls that were originally funded with MCHB TA funds. With the new contract, the TA calls were split between OCCYSHN's Systems & Workforce Development and Assessment & Evaluation teams. Topics included increasing family-centeredness with quality improvement approaches, and supporting LPHA partners in shared care planning for health care transition. In addition, OCCYSHN staff engaged in professional development, including participation in an Ambulatory Care Consortium and a Diversity and Inclusion Task Force, among others. OHSU Inter-Professional Educational opportunities enhanced our agency in supporting team based care coordination.

ESM 1: Percent of shared care plans initiated or re-evaluated by county public health departments contracting with OCCYSHN that serve transition-aged youth 12 years and older. The FY18 objective was 15%, and 19.3% of shared care plans created or re-evaluted served CYSHCN in this age group.

ESM 2: Percent of the shared care plans that are initiated or re-evaluated for youth that address transition planning. Our FY18 objective was Our FY18 objective was 85%, and 66.7% of shared care plans addressed transition planning (see Form 10 for more detail).

Strategy 12.3: Increase the capacity of adult providers to provide care for transitioning YSHCN by conducting professional development activities using Got Transition resources with 4 adult practices.

OCCYSHN staff collaborated on two quality improvement transition projects with OHSU partners. First, through a memorandum of understanding, OCCYSHN worked with OHSU Family Practice on a 6-month quality improvement project to establish a transition policy using the Got Transition framework in an FQHC. With QI support from OCCYSHN and the vetting of language by Family Involvement Program, the practice successfully developed and implemented a transition policy and process for sending "birthday letters" to patients at ages 13, 15 and 18. The letters described changes to the way health care is provided as the youth develops. Second, OCCYSHN provided consultation to a complex care and transition QI project with OHSU Doernbecher Children's Hospital General Pediatrics, (a) developing appropriate informational resources for families through OCCYSHN's Family Involvement Program, (b) sharing lessons learned from content experts in transition, (c) connecting the quality improvement team to additional information and resources, and (d) identifying surveys about family experiences of care from which to draw items for the project.

Further, OCCYSHN collaborated with OHSU Institute on Development and Disability's Lifespan Transition Clinic. The clinic provides assessment of transition needs and works with families and youth referred from general pediatric and pediatric specialty clinics to identify their transition goals. OCCYSHN facilitated warm hand-offs to LPHA-based public health nurses implementing shared care planning, as needed. OCCYSHN staff also participated in the OHSU Transition Task Force, which included adult providers. The purpose of participation was to (a) share information and ideas, and (b) identify opportunities for leveraging OCCYSHN's work.

CMC CoIIN Project

To align with our state Title V CYSHCN priority, Oregon's CoIIN project focuses on health care transition. FY18 overlapped with CoIIN project year 1 and 2. During this time, our CoIIN Advisory Team solidified our problem statement and completed our root cause analysis. Our problem statement is "young adults with medical complexity and their families are not adequately prepared for, or supported in, the transition from pediatric to adult healthcare." We completed our root cause analysis by conducting an environmental scan. Three family representatives serve on the Advisory Team; the Family Involvement Program Manager and two external Family Representatives, Ana Valdez and BranDee Trejo. Essential data for the scan came from 12 interviews conducted by Ana and BranDee, both of whom participated in OHSU's Institutional Review Board-required study team trainings and project-specific data collection trainings conducted by Assessment and Evaluation staff. All three family members recruited potential parents and screened them for study eligibility. Simultaneously, other Advisory Team members (OCCYSHN's System and Workforce Development Manager, Medical Consultant, and Katharine Zuckerman, MD) completed a scan of existing HCT resources to identify those that might be applicable to developing our quality improvement project once the environmental scan was completed.

Other Transition Activities

- OCCYSHN staff used the American Academy of Pediatrics' Health Care Transition Extension for Community Healthcare Outcomes curriculum, which increased internal capacity to support HCT partnerships.
- As part of its work with the OHSU Transition Task Force, in October 2017, OCCYSHN partnered with the OHSU Department of Pediatrics, OHSU's University Center for Excellence in Developmental Disabilities, and the Institute on Development & Disability to successfully host a Transition to Adult Healthcare conference for physicians, care coordinators, residents and medical students throughout the state.

Strategy 12.4: Increase pediatric provider awareness of transition services by incorporating HCT assessment into adolescent well visits.

OCCYSHN continued to explore with the OHA Adolescent and School Health the integration of HCT assessments into adolescent well visit guidance, but schedule constraints limited our ability to progress.

OCCSYHN participated in 2 OHSU HCT workgroups (see Strategy 12.3) and informed the development and modification of clinical workflows to include HCT assessments during well-visits.

2020 Plan: NPM 11 Medical Home

National Performance Measure 11: Percent of children with special health care needs having a medical home.

Planned strategies, ESMs and activities for October 2019 – September 2020

Strategy 11.1: Support regional care integration by implementing a regional, team-based approach to cross systems care coordination based on modifying AHRQ's (2011) medical neighborhood strategy.

LPHAs in Central and Southern Oregon reported limited workforce capacity for Regional Approach to Child Health (REACH). To leverage the work of these teams, OCCYSHN will help them integrate their REACH quality improvement experiences, and the cross-sector relationships they established, into their shared care planning work. This integration will move communities along a continuum of cross-systems care coordination that starts with shared care plans and leads to improving local systems of care for CYSHCN. This aligns with OCCYSHN's long-term vision for building community capacity to serve CYSHCN.

Strategy 11.2: Improve CYSHCN family members' ability to better understand and actively participate in their child's health care decision-making by educating them about Medical Home concepts, REACH, SPOCs, HCT, and CLAS.

The Family Involvement Program works directly with family members of CYSHCN across the state. Family Involvement Program helps families collaborate effectively on their child's health care decisions, and influence systems improvement efforts. The Family Involvement Program will continue to train and support Parent Partners, including bi-cultural Parent Partners. Family Involvement Program will host 10 trainings per year on community-based CYSHCN services and systems to inform Parent Partners. These trainings will include guest speakers from key CYSHCN-serving agencies. Family Involvement Program will host an annual retreat for Parent Partners and other key family representatives. Parent Partners will use practice scenarios to refine their support to families with complex situations, particularly health care financing and systems navigation issues. Using a checklist of prompts called "conversation starters," Parent Partners will practice keeping their support centered on health care and related needs. OCCYSHN medical staff will collaborate with ORF2FHIC to review clinical resources.

Parent Partners will continue to staff ORF2FHIC phone lines, conduct trainings and workshops, do community outreach, and share resources with families. Materials and resources will include family-written tip sheets, tool kits, and worksheets. Topics will include health care financing, systems navigation, emotional support, leadership and advocacy, and specific birth anomalies. Additionally, to reach underserved families of CYSHCN, Parent Partners will continue working with social workers in 8–10 culturally specific organizations in the Portland metro area. They will start establishing relationships with an additional 2–4 culturally specific organizations in rural communities. The goal is to engage social workers, or community leaders, as a bridge to families of CYSHCN. Resources for cultural and linguistic translation and interpretation will be identified to meet the needs of community organizations. Family Involvement Program and the social workers/community members will identify key publications for translation and dissemination in the community.

Family Involvement Program staff will explore the feasibility of families referring themselves for shared care planning, as the process can enhance family agency.

Strategy 11.3: Improve payer and provider responsiveness to CYSHCN by providing or supporting workforce development opportunities focused on the CYSHCN population and their care needs.

OCCYSHN's workforce development activities will continue to include shared care planning (see Strategy 12.2), and the efforts detailed below. OCCYSHN's ongoing support for Coffee Time webinars will be determined.

Provider Training Providing By Family Involvement

The Family Involvement Program (Family Involvement Program) Manager will continue to serve as the Family Faculty for the Leadership Excellence in Neurodevelopmental and related Disability (LEND) fellowship program. She will contribute to the LEND curriculum, supervise the LEND Family Trainee, and coordinate the Family Mentor Program (an experiential learning experience for clinicians). The Family Involvement Program will provide technical assistance to OHSU's School of Medicine

to develop a mentor program similar LEND's, as part of an elective course for medical students focused on family-centered care. The Family Involvement Program, through the Family-to-Family Health Information Center grant, will identify opportunities within the Oregon Department of Consumer and Business Services, the Oregon Health Authority, and the Department of Labor Employee Benefits Security Administration to inform insurers about coverage needs of CYSHCN. Additionally, the Family Involvement Program will collaborate with Oregon midwives and home birth advocates to promote newborn screening initiatives.

The Family Involvement Program Manager contributes regularly to OCCYSHN's Piloting ACT.md for Care Coordination Teams Learning Community (see Strategy 11.4), and monthly shared care planning interactive video learning sessions with LPHAs (see strategy 12.2). She will continue her participation in this venue, which builds LPHA ability to improve families' confidence, skills, and knowledge to care for their CYSHCN. In 2020, Family Involvement Program staff will make presentations, assist with curriculum development, and participate in OCCYSHN Regional Meetings. Family Involvement Program staff will also help LPHAs find resources for families served by shared care planning and CaCoon.

In late 2019, the Family Involvement Program Manager will start contacting LPHAs to identify families who benefited from shared care planning to serve as "ambassadors." With coaching and support from the Family Involvement Program, these ambassadors will raise awareness by speaking to groups of families or professionals about their shared care planning experiences.

CaCoon

The CaCoon program will continue to provide nurse home visiting services focused on care coordination for CYSHCN and their families. OCCYSHN staff will evaluate the needs of the CaCoon workforce, and develop a plan to support areas of identified need. These may include (a) orientation and ongoing training on CaCoon, (b) coordination between OHA and OCCYSHN nurse home visiting programs, (c) Targeted Case Management (TCM) billing and (d) the role of community health workers in enhancing shared care planning. Additionally, OCCYSHN will provide nurses with information about health equity and social determinants of health. Training on unconscious bias will be included in the CaCoon orientation.

OCCYSHN will continue to promote and support family-centered shared care planning as a core component of CaCoon. Although shared care planning represents a shift in CaCoon practice, the goal remains the same: build family confidence and competence in caring for CYSHCN. OCCYSHN will implement learning communities to reinforce shared care planning skills in LPHAs.

OCCYSHN will increase efforts to position CaCoon to support medical homes. OCCYSHN will monitor Coordinated Care Organization (CCO) 2.0 contract implementation, and the state's goal of increasing collaboration between CCOs and the public health sector. As CCO contract implementation unfolds, OCCYSHN will use this information to strengthen collaboration between medical homes and CaCoon, especially on shared care planning. Learning communities and monthly interactive video learning sessions will support the workforce.

OCCYSHN will present about shared care planning at OHA's annual Innovation Café, at national and state conferences, and at regional and local trainings and events. We will disseminate the innovative use of shared care planning with a variety of audiences including CCOs, clinicians, health systems leaders, and community-based organizations. We will also provide TA to one LPHA that is developing a video to promote shared care planning. .

OCCYSHN will continue its close partnership with OHA MCH home visiting programs. OCCYSHN will work with the OHA MCH nurse team to align OHA-MCH home visiting programs (such as Babies First! and CaCoon) and to coordinate activities at both the county and state levels. Additionally, OCCYSHN staff will continue working with OHA MCH to develop and launch the new Tracking Home visiting Effectiveness in Oregon (THEO) database.

Assuring Comprehensive Care through Enhanced Service Systems (ACCESS)

OCCYSHN will support the ACCESS program's community-based Autism Identification Teams. Support will include building local capacity by (a) offering expert medical consultation on cases, (b) establishing an Extension for Community Healthcare Outcomes community (see Strategy 11.4) so teams can pursue collaborative case-based learning, and (c) informing team members of relevant professional development opportunities at OHSU. OCCYSHN will provide technical assistance to teams on establishing and sustaining teams, and on integrating shared care planning as appropriate. OCCYSHN will also establish a telehealth process to secure remote medical participation when it is needed. OCCYSHN wants to help spread this model of local Autism Spectrum Disorder evaluation if sustainability barriers can be successfully addressed.

Payment Infrastructure

OCCYSHN and its Medicaid partners will explore billing codes that support shared care planning and transition planning for CYSHCN. Additionally, the Assessment and Evaluation Manager (Oregon's Children with Medical Complexity CoIIN project Principal Investigator) and the Oregon CoIIN Advisory Team will explore testing these codes with Medicaid's Fee-For-Service program. The CoIIN root cause analysis revealed that inadequate payment for provider time contributes to adult providers' reluctance to work with young adults with medical complexity. For example, Medicaid reimbursement for a 40-minute visit (necessary for caring for medically complex child) is less than the reimbursement for two 20-minute visits conducted with non-medically complex patients. Although this payment structure reflects the historical fee-for-service approach, OCCYSHN will collaborate with Medicaid partners to develop a payment approach that aligns better with current primary care payment reform, and to test it in Medicaid's Fee-For-Service program.

Cultural Responsivity in Title V CYSHCN Strategies

Over the past several years, OCCYSHN has worked to build its understanding of cultural responsivity and humility – to better understand what we do not know. Although we have expertise on CYSHCN and their families generally, we lack expertise about the experiences and needs of CYSHCN and their families from communities of color. Strategy 11.6 describes partnerships OCCYSHN is developing with culturally specific groups to conduct needs assessment activities. We hope to maintain these partnerships beyond the needs assessment to adapt existing, or develop new, strategies to reflect the experiences and needs of CYSHCN and their families who are members of communities of color.

Strategy 11.4: Enhance local community infrastructure to implement child health teams by providing consultation and TA to Community Connection Network teams to become self-sustaining.

OCCYSHN will continue to support Community Connection Network (CCN) teams in Coos Bay and Clatsop as well as other re-emerging teams by helping them leverage community infrastructure for shared care planning. Although OCCYSHN no longer funds CCN, we are using lessons learned from CCN to support communities where they are establishing "standing teams" for shared care planning. Like CCN teams, standing teams have regular members who meet consistently for shared care planning, as opposed to including only professionals who serve a specific child and family for a one-time meeting.

OCCYSHN initiated a distance-learning collaborative called Piloting ACT.md for Care Coordination Teams (PACCT). PACCT supports communities to build standing teams for shared care planning. PACCT is piloting a cloud-based care coordination platform to facilitate communication about shared care plans. PACCT uses quality improvement methods to develop or strengthen their standing care coordination teams. This learning community uses the University of New Mexico's Project ECHO (Extension for Community Healthcare Outcomes) model, which uses video technology to engage participants in case-based learning. Three of the five LPHAs participating in the first PACCT cohort have experience with CCN. ECHO will allow people from those three teams to share their knowledge with the less experienced teams. The Project ECHO model supports increased community capacity to coordinate care for CYSHCN, and to implement continuous quality improvement (see Strategy 12.2). LPHAs' cross-sector partners on these teams will be invited to participate in PACCT learning collaborative cohorts. OCCYSHN will establish a second PACCT cohort midway through the fiscal year, using the first cohort as peer coaches.

Strategy 11.5: Integrate state systems of services for CYSHCN and their families through cross-sector collaboration, workforce and system infrastructure development.

OCCYSHN's efforts to integrate state systems will focus on enhanced integration of CaCoon with OHA-MCH home visiting programs (as described in Strategy 11.3), identifying opportunities to insert family voice into systems serving CYSHCN, raising the visibility of Title V CYSHCN and Oregon CYSHCN and their families, and promoting emergency preparedness. A description of the latter three activities follows.

Family Involvement

OCCYSHN will actively integrate family voices in ongoing efforts to integrate systems of service for CYSHCN and their families. The Family Involvement Program will identify and track opportunities to bring family perspective to key state and local efforts with potential to impact CYSCHN. The Family Involvement Program will seek input from families of color and other underrepresented groups, building upon existing relationships with culturally specific organizations in the Portland metro area. As families have a range of capacities for leadership roles, the Family Involvement Program will develop a more formal method to recruit and track family involvement, with the goal of serving as a clearinghouse for leadership opportunities. When state or local systems approach OCCYSHN for family perspective on their work, the Family Involvement Program Manager will use OCCYSHN's family involvement framework to secure the most effective person or people for the task.

Family Involvement Program-211info Collaboration

A professional development collaboration between OCCYSHN, ORF2FHIC, and 211info will continue. ORF2FHIC and will meet the MCH Resource Coordinator, and with 211info call center staff. Discussion will include referrals, mechanisms to identify needs, and updating resources in 211info's database. 211info will share current data and trends on calls related to CYSHCN. They will also update resources and information for the ORF2FHIC website. In addition, OCCYSHN Assessment and Evaluation team staff will continue to meet quarterly with the 211info Child Care Line Manager and Lead Data Analyst to review relevant data.

Building OCCYSHN's State-Level Visibility

OCCYSHN will promote systems integration by strengthening strategic state-level relationships. We will increase awareness of CYSHCN, and participate in policy work that impacts them. We will sit on relevant committees and taskforces, develop the Collaborative to Align Systems for CYSHCN; and expand external communications.

OCCYSHN's Director will continue his membership on Oregon's Patient-Centered Primary Care Home (PCPCH) Advisory Board, Oregon's Council on Developmental Disabilities, and Health Share's Kindergarten Readiness Network. He also will provide guidance and offer testimony about CYSHCN to policy makers at municipal, state and federal levels. The Family Involvement Program Manager will continue to sit on Oregon's Medicaid Advisory Committee; and the Care Coordination Specialist will sit on the State Interagency Coordinating Council. The Systems and Workforce Development Manager will continue to serve on the advisory board for the Early Hearing Detection and Intervention (EHDI) program. Additionally, OCCYSHN staff will continue to track relevant state-level work (e.g., Health Plan Quality Metrics, Metrics and Scoring, Early Learning Council, public health modernization). OCCYSHN's Director and its Assessment and Evaluation Manager will use the Title V–Medicaid MOU meetings to strengthen relationships with OHA's Health Policy Division, which includes Medicaid.

OCCYSHN will continue developing the Collaborative to Align Systems for CYSHCN, the successor to the CYSHCN Advisory Group discussed above. OCCYSHN leadership will prioritize standards for Medical Home, Access to Care, and Health Care Transition for CYSHCN. OCCSYHN's Director will meet individually with potential key partners to discuss the prioritized standards. He will solicit feedback and gauge interest in promoting those standards through state-level systems integration.

Finally, OCCYSHN will develop and revise communication strategies to raise awareness of issues facing Oregon CYSHCN and their families. OCCYSHN will identify strategic audiences for the five-year needs assessment findings. OCCYSHN will (a) develop and disseminate data visualization products and issue briefs. (b) assess effectiveness of various social media platforms and adapt accordingly, and (c) seek technical assistance on external communication from MCH Workforce Development Center.

CYSHCN-Focused Emergency Preparedness

OCCYSHN will continue to develop expertise about cross-systems emergency preparedness planning for CYSHCN. OCCYSHN will participate on committees and workgroups addressing the issue, and will inform OHA's Office of Equity and Inclusion about disaster planning for CYSCHN and their families.

Strategy 11.6: Conduct ongoing assessment of Oregon's CYSHCN by developing studies focused on subpopulations of CYSHCN.

In FY2020, OCCYSHCN will be focus primarily on the five-year needs assessment. That effort will help establish assessment and evaluation priorities going forward. Additionally, OCCYSHN will continue its analyses of children with medical complexity.

Five-Year Needs Assessment

OCCYSHN will collaborate with two organizations, one serving African American/Black families and one serving Latinx families, to learn about the experiences and needs of Oregon CYSHCN and their families in these communities. OCCYSHN developed these partnerships through a Request for Information and Request for Proposal process. OCCYSHN will contract with these organizations to serve as equal, essential partners in project planning, decision-making, implementation, and dissemination. OCCYSHN will collaborate with them to collect, analyze and interpret data, and to share findings. If the project goes well, OCCYSHN will seek ongoing input from the two organizations on adapting Title V strategies to better serve their communities. This experience will inform future collaborations with communities of color. OCCYSHN would like to partner with Oregon American Indian/Alaska Native and Asian/Pacific Islander communities in the future.

The Assessment and Evaluation team will collaborate with OHA's Adolescent and School Health section to implement a Photovoice project with YSCHN aged 16 through 22 who experience behavioral or mental health conditions. Photovoice is a method that "involves providing community people with cameras so that they can take pictures of their everyday health and work realities and use these pictures as the basis of group discussion and action" (Wang & Pies, 2008, p. 184). OCCYSHN and ASH will recruit a small, diverse group of youth in the Portland Metro area. Working within the metro area will allow us

ready access to support the youth in the project. If this model proves successful, we will seek to expand it to other areas of the state.

Assessment and Evaluation's new Research Associate will use NSCH 2016-2018 data to compute more in-depth analyses of Oregon CYSHCN. These analyses will inform the five-year needs assessment. A&E will also develop a process for updating Oregon CYSHCN analyses regularly, and for sharing current findings with strategic state and local partners.

Our Assessment and Evaluation Manager will continue to collaborate with the OHA-MCH Epidemiologist to facilitate a state-level group of partners to develop a NSCH Oversampling Strategy for Oregon. The strategy will oversample multiple ethnic/race categories, with OCCYSHN providing partial funding. OCCYSHN is eager to collaborate with OHA, MCHB, and Census to learn more about CYSHCN response behavior within these ethnic/race communities.

Children with Medical Complexity

In FY2020, A&E Manager (Dr. Alison Martin) will work with Dr. Neal Wallace to disseminate information about children with medical complexity to state-level partners. They also will submit a paper on the subject to a peer-reviewed journal.

Strategy 11.7: Develop evidence that may show support for the benefit of care coordination for Oregon CYSHCN by designing a study to evaluate SPOC.

In FY2020 OCCYSHN will conduct a small outcome evaluation pilot, disseminate results, and consider pursuing grant funding to support additional outcome evaluation activities.

Pilot: OCCYSHN will continue to collect family-level outcome data. We will finalize a survey to administer to a comparison group of 3-5 families who do not participate in shared care planning. We will identify a subset of counties in which to pilot the use of a comparison group, and submit a modification to our current IRB protocol. We will continue to get technical assistance from Jeannie McAllister on our data collection instrument and administration procedures, and on our shared care planning work in general.

Dissemination: Based on advice from Jeannie McAllister, OCCYSHN will assess which data collected and analyzed to date are publishable. OCCYSHN will research journals whose interests and publications align with our work. Led by the Assessment and Evaluation Manager, OCCYSHN will write and submit a paper for publication in FY2020.

Funding: Alison Martin and Katie Zuckerman may re-submit the outcome evaluation proposal, depending on the availability and timing of grant opportunities.

Autism Society of Oregon
Boston University
CCOs
CDRC clinics
Children's Health Alliance/Foundation
Community Vision
Culturally-specific organizations
DCH Lifespan Transition Clinic
DCH Primary Care Pediatrics
Department of Labor Benefits Advisor
DHS Community Developmental Disabilities Programs
EDHI
Families of YSCHN in transition to adult healthcare
Family Training and Outreach Collaborative
Georgetown's National Center on Cultural Competence
Got Transition
Health Share Systems Integration Task Force
Intermountain Education Service District
Jeanne McAllister, BSN, MS, MHA at Indiana University
Katharine Zuckerman, MD, MPH, OHSU
Local Public Health grantees
OHA Adolescent and Reproductive Health
OHA Adolescent and School Health (ASH)
OHA Health Policy Division
OHA MCH
OHA Public Health Division
OHP Care Coordination Program (KEPRO or new contractor)
OHP Ombuds Program
OHSU Family Clinics
OHSU General Pediatrics Staff
OHSU IDD
OHSU Primary Care Pediatrics Complex Care Collaborative
OHSU Specialty Clinics
OHSU Transition Task Force
OHSU's Office on Inclusion and Diversity
OR Education Service Districts
Oregon Dep't. of Business and Consumer Services
Oregon Department of Education
Oregon DHS Community Developmental Disability Programs
Oregon Family Networks (9)
ORPRN
Other Parent/Family Groups (15)
Physician professional associations including OPS, OPCA, OAFP
Regional Early Learning Hubs
Regional/local PCPs
Shriner's Children's Hospital
St Charles Family Care Redmond
State Interagency Coordinating Council (SICC)
Tribes and Tribal Organizations
UCEDD (OHSU)
UCEDD/LEND Training Coordinators
Unaffiliated Family Representatives
YSHCN

Critical partnerships:

2020 Plan: NPM 12 Health Care Transition (HCT)

National Performance Measure 12: Percent of adolescents with special health care needs who received services necessary to make transitions to adult health care.

Planned strategies, ESMs and activities for October 2019 – September 2020

Strategy 12.1: Increase the number of family members of YSHCN who are informed about HCT through

community conversations and the dissemination of resources based on Got Transition materials.

The Family Involvement Program will develop an adaptation of traditional patient One Page Profiles specific to the Medical Home. Information about, and demonstration of, the One Page Profile for the Medical Home will be integrated into Family Involvement Program's Health Care Transition workshops for families.

Parent Partners will receive training on answering calls to the ORF2FHIC related to Transition. Practice scenarios will include dilemmas related to culture, financing, and medical complexity. Parent Partners will use "Conversation Starter" prompts. Follow-up training for Parent Partners will come from OHSU's Center for Diversity and Inclusion and Georgetown's National Center on Cultural Competence.

As new information about transition is developed for families, Family Involvement Program staff will work with the OCCYSHN Communications Coordinator to ensure materials meet health literacy standards. Because transition is varied and complex across cultures, Family Involvement Program staff will work with culturally specific organizations to vet transition information for families and incorporate changes where needed. Following the approach used with Black communities, the Family Involvement Program will its introduce HCT materials to the Latinx community in FY2020. Our bi-lingual Parent Partner will identify community CYSHCN leaders to vet the training, host an event to demonstrate the materials, and solicit their input. Afterward, she will help modify program materials based on their recommendations. Additionally, Family Involvement Program will work with 1 or 2 culturally-specific organizations to translate HCT materials, and to explore offering HCT trainings to families in those communities.

Family Involvement Program will use Facebook and the ORF2FHIC website to promote transition activities to families, including activities offered by other organizations. Drawing on the belief that health is fundamental to other elements of transitioning to adulthood, Family Involvement Program will work with community and family groups to incorporate HCT into their conferences and trainings. The Family Involvement Program and ORF2FHIC staff will offer to present at such events.

Family Involvement Program will use announce the use of Twitter at the Statewide Family Training and Outreach Collaborative, which is comprised of directors of family-led organizations. We will ask those stakeholders to help us build momentum by following Family Involvement Program and retweeting news and information about HCT.

Working with Community Vision and/or the Autism Society of Oregon, the Family Involvement Program will host a parent/youth transition workshop in the Portland metro area for 10–12 families, and will explore adding this activity to the permanent menu of ORF2FHIC trainings.

Strategy 12.2: Enhance cross-systems care coordination for CYSHCN by building county public health workforce capacity to lead or participate in shared care planning that includes transition-aged youth.

OCCYSHN will partner with LPHAs to implement shared care planning in communities, aiming to support workforce development and continuous quality improvement. Using the Project ECHO (Extension for Community Healthcare Outcomes) model, OCCYSHN will continue to facilitate an interactive, distance-based learning community around shared care planning in parallel with Piloting ACT.md for Care Coordination Teams (see Strategy 11.4), designed for all LPHAs implementing shared care planning. Transition-related "practice situations," will be included. The sessions serve as a venue for shared learning among participants. Over time, we anticipate that participating partners will present their own practice situations, and lead discussions about them. This level of participation will allow our partners to choose discussion topics, including transition. The Family Involvement Program Manager will contribute information on transition-related topics such as alternatives to guardianship and finding adult providers. Annual OCCYSHN Regional Meetings for LPHAs, and their partners in shared care planning, will continue to be a venue for identifying what is working well and what support is needed.

Over the course of FY2020 (and into FY2021), we will learn from Piloting ACT.md for Care Coordination Teams about the feasibility of using ACT.md as a tool to address communication barriers experienced by cross-sector shared care planning teams. As standing shared care planning teams experience the benefits of using ACT.md, we hope to expand its use to other teams.

OCCYSHN will continue to encourage use of the cloud-based file-sharing application Box for cross-sector information-sharing, and for sharing materials from monthly learning community sessions.

OCCYSHN will consider updating shared care planning materials based on feedback from LPHAs and families. For example, the shared care plan template could potentially have an option to a "One Page Profile for the Medical Home" (see Strategy 11.1). OCCYSHN will also help LPHAs communicate with each other about how they integrate care planning templates into their Electronic Health Records. We will continue supporting an LPHA that is producing a video on shared care planning for outreach to professional partners.

OCCYSHN's Systems and Workforce Development staff maintains a technical assistance database to track and improve support for LPHAs. Consultation will continue with Jeanne McAllister, BSN, MS, MHA, a national subject matter expert on medical home and shared care planning. OCCYSHN tracks community fidelity to program standards through the annual

CaCoon Accountability Report and the Shared Care Planning End of Year Report.

OCCYSHN plans to increase statewide visibility for shared care planning, including its potential benefits for transition-aged youth and their families. We will accomplish this by (a) exploring the feasibility of contracting with partners outside of public health, (b) working with the Assessment and Evaluation Team to publish initial findings on shared care planning in a peer-reviewed journal, (c) considering the establishment of an advisory group of partners to inform future sustainability conversations, and (d) increasing OCCYSHN's outreach on the shared care planning initiative at state and regional conferences. We also plan to conduct site visits to key counties around the state. This will create opportunities for OCCYSHN staff to strengthen relationships with partners in their communities, and to observe how the shared care planning process aligns with AMCHP's (2014) *Standards for Systems of Care for CYSHCN*.

As referenced in Strategy 11.6 and the Culturally and Linguistically Responsive Services state specific priority, OCCYSHN staff will initiate facilitated discussions with representatives from Native American tribes, and from organizations serving Black and Latinx communities. We will ask whether and how our shared care planning and transition strategies are culturally appropriate, and how we can best serve CYSHCN in their communities

Strategy 12.3: Increase the capacity of adult providers to provide care for transitioning YSHCN by conducting professional development activities using Got Transition resources with 4 adult practices.

As described in Strategy 12.2, OCCYSHN's contracts with LPHAs require that about 20% of the of shared care plans address health care transition for a child ≥ 12 years, incorporating primary care as a required partner. As our shared care planning initiative evolves, OCCYSHN will encourage partners to formally invite adult health care providers to participate in shared care planning meetings for transition age youth. Additionally, we will support providing the shared care plan to any YSHCN's new adult primary care provider. The goal is to increase adult provider awareness, confidence, and willingness to care for YSHCN. The visible increase in attention to HCT at the national and state levels may lead to new opportunities for this work.

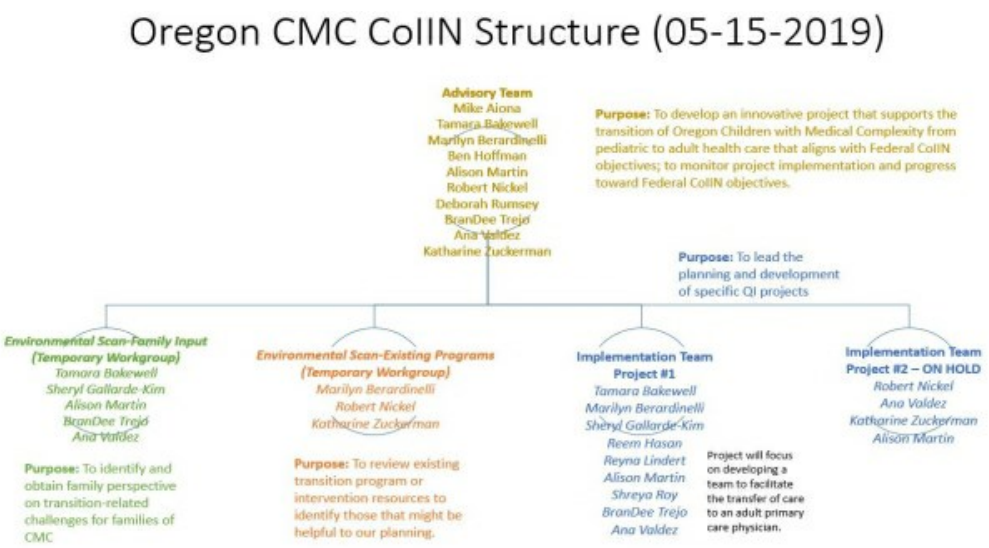
The availability of more resources, including those from Got Transition, has supported initial efforts by adult providers at OHSU to address HCT. OCCYSHN will explore leveraging these resources and other forms of TA from Got Transition to strengthen provider knowledge of HCT within OHSU. In addition, OCCYSHN staff participation on the OHSU Transition Task Force provides opportunity to inform their efforts, such as the suggestion for an OHSU Electronic Health Records work group focused on smart phrase development for transition plans. Such efforts may improve communication between pediatric and adult providers.

OCCYSHN will continue informing two HCT quality improvement workgroups within OHSU Doernbecher Children's Hospital —Primary Care Pediatrics (see below) and the Institute on Development and Disability Lifespan Transition Clinic. OCCYSHN will offer LPHAs examples and resources gleaned from these workgroups. As shared care planning continues to develop and grow, opportunities will emerge to support community-based care planning connections to OHSU. For example, one LPHA is working with two community pediatricians and the Lifespan Transition Clinic on transition planning.

As referenced in State-specific priority – Culturally and Linguistically Responsive Services, OCCYSHN will work with culturally specific groups to have facilitated conversations with families about how shared care planning and transition planning might work in their communities. We will use information gathered from these conversations to inform child health providers, who are involved with shared care planning, about family perspectives on the transition process. We will work with Got Transition to learn how their materials are culturally responsive.

CMC CoIIN

OCCYSHN's CMC CoIIN project implementation team will continue collaborating with the Principal Investigator for OHSU Primary Care Pediatrics Complex Care Collaborative, Reem Hasan, MD, PhD, and two other clinical staff to implement a quality improvement project to improve the transfer of care experience for young adults with medical complexity and their families. The project will focus on the transfer from pediatric to adult primary care providers. After this project is underway, the Advisory Team (see below) will focus on payment supports for these care transfer activities (see Strategy 11.5). These efforts may create opportunities to identify and disseminate effective HCT strategies and tools.



Strategy 12.4: Increase pediatric provider awareness of transition services by incorporating HCT assessment into adolescent well visits.

OCCYSHN will work with OHA and with providers to explore integrating HCT assessments and culturally responsive information into adolescent well visit guidance. We will also explore further opportunities for collaboration with OHA Adolescent and School Health, such as providing input on relevant publications.

Critical Partnerships

CCOs
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DCH Primary Care Pediatrics
Department of Labor Benefits Advisor
DHS Community Developmental Disabilities Programs
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OHSU Primary Care Pediatrics Complex Care Collaborative
OHSU Specialty Clinics
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Shriner's Children's Hospital
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State Interagency Coordinating Council (SICC)
Tribes and Tribal Organizations
UCEDD (OHSU)
UCEDD/LEND Training Coordinators
Unaffiliated Family Representatives
YSHCN

Cross-Cutting/Systems Building

State Performance Measures

SPM 1 - A) Percentage of new mothers who experienced stressful life events before or during pregnancy B) Percentage of mothers of 2 year olds who have adequate social support

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		43	41
Annual Indicator	43.9	41.3	44.8
Numerator	19,174	18,021	18,675
Denominator	43,650	43,639	41,666
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2014	2015	2017
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	43.0	42.0	41.0	40.0	39.0	38.0

SPM 2 - A) Percentage of households experiencing food insecurity B) Percentage of households with children < 18 years of age experiencing food insecurity

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		15.9	14.1
Annual Indicator	16.1	16.1	12.9
Numerator			
Denominator			
Data Source	USDA	USDA	USDA
Data Source Year	2013-15	2014-16	2015-17
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	12.8	12.6	12.4	12.2	12.0	11.8

SPM 3 - A) Percentage of children age 0 - 17 years who have a healthcare provider who is sensitive to their family's values and customs B) Percentage of new mothers who have ever experienced discrimination while getting any type of health or medical care

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		90.7	94.6
Annual Indicator	90.5	94.4	93.3
Numerator	733,554	671,582	694,824
Denominator	810,688	711,654	744,578
Data Source	National Survey of Childrens Health	National Survey of Childrens Health	National Survey of Childrens Health
Data Source Year	2011/12	2016	2017
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	93.5	93.7	93.9	94.1	94.3	94.5

State Action Plan Table

State Action Plan Table (Oregon) - Cross-Cutting/Systems Building - Entry 1

Priority Need

Safe and nurturing relationships; and stable, attached families.

SPM

SPM 1 - A) Percentage of new mothers who experienced stressful life events before or during pregnancy B) Percentage of mothers of 2 year olds who have adequate social support

Objectives

By October 1, 2020 decrease exposure to toxic stress/trauma and ACES and build foundations for resilience as measured by: a decrease from 44.8% to 42.0% in the percentage new mothers who experienced stressful life events before or during pregnancy; and an increase from 92.5% to 94% in the percentage of mothers of two year old children who have adequate social support.

Strategies

Provide technical assistance to local Title V grantees implementing toxic stress, ACEs and resilience work in their communities.

Promote family friendly policies that decrease toxic stress and adversity, increase economic stability, and promote health.

Provide outreach and education to increase understanding of NEAR* science, and the impact of childhood adversity on lifelong health. *neurobiology, epigenetics, ACEs, and resilience

Engage partners to build capacity for safe, connected, equitable and resilient communities.

Conduct assessment, surveillance, and epidemiological research. Use data and NEAR science to drive policy decisions.

Develop trauma-informed workforce, workplaces, systems, and services.

Support programs that strengthen protective factors for individuals, families and communities.

State Action Plan Table (Oregon) - Cross-Cutting/Systems Building - Entry 2

Priority Need

Improved maternal, infant, child, adolescent and family nutrition.

SPM

SPM 2 - A) Percentage of households experiencing food insecurity B) Percentage of households with children < 18 years of age experiencing food insecurity

Objectives

By Oct 1, 2020 decrease the percentage of Oregon households experiencing food insecurity from 12.9% to 12.6%; and decrease the percentage of households with children under 18 experiencing food insecurity from 19.2% to 18.8%.

Strategies

Provide technical assistance to grantees working on strategies to reduce food insecurity in their communities.

Screen clients for food insecurity and provide referrals for food assistance.

Support or provide food security education.

Increase access to healthy, affordable food, including access to food assistance safety net programs.

Engage with state and local partners to enhance policies, systems and programs that address reduction of food insecurity in Oregon families,

State Action Plan Table (Oregon) - Cross-Cutting/Systems Building - Entry 3

Priority Need

Improved health equity and reduced MCH disparities.

SPM

SPM 3 - A) Percentage of children age 0 - 17 years who have a healthcare provider who is sensitive to their family's values and customs B) Percentage of new mothers who have ever experienced discrimination while getting any type of health or medical care

Objectives

By October 1, 2020 improve cultural and linguistic accessibility of MCAH services as measured through an increase from 93.3% to 93.7% in the percentage of children age 0-17 who have a healthcare provider sensitive to their family's values and customs; and decrease the percentage of new mothers who have ever experienced discrimination while getting any type of health or medical care from 10.9% to 10.6%.

Strategies

Provide effective, equitable, understandable, and culturally responsive services.

Develop and improve organizational policy, practices, and leadership to promote CLAS and health equity.

Conduct ongoing assessments of the organization's CLAS related activities and integrate CLAS related measures into continuous quality improvement activities.

2018 Report: Toxic Stress, Trauma, and ACEs

State Performance Measure (#1):

1. Percentage of new mothers who experienced stressful life events before or during pregnancy;
2. Percentage of mothers of 2-year olds who have adequate social support.

Interpretation of state performance measure data:

The percent of new mothers who experienced stressful life events before or during pregnancy stayed relatively stable between 2014 and 2017, from 43.9% to 44.8%. The percent of mothers of 2-year olds who have adequate social support increased between 2015 and 2017, from 68.7% to 92.5%.

Strategies and Activities

Strategy: Promote family friendly policies that decrease stress and adversity for all parents, increase economic stability, and/or promote health.

Accomplishments

- Oregon's Title V program developed and disseminated a brief for Oregon MCAH partners addressing paid family leave and its impact on maternal, child and family health (spanning early childhood, adolescence, and adulthood). The brief is being used by partners to promote paid family leave policies at the state and local level, as well as to educate partners on the link between paid family leave and health.
- Oregon's Title V program supported an intern who developed partnerships and conducted research on the health of incarcerated women and their families.
- The Title V program strengthened our partnerships with several organizations who work to reduce parental stress and promote family friendly policies, including Family Forward, an organization whose mission is to support policy change which decreases stress for women in their roles as caregivers.
- Data from the Adverse Childhood Experiences (ACEs) module of Oregon's Behavior Risk Factor Surveillance Survey (BRFSS) survey, and the Pregnancy Risk Assessment Monitoring System (PRAMS) and PRAMS follow-up surveys were provided to state and local partners to inform local and state policy work.
- Oregon's Title V program provided support to disseminate information about and support implementation of several bills related to trauma and trauma-informed approaches which were passed by the 2017 Oregon legislature, including HCR 33 (related to developing a trauma-informed state workforce) and bills implementing pilot trauma-informed school projects in several Oregon jurisdictions.

Challenges and emerging issues

Opportunities for promoting family friendly policies to reduce toxic stress and trauma for children and families are vast, and the challenge is primarily in finding the resources and staff time to support needed partnerships.

Strategy: Provide outreach and education on the importance of early childhood, NEAR (neurobiology, epigenetics, ACEs, and resilience) science, and the impact of childhood

adversity on lifelong health.

Accomplishments

- The State Title V program's trauma-informed workplace work group sponsored a series of workplace educational programs throughout the grant year to increase the state public health workforce understanding of NEAR science and the impact of childhood adversity on lifelong health. These included viewings and discussions using the Raising of America series, the documentary Paper Tigers, and a public reading of HCR 33 with discussion of the implications for developing a trauma-informed public health workforce.
- The state Title V program presented on Trauma and ACEs to policy makers, state and community partners including state early childhood partners and local Title V grantees.
- Lane County Public Health Division provided community outreach and education on trauma and ACEs through showings and discussion of the "Raising of America" series.

Challenges and emerging issues

Challenges related to this strategy were primarily related to the variations in familiarity partners have with NEAR science, its public policy, and program implications. Although some partners are very familiar and ready to engage and move forward, others are still at the introductory stages. Furthermore, the broad underlying causes of toxic stress and the complex links to racism and generational trauma can make the issues difficult to grasp and feel overwhelming for some audiences.

Strategy: Develop community partnerships, inter-agency collaborations, and cross-systems initiatives to prevent/address ACEs and trauma and promote family and community resilience.

Accomplishments

- State Title V staff provided ongoing support and leadership to a variety of internal, as well as cross-agency trauma efforts including the Public Health Division's Trauma Forum, the Department of Education's trauma-informed schools pilot project, and Trauma-Informed Oregon's Advisory Council.
- State Title V staff provided support and resources to local Title V grantees working to implement community partnerships and cross-system initiatives.
- State Title V staff have partnered with the Oregon Climate Health and Emergency Preparedness programs to promote community resilience and strengthen protective factors for the MCAH population within their work.

Challenges and emerging issues

Interest in this issue and requests for participation in a variety of groups examining all aspects of trauma and resilience are growing faster than Title V's capacity to staff the initiatives.

Strategy: Conduct assessment, surveillance, and epidemiological research. Use data and NEAR science to drive policy decisions.

Accomplishments

- Oregon's Title V program funded the inclusion of the ACEs module in Oregon's BRFSS, and supported

the PRAMS and PRAMS 2 surveys which include critical questions related to trauma, toxic stress, social support and resilience among pregnant women and mothers of 2-year olds.
- Data from these surveys was analyzed and used in a variety of presentations throughout the grant year including presentations to the Oregon Legislature, Early Childhood partners, and Title V grantees.
- Parental stress and social support questions in Oregon's PRAMS, and PRAMS 2 surveys were analyzed.
- The Oregon subset of the National Survey of Children's Health (NSCH) data on children's exposure to ACEs for Oregon children was analyzed and information on flourishing and ACEs, as well as other children's resiliency indicators was disseminated to partners.

Challenges and emerging issues

Limitations in sample size, especially for the Oregon sub-sample of NSCH data – as well as constraints on available analyst time impose limits on what can be accomplished in this strategy area. Exploration of the opportunity for NSCH oversample in future years may help to address some of the data limitations.

Strategy: Develop a trauma-informed workforce and trauma-informed workplaces.

Accomplishments

- The State MCH trauma-informed care work group was integrated with the MCH health equity work group to ensure that the links between toxic stress and adversity, and racism and health equity are recognized and interwoven throughout our work.
- State Title V staff lead the trauma-informed workforce workgroup within the Maternal and Child Health Section. This work group addresses equitable access to workplace supports, transparent communications, modifications in physical space, and workplace practice to promote balance and prevent re-traumatization. During this grant year the work group developed a variety of tools, implemented physical workplace changes to address staff concerns, and provided activities to promote "trauma readiness' within our workplace and workforce. These have included changes to physical space, development of trauma-informed meeting guidelines, policy changes, and staff wellness activities.
- Two local grantees – Deschutes and Washington Counties – have used Title V funds to develop trauma-informed workforce and workplace initiatives. Their activities include staff training, as well as development and implementation of policy and practices to integrate ACEs and trauma awareness into MCAH services.

Challenges and emerging issues

Challenges related to this strategy include the recognition that development of trauma-informed systems and services is complex and long-term, spanning both how our MCAH systems treat employees and workforce, as well as how we address trauma and racism and its impact on our clients and the public's health.

Strategy: Identify children, youth and families experiencing adversity and connect them to needed supports and services.

Accomplishments

- The State Title V Program continued to fund an MCH information and referral line as well as two dedicated MCH specialists as part of Oregon's 211info service. These services provide information and referral for a

wide range of health, housing, childcare, and other human service needs statewide, as well as more in-depth resources and support to families with specific MCH needs spanning parenting, child health, etc.
- Title V funding also supported local Title V grantees in delivering MCH services including Oregon MothersCare and Home Visiting. Both of which are programs that identify children and families who are experiencing stress and adversity and refer them to appropriate supports and care.

Challenges and emerging issues

Challenges related to identification and referral of children and families experiencing stress and adversity are many – including the variability in services and supports available in different parts of our geographically large and diverse state.

Strategy: Strengthen protective factors for individuals and families; support programs that build parent capabilities, social emotional competence, and supportive/nurturing relationships; and foster connection to community, culture and spirituality.

Accomplishments

- State Title V staff work closely with Maternal Infant and Early Childhood Home Visiting (MIECHV) and other home visiting programs to support the work with individuals and families to build parental capabilities, social emotional competence, and supportive/nurturing relationships; as well as to foster connection to community, culture and spirituality.
- Two local Title V grantees - Lane and Clackamas Counties – have supported integration of NEAR science and/or ACEs screening into their MCH home visiting programs during this grant year. A majority of other Title V grantees use some portion of their Title V funding to support home vising programs, which strengthen protective factors for mothers, children and families. This work is described under a variety of other domains and strategies in this plan.

Challenges and emerging issues

Most of the challenges related to this strategy are reported at the local level, where ongoing support is needed to develop methods for successfully integrating NEAR science into home visiting.

Strategy: Provide technical assistance to local Title V Grantees implementing toxic stress/trauma work in their communities.

Accomplishments

- Grantees were provided individualized technical assistance throughout the grant year.
- Information related to the topic, including local and national conferences, trainings, and webinars were disseminated throughout the grant year, and made available through the Title V website.
- Webinars including all local grantees working on this priority were held periodically to provide grantees opportunities for shared learning and technical assistance. Topics included training in use of the NEAR toolkit for home visiting; and development and implementation of trauma policies in the workplace.

Challenges and emerging issues

The field of trauma, ACEs, and resilience is growing so quickly that keeping up with new information and providing

ongoing to support to local public health agencies to develop trauma-informed workforce and practices, as well as to engage in community level ACEs initiatives is challenging. Each grantee is in a different stage of developing this work, and community readiness to address this issue varies widely. As the field continues to grow, more dedicated staff time at the state Title V level would greatly enhance this work.

2018 Report: Food Insecurity

State Performance Measure (#2):

1. Percent of households experiencing food insecurity;
2. Percent of households with children under 18 years of age experiencing food insecurity.

Interpretation of state performance measure data:

1. The rolling percent of Oregon households experiencing food insecurity decreased from 16.1% in 2013/15, to 12.9% in 2015/17. The rate in Oregon is slightly higher than the 2015/17 rate of 12.3% nationally.
2. From 2003 to 2011, the rolling percent of households with children under 18 years of age experiencing food insecurity was 19.2%. No new data has been released since then. The rate in Oregon is slightly higher than the national average of 18.3%, during the same time frame of 2003 to 2011.

Strategies and Activities

Strategy: Provide technical assistance to grantees working on strategies to reduce food insecurity in their communities.

Accomplishments

- The food insecurity SPM was selected by six grantees. Each grantee has a plan of activities and measures tailored to their community's needs. The most frequently selected strategy was to conduct screening and referral in their community. Additional strategies included conducting motivational interviewing training to improve nutrition education, increasing access to fruits and vegetables and strengthening partnerships to improve community resources to address food insecurity. The WIC Program additionally has been working with local programs to offer food insecurity screening and intervention training.
- Collaborated with WIC Program and Vista volunteer to identify local health agency technical assistance needs.
- Technical assistance was provided individually upon request by grantee and occurred via phone conferencing.
- Identified and developed resources and articles about strategies to reduce food insecurity for dissemination to local county partners. A toolkit of implementation resources to address food insecurity was developed and shared. Articles of interest as available were also shared.

Strategy: Screen clients for food insecurity and provide referrals for food assistance.

Accomplishments
Hood River, Josephine, Lane, Malheur and Morrow counties provided food insecurity screening and referral as well as addressed risk factors related to food insecurity. Collectively close to 5000 clients received food insecurity screening (some of the counties are very small) and clients were referred to resources.

Challenges and emerging issues
Data collection was a challenge for many. This included collecting, documenting and retrieving data for reporting. Incorporating food insecurity screening and referral into the electronic medical record (EMR) as well as accessing data from the EMR were challenges. Another challenge was staffing issues. This included staff not understanding how to do the screening and not having enough staff in general.

Strategy: Support or provide food security education.

Accomplishments
Lane County provided motivational interviewing training and it is now systemized within public health so that staff can effectively counsel clients facing many challenges related to low resources.

Strategy: Promote access to healthy and affordable food.

Accomplishments
Josephine and Umatilla counties promoted access to healthy and affordable food through “Veggie Rx” vouchers and community outreach/education. Josephine County initially had difficulty finding traction with Veggie Rx but switched to Double Up Food Bucks with local CCO support so community members had increased access to healthy food. Partnerships in Umatilla County enabled the grantee to provide marketing and outreach about healthy food access at farmers markets and schools and this was paired with the county’s Year in Wellness campaign. Partnerships also enabled the county to provide education in the schools about healthy food access.

Challenges and emerging issues
Josephine County initially had difficulty finding a retail store to partner with until their CCO became involved. Umatilla County had difficulty with reach in the schools and will work to integrate health screening in the classroom as well as do outreach with individual families.

Strategy: Develop policy brief and logic model to support implementation of evidence-informed state and local strategies for addressing food insecurity and impact on maternal, child and family health.

Accomplishments
State Title V staff developed a logic model and shared it with grantees to increase understanding of how strategies and activities support outcomes for improved health of families. A toolkit of food insecurity implementation resources was developed that aligned with strategies and shared with grantees.

Strategy: Engage with state and local partners to enhance policies, systems and programs that address reduction of food insecurity in Oregon families.

Accomplishments

State Title V staff continued to be actively involved in statewide partnerships which address food security issues such as the Childhood Hunger Coalition, SNAP-Ed Stakeholder Group, Nutrition Council of Oregon, Oregon Department of Education – Child Nutrition Programs, Partners for a Hunger Free Oregon and WIC Program. Staff also co-lead a CollN which addressed increasing access to healthy food in low resource areas by providing outreach about the Child and Adult Care Food Program.

2018 Report: Culturally and Linguistically Responsive Services (CLAS)

State Performance Measures (#3):

1. Percent of children age 0-17 years who have a healthcare provider who is sensitive to their family's values and customs;
2. Percent of new mothers who have ever experienced discrimination while getting any type of health or medical care.

Interpretation of State performance measure data:

1. The percent of children age 0-17 years who have a healthcare provider who is sensitive to their family's values and customs has remained stable in Oregon from 94.4% in 2016 to 93.3% in 2017, since the difference between the two years is not statistically significant.
2. The percent of new Oregon mothers experiencing discrimination while accessing health care has decreased from 12.5% in 2014, to 10.9% in 2016.

Strategies and Activities

Strategy: Provide effective, equitable, understandable, and culturally responsive services.

Accomplishments

1. The Confederated Tribes Warm Springs worked to invite 90% of expecting and postpartum women to join the classes to make a traditional native baby board. The baby board is a board or frame to which an infant is secured with blankets or straps. Cradleboards are used for infant transport and sleep. They provide a safe sleep environment for infants. This traditional practice was a cultural protective factor in the past, and this approach provides an opportunity to return to traditions that had long kept American Indian babies safe. The classes were offered to 98% of women meeting these criteria. These classes are a tool to connect Native women to traditional practices, as well as a venue to discuss and promote safe sleep practices.

2. The Klamath Tribes held Positive Indian Parenting classes (an evidence-based, culturally responsive model for parenting classes). Although the classes are open to all caregivers, pregnant and new mothers were encouraged to get prenatal and postpartum care, with the incentive of receiving a diaper bag full of necessities for their newborn.

3. Work done in Multnomah County:

    1. Multnomah County Future Generations Collaborative (FGC) worked to improve healthy pregnancy planning and reduce substance-exposed pregnancies in the urban American Indian and Alaska Native (AI/AN) population by providing FASD prevention-intervention technical assistance and training. FGC reached 680 community members, and 90% if participants reported increased knowledge of Fetal Alcohol Spectrum Disorders (FASD).
    2. Multnomah County Health Department served nearly one hundred families through their Community Health Worker (CHW) program (twice as many as the original target). Additionally, the CHW provided over 600 referrals to help families connect with resources and developed 17 new partnerships with community organizations.

Challenges and emerging issues

1. The Confederated Tribes of Warm Springs found that mothers are typically very eager to sign up for the classes, but it is difficult to get them to attend. Mail, email, text and Facebook are all used to connect with potential participants.
2. Consistent attendance is an ongoing challenge faced by the Klamath Tribes MCH program.
3. Multnomah County:
    a. FGC: Takes time to build/develop relationships with community partners; and sustaining buy-in from leadership to ensure that priorities and strategies are integrated.
    b. The high demand for CHW's is a big challenge for the program. In addition, the high needs of refugee communities and limited resources available is a major challenge.

Strategy: Establish CLAS/health equity goals, policies, and accountability, and infuse them throughout the organizations' planning and operations.

Accomplishments

The state MCH program continued its work on racial equity internally and served as a resource for local public health departments as well as other state public health sections. We developed three subgroups of our Health Equity Workgroup that took on various parts of our Racial Equity Action Plan. We developed a Racial Equity Policy and a written statement of our commitment to racial equity. Additionally, we drafted *Hiring for Equity*, a compilation of best practices for recruitment and hiring, organized in checklists for easy application by hiring teams. MCH's Trauma Informed Workplace committee has implemented many changes to improve our organizational culture and climate, which is also part of the Racial Equity Action Plan.

Multnomah County's transition team drafted their trauma-informed plan for pursuing health equity. Throughout this process they have also been creating a "starter kit" for all employees on equity topics. These include videos, activities, personal assessments on power and privilege, and empathy and mindfulness.

Challenges and emerging issues

Assessing and addressing white supremacy and structural racism in government agencies is a difficult endeavor. It takes a lot of time, patience and investment of resources. The State MCH office has continuously demonstrated leadership in this area by committing staff time and financial resources to CLAS standards as a tool to achieve racial equity in health outcomes. Local public health departments and tribes struggle to provide staff time and other resources for this area of work.

Strategy: Develop and improve organizational policy, practices, and leadership to promote CLAS and health equity.

Accomplishments

1. Polk County used a portion of their funding to assess their agency on cultural responsiveness. They chose the Bay Area Regional Health Inequities Initiative (BARHII) assessment. They are using the assessment results to inform an action plan for health equity across Title V and the rest of their public health department.
2. The State MCH CLAS lead facilitated two focus groups for Polk County Public Health staff and management. These focus groups were part of the BARHII assessment and informed areas of organizational culture, workforce diversity, training opportunities, and other related topics.
3. [as referenced above] Oregon MCH developed three subgroups of our Health Equity Workgroup. One group drafted and implemented our Racial Equity Policy and our written statement of our commitment to racial equity. The workforce diversity subgroup drafted *Hiring for Equity*, a compilation of best practices for recruitment and hiring, organized in checklists for easy application by hiring teams. MCH's Trauma Informed Workplace subgroup has implemented many changes to improve our organizational culture and climate, which is also part of the Racial Equity Action Plan.
4. The state office developed a racial equity website for MCAH grantees and partners. It includes health equity and trauma informed resources for the MCAH workforce. We are still developing the areas of the site to include webinars for cultural agility, health literacy, legal responsibilities for service providers, and other topics as identified.

Challenges and emerging issues

Polk county partners and staff are unaware if they do equity work. During the assessment, it became clear that staff members are all at different places in this work. Doing a comprehensive assessment is very time consuming and for a small team, taking the time to really dig into an assessment can be difficult.

2020 Plan: Toxic Stress, Trauma, and Adverse Childhood Experiences

State Performance Measures (#1):

1. Percentage of new mothers who experienced stressful life events before or during pregnancy;
2. Percentage of mothers of 2-year olds who have adequate social support.

Related state priority need:

Safe and nurturing relationships; and stable, attached families.

Planned strategies, ESMs, and activities for October 2019 – September 2020

A logic model containing the full menu of Oregon's local level toxic stress, trauma and ACEs strategies, sample activities and measures can be found in Supporting Document #4. The logic model represents all the evidence based/informed strategies that Oregon's Title V grantees may work on during the 2016-2020 Title V grant cycle. The plan that follows details strategies, activities and measures selected for implementation during the 2020 grant year at both the state and local levels. A table outlining which local grantees are implementing different well woman care strategies is included in Supporting Document 4.

Strategy: Provide technical assistance to local Title V Grantees implementing toxic stress, ACEs, and resilience work in their communities.

Note: timeline for all activities below is throughout the grant year as needed unless otherwise noted.

Activities – State Level

- Assess grantee needs related to technical assistance and networking / October 2019.
  Note: Seven Title V grantees have selected to work on ACEs, trauma and resilience in the coming year. All seven chose this priority last year, so will be building on ongoing work. Strategies selected address: community outreach and education on NEAR science, developing trauma-informed workplace and workforce, and supporting programs that strengthen protective factors for individuals and families. See individual strategies more information.
- Convene quarterly cross-grantee discussions to assess opportunities for shared learning and technical assistance. Likely topics include challenges related to the development of trauma-informed systems and services, and implementation of the NEAR toolkit in home visiting. Ongoing Oct 2018 – Sept 2019.
- Provide and/or facilitate access to technical assistance for local grantees and other partners.

Strategy: Promote family friendly policies that decrease stress and adversity for all parents, increase economic stability, and/or promote health.

Note: timeline for all activities below is throughout the grant year as needed unless otherwise noted.

Activities – State Level

- Develop and disseminate information for Oregon MCAH partners addressing toxic stress/trauma and its impact on maternal, child and family health (spanning early childhood, adolescence, and adulthood). Make the case for the link between family friendly policies such as paid family leave, food insecurity and

quality affordable childcare, and early brain development and family stability/resilience.

- Provide Oregon data and resources to state and local partners to inform local and state policy work.
- Provide legislative analysis and information as requested on bills and policy changes under consideration by the Oregon Legislature that impact stress and adversity for Oregon women, children, and families.
- Lead Social Determinants of Health CoIIN focused on use of digital stories to influence policy-making around access to high quality, affordable, safe, and healthy, culturally appropriate childcare.

Strategy: Provide outreach and education to increase understanding of, NEAR (neurobiology, epigenetics, ACEs, and resilience) science, and the impact of childhood adversity on lifelong health.

Note: timeline for all activities below is throughout the grant year as needed unless otherwise noted.

Activities – State Level

- The State Title V program will continue to partner with other state offices and community partners to sponsor presentations and discussions on Trauma and ACEs with policy makers, state and community partners as the opportunity arises throughout the year.

Activities – Local Level

- Jackson County will provide outreach and education on trauma and ACEs to community partners.

Strategy: Engage partners to build capacity for safe, connected, equitable and resilient communities.

Note: timeline for all activities below is throughout the grant year as needed unless otherwise noted.

Activities – State Level

- Provide ongoing support and MCH participation/leadership to cross-agency efforts such as the Public Health Division's trauma work group, Trauma-Informed Oregon, OHA's trauma-informed system initiative, etc.
- Provide support and resources to local Title V grantees working to implement community partnerships and cross-system initiatives.
- Partner with the Oregon Climate Health program to promote community resilience and strengthen protective factors for the MCAH population.
- Support community colleges to build supports for parent/students through the Support to Expectant and Parenting Students (STEPS) grant.

Strategy: Conduct assessment, surveillance, and epidemiological research. Use data and NEAR science to drive policy decisions.

Note: timeline for all activities below is throughout the grant year as needed unless otherwise noted.

Activities – State Level

- Fund inclusion of the ACES module in Oregon's BRFSS.
- Analyze past year's data and revise the Oregon report on ACEs as needed.
- Include toxic stress and trauma questions in Oregon's PRAMS and PRAMS 2 surveys.
- Analyze past years' data on parental stress and social support.

- Analyze the NSCH data on children's exposure to ACEs for Oregon.
- Work with partners to develop and fund an NSCH oversample in Oregon for 2021.
- Educate policy makers and others about Oregon's ACEs data, the lifelong impact and cost of trauma and ACEs; and policy approaches to prevent or mediate the impact.

Strategy: Develop a trauma-informed workforce, workplaces, systems, and services.

Note: timeline for all activities below is throughout the grant year as needed unless otherwise noted.

Activities – State Level

- Continue implementation of shared MCH Section work on trauma-informed care and health equity work, including:
    - Equitable access to workplace supports
    - Transparent communications
    - Modifications in physical space and workplace practice to promote balance and prevent re-traumatization
    - Integration of trauma-informed approaches into MCH Section policies and practices.
- Support ongoing staff development in NEAR science and trauma-informed approaches.
- Participate in OHA-wide work to champion agency-wide readiness to implement trauma-informed care, including the trauma sub-committee of the PHD Health Equity Work Group, and the quarterly trauma forum.

Activities – Local Level

- Five local grantees – Benton, Deschutes, Lane, Linn, and Washington Counties - are using Title V funds to develop trauma-informed workforce, workplaces, and services. Their activities include staff training, as well as development and implementation of policy and practices to integrate ACEs and trauma awareness into MCAH services.

Strategy: Strengthen protective factors for individuals and families through support for programs that build parent capabilities, social emotional competence, supportive/nurturing relationships; and foster connection to community, culture, and spirituality.

Note: timeline for all activities below is throughout the grant year as needed unless otherwise noted.

Activities – Local Level

- Three local Title V grantees – Benton, Lane, and Linn, Counties – will support integration of NEAR science and/or ACEs screening into their MCH home visiting programs, and delivery of home visiting services with Title V funds. Other Title V grantees will use some portion of their Title V funding to support home vising programs that strengthen protective families for mothers, children, and families. That work is described under a variety of other domains and strategies in this plan.

Critical Partnerships

- Oregon home visiting programs (including MIECHV)
- Early childhood providers
- Trauma Informed Oregon
- Oregon Parenting Education Collaborative
- Oregon Early Learning Division

- 211 Info
- Addictions and mental health providers
- Pediatric and Family Practice providers
- Coordinated Care Organizations
- OHA Health Systems Division
- OHA Injury Prevention Section

2020 Plan: Nutrition and Food Insecurity

State Performance Measures (#2):

1. Percent of households experiencing food insecurity;
2. Percent of households with children under 18 years of age experiencing food insecurity.

Related state priority need:

Improved maternal, infant, child, adolescent and family nutrition.

Planned strategies, ESMs, and activities for October 2019 – September 2020

A logic model containing the full menu of Oregon's local level food insecurity strategies, sample activities and measures can be found in Supporting Document #4. The logic model represents all the evidence based/informed strategies that Oregon's Title V grantees may work on during the 2016-2020 Title V grant cycle. The plan that follows details strategies, activities and measures selected for implementation during the 2020 grant year at both the state and local levels. A table outlining which local grantees are implementing different well woman care strategies is included in Supporting Document 4.

Strategy: Provide technical assistance to grantees working on strategies to reduce food insecurity in their communities.

Activities - State Level

- The food insecurity SPM was selected by four grantees. Each grantee has a plan of activities and measures tailored to their community's needs. All four grantees selected the strategy to conduct screening and referral in their community. State Title V staff will provide technical assistance as requested.

Strategy: Screen clients for food insecurity and provide referrals for food assistance.

Activities - Local Level

- Josephine, Lane, North Central Public Health District and Umatilla counties will address food insecurity through screening and referral.

Strategy: Support or provide food security education.

Activities - Local Level

- Josephine and Umatilla counties will address food insecurity through education of clients and community.

Strategy: Increase access to healthy, affordable food.

Activities - Local Level

- North Central Public Health District will address food insecurity through community coalition building and food access.

Critical partnerships

- WIC Program
- Oregon Food Bank
- Partners for a Hunger Free Oregon
- Childhood Hunger Coalition
- Nutrition Council of Oregon
- SNAP and SNAP-Ed
- Oregon Department of Education, Child Nutrition Programs

2020 Plan: Culturally and Linguistically Responsive Services (CLAS)

State Performance Measures (#3):

1. Percent of children age 0-17 years who have a healthcare provider who is sensitive to their family's values and customs;
2. Percent of new mothers who have ever experienced discrimination while getting any type of health or medical care.

Related state priority need:

Improved health equity and reduced MCAH disparities.

Planned strategies, ESMs, and activities for October 2019 – September 2020

A logic model containing the full menu of Oregon's local level culturally and linguistically responsive services strategies, sample activities and measures can be found in Supporting Document #4. The logic model represents all the evidence based/informed strategies that Oregon's Title V grantees may work on during the 2016-2020 Title V

grant cycle. The plan that follows details strategies, activities and measures selected for implementation during the 2020 grant year at both the state and local levels. A table outlining which local grantees are implementing different well woman care strategies is included in Supporting Document 4.

Strategy: Develop and improve organizational policy, practices, and leadership to promote CLAS and health equity.

Activities - State Level

- The State MCH Office will continue to provide technical assistance to local grantees. Specifically, we will provide web-based training on CLAS standards, as well as trainings on addressing racism in maternal health, and a follow-up to the Plain Language and Design training we offered earlier this year.
- The State MCH office will continue to convene the Health Equity Workgroup to identify priorities for our internal work. We will continue to work on Hiring & Retention practices and improving our internal culture through trauma informed workplace practices. Additionally, we will focus on developing our relationships with community partners and begin assessing our data to determine how we can improve report collect and report out.
- The State Office will continue to build on the existing website (www.healthoregon.org/mchequity)

Activities – Local Level

Multnomah County:

The maternal, child and family health (MCFH) transition team will continue its trauma informed implementation plan to relentlessly pursue health equity. The team will shift to a community of practice and continue capacity building at the team level by including the participation of staff throughout the program. The Transition Team community of practice will build capacity through trainings and interactions that are modeled and shared by staff, and managers and supervisors as individuals and in partnership.

Coos County:

The health department is contracting with Gilda Montenegro-Fix, Cultural Agility Trainer and Consultant to provide three full days training sessions on implicit bias, systemic oppression, and cultural agility. These trainings will be mandatory for all Coos County Public Health staff.

Strategy: Provide effective, equitable, understandable, and culturally responsive services.

Activities - Local Level

Multnomah County:

The Future Generations Collaborative (FGC) continues its work to improve healthy pregnancy planning and reduce substance-exposed pregnancies in the urban American Indian and Alaska Native (AI/AN) population of Multnomah County. They continue to provide FASD prevention-intervention technical assistance and training.

The We Are Home Project consists of a collaboration between Multnomah County Health Department, and several emerging immigrant/refugee-led community organizations. Each of the partner organizations have hired and trained a community health worker, and a supervisor that sits on a steering committee with the Project Coordinator and representatives from MCHD. During the 2019-2020 cycle, the CHWs will continue to serve families with children 0-3 from African, Bhutanese and Micronesian communities.

Warm Springs:
Staff will hold Back to Boards classes for families to make a baby board following Tribal traditional practices. The baby board is a board or frame to which an infant is secured with blankets or straps. Cradleboards are used for infant transport and sleep. They provide a safe sleep environment for infants. This traditional practice was a cultural protective factor in the past, and this approach provides an opportunity to return to traditions that had long kept American Indian babies safe. They plan to provide an instructor, materials, supplies, and equipment needed for sewing and creating baby boards for classes. They plan to attend community events to promote SIDS prevention and baby board classes using culturally appropriate materials and incentives.

Lincoln County:
The health department plans to hire and train a LatinX Community Health Worker to provide translation and outreach for nurse home visits.

Klamath Tribes:
Staff will hold Positive Indian Parenting classes to help clients regain a connection with their culture and learn traditional parenting patterns and skills.

Critical partnerships

- Oregon Health Authority, Office of Equity and Inclusion
- Oregon Center for Children and Youth with Special Health Care Needs (OCCYSHCN)
- OHA Internal equity workgroups
- Oregon tribes: specifically Warm Springs
- US DHHS: Think Cultural Health
- Local Public Health grantees workforce
- Native American Youth & Family Center
- Public Health Division Health Equity Workgroup

Other Programmatic Efforts

In addition to investments in the three state-specific cross-cutting priorities, Oregon's Title V program also invests in cross-cutting system-building activities including MCAH and CYSHCN data infrastructure (epidemiology, assessment, evaluation, and informatics), communications, workforce development, and partnerships to develop MCAH policy and coordinated systems which go beyond any one priority or domain. This work is essential to carry 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 Title V CYSHCN Director, will continue during the upcoming grant year and is described below.

Policy and System Development

MCAH

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 MCAH policy staff work with multiple agency and health system partners to improve quality, coordination, and accessibility of a broad range of services and policy initiatives that impact health and development of the MCAH population. They also coordinate and serve on the Title V-Medicaid MOU team. Positions supported include the Title V Director, and the MCH Policy Lead/Title V coordinator, the MCH Health Educator, the Adolescent Health policy analyst, the Title V Adolescent Health Coordinator, as well as staff working on intimate partner violence, ACEs, perinatal access, and quality of care, MCAH impact of marijuana legalization, a variety of other child health policy initiatives, and work on emerging issues such as maternal mortality and opioids.

CYSHCN

Title V CYSHCN's work in policy and systems development includes support for OCCYSHN staff to collaborate with state partners and participate on relevant committees to increase awareness about the needs and challenges facing Oregon CYSHCN, their families, and their care providers. OCCYSHN's Director and Assessment and Evaluation Manager are members of Oregon's Title V Leadership Team and the Title V-Medicaid MOU team, which meets on a quarterly basis. OCCYSHN's Director and Systems and Workforce Development (S&W) Manager meet regularly with OHA home visiting nurse consultants. The S&W Manager also participates in the monthly Title V Priority Leads coordination meetings. OCCYSHN's Director and unit managers attend state-level committee meetings (e.g., Early Learning Council, Health Plan Quality Metrics) when the content or decision-making of meeting topics will directly affect CYSHCN. Additionally, OCCYSHN staff participate on policy committees. OCCYSHN's Family Involvement Program (FIP) Manager sits on the state Medicaid Advisory Committee (MAC). The A&E Manager concluded participation on a state-level committee to develop a Kindergarten Readiness Metric to hold CCOs accountable for healthcare's role in preparing young children for kindergarten. OHA's Metrics and Scoring Committee adopted the Kindergarten Readiness recommendations. OCCYSHN's Director serves on the Oregon Commission on Developmental Disabilities and Oregon Senator Steiner-Hayward's Children with Special Needs Workgroup. The FIP Manager and OCCYSHN Director serve on a regional Kindergarten Readiness Network Advisory Board. OCCYSHN's Medical Consultant serves on OHSU's Health care Transition Taskforce. Participating in policy workgroups is essential to promoting integrated systems for CYSHCN. OCCYSHN will continue to seek such opportunities in 2019-2020.

Communications, Outreach, and Community Engagement

MCAH

Title V supports a state-level health education and communications specialist who works on dissemination of MCAH data and educational messaging, social media outreach, as well as cultural and linguistic accessibility of MCAH materials, and communications consultation to Local Public Health Authorities. The communications specialist is also the primary MCH liaison to the state Public Health Division team that manages the state website, as well as to the publications team. Her work ensures that MCAH programs and materials are easily accessible to the public. 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. Reports on the MCH outreach and community engagement conducted through 211info are delivered quarterly to a steering committee made up of representatives from MCH, immunizations, adolescent and reproductive health, and WIC. Working with 211info

across the different programs that impact our MCAH populations ensures that clients receive comprehensive and integrated services when they contact our MCH warm-line.

CYSHCN

Title V has a Communications Coordinator charged with collaborating with staff to develop and implement a strategic plan for effective communication. The Coordinator develops and disseminates OCCYSHN program materials and needs assessment findings through print, web, and social media. The Coordinator works with OCCYSHN staff to ensure cultural and linguistic health literacy standards are incorporated into all communication efforts. In addition, OCCYSHN supports FTE for the FIP Manager to outreach to families around the state on behalf of Title V.

Epidemiology, Assessment, Evaluation, and Informatics

MCAH

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, Birth Anomalies Surveillance System, and Oral Health Surveillance System), ongoing needs assessment, evaluation and data collection/management and MCAH data dissemination functions across MCAH populations and programs. A critical project that crosses SSDI and Title V work continues to be the online Title V database that is available to all Title V grantees (Local public health and Tribes). This database allows grantees to enter their Title V reports, plans, measures – as well as to record how much of their Title V funds will be directed to work in each Title V priority area. Title V staff can review and analyze the grantee plan, as well as extract reports on strategies and priorities being undertaken across the state.

CYSHCN

OCCYSHN supports an Assessment and Evaluation (A&E) unit, which is the data center of OCCYSHN. A&E is comprised of an A&E Manager, two A&E research associates (one who began work with OCCYSHN in May 2019), and student interns (when needed). A&E is responsible for conducting ongoing and five-year assessment of the needs of Oregon CYSHCN and their families, evaluating block grant strategies, and coordinating with other OCCYSHN units to disseminate findings. A&E ensures that OCCYSHN's goals and block grant strategies are guided and informed by empirical findings. OCCYSHN also continues to provide financial support to the ORCHIDS data system into which public health nurses record required home visiting program data, including CaCoon data.

Infrastructure and Finance

MCAH

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 for management, fiscal, and clerical staff required to support the Director and other OCCYSHN staff.

III.F. Public Input

The Oregon Public Health Division 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. MCAH 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 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 ongoing methods used by both branches of Title V to solicit stakeholder and public input over the past year is provided below.

Title V MCAH Public Input Process

Stakeholder and public input into the implementation of Oregon's Title V Block Grant priorities took place throughout the year as the program's work on implementation of current Title V priorities continued, while at the same time work on the 2020 Title V Needs Assessment began. The Title V program was also integrally involved with implementation of the Maternal and Child Health Section's strategic plan, which had a strong public input process. Additionally, Title V participated in the public input process for the revision of the State Health Improvement Plan - which has important MCAH components. The development of each of these had significant state and local level public input which Title V both supported and obtained public input from. Methods used to solicit public and stakeholder input this year have included: Presentations and dialogue at partner meetings, webinars, surveys, focus groups, posting of on the Title V website, and social media outreach. Specifics of key strategies used to solicit stakeholder and public input over the past year are provided below.

Engagement/input for Title V Block Grant planning and implementation

The Title V program seeks input for overall Title V policy and implementation throughout the year from the Conference of Local Health Officials (CLHO), and from Oregon's tribes through the regular SB770 state – tribal meetings.

The state Title V State leads conducted webinars on each Title V priority to solicit input on the program, strategies and measures, and to support implementation issues in Title V communities around the state. These webinars were also used to generate input into modification of the priority specific logic models and standardized measures which provide a foundation for Oregon's Title V program infrastructure and local level data collection. Program input is also solicited in writing twice a year as part of the Title V grantee annual plan and reporting process.

Lists of Title V strategies, maps of priority work around the state, logic models, and other resources and information related to the Title V program are publicly available on the Title V website (http://healthoregon.org/titlev), which is open for public input on an ongoing basis.

Engagement/input for 2020 Title V Block Grant Needs Assessment

Planning for the 2020 Title V Needs Assessment began in November 2018 with engagement of Title V grantees

through discussions with the Conference of Local Health Officials. Broader input on the Needs Assessment plan including methods, data sources, communities of focus, and other stakeholders to engage was obtained through a February 2019 webinar in which nearly 100 stakeholders participated (See supporting document #3) Public input for the Title V Needs Assessment is currently being solicited through a variety of methods including a scan of community assessments and an online survey. Additionally, in depth input from 8 communities which have been traditionally under-represented in the Needs Assessment is being solicited through grants to community agencies. This work will continue throughout the summer and will be incorporated into the Needs Assessment priority setting process next winter.

Engagement/input for the MCH Section Strategic Plan and State Health Improvement Plan

Implementation of the Maternal and Child Health Section's strategic plan, led by the Title V Director, Title V Coordinator, and MCH policy team, involves ongoing input from internal and external stakeholders to ensure that Title V work reflects critical MCH strategic directions, as well as alignment with partner priorities and emerging opportunities. (See supporting document # 3).

Given the close alignment with the MCH strategic plan priorities, Title V partnered with and benefited from input solicited during State Health Improvement Plan (SHIP) community meetings, as well as a series of community feedback mini-grants that were conducted as part of the SHIP process. MCH priorities featured prominently in the SHIP input, and in the resulting priorities which include: institutional bias; adversity, trauma and toxic stress; economic drivers of health; access to equitable preventive health care; and behavioral health. The MCH strategic plan priorities also align with and support the OHA Performance Management System and the CCO Social Determinants of Health work.

Ongoing mechanisms for Title V public input

Public input is solicited on an ongoing basis through the Title V website (http://healthoregon.org/titlev), as well as through participation in periodic community meetings and outreach events throughout the year. The annual Title V application/report is posted on the website, along with data, resources, and links to contact state and local MCAH staff. The public also has the opportunity to access the Title V Needs Assessment survey, apply for special funding opportunities, and contact MCAH staff about involvement in upcoming MCAH events through the website.

This year the MCH Section has also continued to increase our visibility and engage the public through Facebook and twitter (www.facebook.com/oregonmch and www.twitter.com/oregonmch). In the last year, we have added nearly 100 followers on Facebook, and have doubled our followers on Twitter. We have posted nearly 150 posts related to maternal and child health on both platforms, currently reaching thousands of people through our networks (reach includes our content showing up on a user's screen). In the last year, followers have engaged with our content 1,500 times (this means that have "liked" something, commented on a story, or clicked on a link provided).

Social media is strategic and requires a lot of time. As we move forward we have identified ways to improve our online presence through interns, as well as dedicated staff time to this work. Title V works with other public health partners to extract information related to MCAH priorities and the health of our populations from public input and engagement processes conducted by partner programs and agencies.

Oregon Center for Children and Youth with Special Health Needs (OCCYSHN) Public Input Process

OCCYSHN's S&W unit hosted 5 regional meetings across the state in both 2018 and 2019. These meetings brought together LPHA staff that implement OCCYSHN strategies (including shared care planning, CaCoon, and REACH) and their community partners. The purpose of the meetings was to discuss shared care planning implementation, lessons learned (including engaging primary care, quality improvement in the shared care planning workflow, preparing families for the shared care planning meeting, getting at what matters most to families though goal setting, and ways OCCYSHN can support local success), and the relationship between CaCoon and shared care planning. OCCYSHN used these meetings as an opportunity to dialogue with local partners about their implementation experiences, areas for program improvement, and challenges facing their organizations and communities, such as public health nurse recruitment and retention. OCCYSHN adjusted its Title V strategies and LPHA contracts based on this input.

This year OCCYSHN obtained input from ORF2FHIC Parent Partners about our 2020 state action plan. In addition, ORF2FHIC, in partnership with OCCYSHN, conducts family listening sessions around the state to collect information about family experiences with health services, delivery, gaps, and access. This past year, 11 family listening sessions were conducted. Four of those listening sessions were in rural communities, 2 were for Latino families, one for a tribal community, one for African American/Black families, and one for grandparents raising grandchildren. Input is shared with Family Voices and with OCCYSHN staff to inform ongoing needs assessments, activities, and strategies.

OCCYSHN's Communication Coordinator is implementing a communications plan. The plan lays out strategies for effective internal and external communication to support our efforts on behalf of CYSCHN. For more detail, please see OCCYSHN's planned activities for the CLAS state priority in section III.E.2.c.

Like OHA's Maternal and Child Health Section, OCCYSHN maintains a website and a general mailbox where people can submit feedback to OCCYSHN. The feedback is shared with OCCYSHN leadership and helps inform our work.

OCCYSHN continues to use results of its 2015 Needs Assessment (https://www.ohsu.edu/sites/default/files/2019-02/OCCYSHN%20NA%20Final%206.22.15.pdf) to guide our efforts. The needs assessment collected data from families of CYSHCN, YSCHN, providers who serve CYSHCN (including CaCoon nurses), and other key stakeholders who work in systems that serve CYSHCN and their families.

OCCYSHN created a CYSHCN Advisory Group (CAG) for its D70 State Implementation Grant (2014-2017) focused on systems serving CYSHCN. OCCYSHN planned to sustain the CAG beyond the D70 grant to develop a vehicle with which state-level partners could advise OCCYSHN. The CAG's membership was diverse, including a variety of systems that serve CYSHCN. Group members represented parents of CYSHCN, Children's Health Alliance, Medicaid, mental and behavioral health systems, Oregon Department of Education EI/ECSE, Oregon DD services, Oregon Pediatric Improvement Partnership, Oregon Pediatric Society, Oregon Rural Practice-based Research Network, and the Patient Centered Primary Care Home (PCPCH) program.

During the 2018-2019 block grant year, OCCYSHN began to re-envision the CAG, which was renamed the "Collaborative for Alignment of Systems for CYSHCN" or CASC. In addition to providing OCCYSHN with input on our work, the CASC also would like to serve as an advocacy coalition for CYSHCN. Initial focus will be on the medical home, access to care, and transition to adult healthcare domains of the *Standards for Systems of Care for CYSHCN*. We intend to start with a small group of key stakeholders and expand membership over time. Data collected for our 2020 needs assessment will help identify specific foci within each of the three targeted domains.

For the 2019-2020 block grant year, our goal is to identify and meet with the initial group members.

III.G. Technical Assistance

Oregon Title V Medicaid MOU project

Brief description:

Oregon recently completed a Title V MOU with Medicaid. One project that our collaboration would like to take on this year is looking at EPSDT in Oregon – how it's done, how well it works, and what modifications might improve it. Once we have completed the groundwork, technical assistance from someone who has expertise in how different states implement EPSDT may be helpful.

Performance measure: NA

Proposed TA source: TBD

Estimated Budget: TBD

Estimated Dates: 12/2019 – 6/2020

Trauma informed workforce, workplaces, and MCAH systems of care

Brief description:

Oregon is working on both state and local levels to implement trauma-informed approaches to MCAH, and promote family and community resilience. To that end, the Title V program may request TA for trauma-informed workforce development activities which may include state and/or local MCAH staff training and/or support for a statewide meeting of local MCAH programs that are engaged in developing work around ACEs and trauma.

Performance Measure: State Toxic stress, trauma, and ACEs performance measure

Proposed TA source: TBD

Estimated Budget: TBD

Estimated Dates: TBD

Skills building for ongoing needs assessment activities

Brief description:

As a part of ongoing statewide needs assessment activities, Oregon would like to conduct qualitative data collection among special communities of focus, to improve the equity of Title V activities being conducted in the state. These activities could include methodology such as focus groups, listening sessions, etc.. Local Title V grantees in Oregon are well positioned to conduct some of this work, however due to differing levels of local epidemiological staff capacity, many grantees could benefit from training and guidance on how to conduct this qualitative data collection. The provision of this technical assistance would also have the added benefit of building capacity among local level public health and tribal health staff.

Performance Measure: NA

Proposed TA source: TBD

Estimated Budget: TBD

Estimated Dates: 01/2020 – 06/2020

Data support to local Title V grantees in Oregon

Brief description:

Local Title V grantees in Oregon, which include counties and tribes, are expected to select priority areas based on local needs assessment activities. Due to differing levels of local evaluation and epidemiological staff capacity, several grantees could benefit from training and guidance on how to complete these needs assessment and evaluate related Title V activities. Opportunities to provide TA may include online sessions or piggybacking on other

state-wide meetings that grantees may attend during the grant year.
Performance Measure: NA
Proposed TA source: TBD
Estimated Budget: TBD
Estimated Dates: TBD

Social Media TA

Brief description:
A number of Title V grantees and the state Title V program have identified social media as a strategy to increase the public's awareness around some of the Title V priorities (e.g. Well-Woman Care, Adolescent Well Care) however there is limited expertise in how to create and deliver an effective social media campaign.
Purpose: Provide TA to support the development of a robust social media strategy to support the Title V priorities.
Performance Measure*:* Number of people reached through social media.
Proposed TA source*:* TBD
Estimated budget: TBD
Estimated dates: TBD

Systems Change and Systems of Services for CYSHCN: Long Term Planning Consultation

Brief description: Oregon's healthcare system transformation is significantly changing healthcare delivery and organizational structures at the state and regional levels. Simultaneously, changes in education and public health are occurring. OCCYSHN seeks consultation on long-term planning for responding to these changes cutting across all community, regional and state levels within the state.
Purpose: Support OCCYSHN in long-term planning and systems level change
Performance Measure*:* NPM 11 & 12, CLAS State Performance Measure
Proposed TA source*:* Pennie Foster-Fishmann, Ph.D., System exChange
Estimated budget: $12,000
Estimated dates: 01/2020 – 09/2020

Teaching Families About Youth Privacy Rights Before & During Health Care Transition

Brief Description: Health Care Transition is one of Oregon's Title V CYSHCN priorities. OCCYSHN's Family Involvement Program (FIP) provides training on this topic to families at Regional Family Gatherings in communities across the state. Parent Partners (PP) of the Oregon Family to Family Health Information Center (F2F) are trained to conduct 90-minute interactive workshops on transition topics for parents. Comments received during the workshops show that families are interested in learning more about their youth's rights to confidentiality in the medical home beginning at age 14. While some parents welcome the idea, others, particularly if their children experience developmental or intellectual disabilities, desire more specific information and/or seek to circumvent the policies. This can result in a complex, difficult situation for PPs seeking to provide information to families and youth.
Purpose: Increase the understanding of FIP staff, PPs, and Title V staff of the medical rights of youth at age 14, and then at age 18. Explore the ethical and cultural issues affecting youth who experience health complexity, mental health concerns, and/or intellectual disabilities. Develop a framework for communicating these concepts to families in the community.
Performance Measure: NPM 12
Proposed T.A. Source: TBD. Trainers would be considered from Disability Rights Oregon, National Alliance to

Advance Adolescent Health, and others.
Estimated Budget: $4,000
Estimated Dates: 11/2019 – 6/2020

Photovoice Training

Brief description: In conducting the needs assessment, Title V grantees often rely on quantitative research methods such as surveys and analysis of secondary data. These methods are useful for capturing needs and challenges broadly, but can be difficult to meaningfully disaggregate by subpopulations of CYSHCN because of small sample sizes. Such data collection methods may not align well with the cultures of these subpopulations. OCCYSHN is planning to pilot Photovoice in its 2020 needs assessment as a tool to capture the perspective of youth with special health care needs (YSHCN) to inform our NPM 12 work. We anticipate this tool will increase our understanding of the experience and educational needs of YSHCN with behavioral/mental health conditions. This builds upon NSCH analyses we conducted in partnership with Dr. Olivia Lindly, which we are currently seeking to publish. Photovoice has been successfully used with youth on a variety of topics. It is well-suited to the policy environment, helping to "tell the story." If it works well, OCCYSHN will use the method with families of subpopulations of CYSHCN. OCCYSHN's Assessment & Evaluation (A&E) Coordinator and 1 Research Associate would participate in Photovoice's regular 3-day training in London, and would share learning with OCCYSHN, OHA MCAH, and OHSU UCEDD A&E staff.
Purpose: Ongoing needs assessment & policy activity
Performance Measure*:* NPM 12 & 11, CLAS SPM
Proposed TA source*:* PhotoVoice
Estimated budget: $14,000
Estimated dates: October or November 2020

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - MOU between Medicaid and Title V FINAL SIGNED.pdf

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - OCCYSHN Partnerships and Public Comment Letters 2019.pdf

Supporting Document #02 - OCCYSHN Contracts_LPHAs_OHSU-OHA.pdf

Supporting Document #03 - MCAH Guiding Documents.pdf

Supporting Document #04 - Local Title V MCAH Grantee Information.pdf

Supporting Document #05 - MCAH Title V Reports and Publications.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - BG2020_Combined OCCYSHN and OHA Org Chart May 2019.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Oregon

	FY 20 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 6,178,818	
A. Preventive and Primary Care for Children	$ 2,673,152	(43.2%)
B. Children with Special Health Care Needs	$ 1,853,646	(30%)
C. Title V Administrative Costs	$ 617,881	(10%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 5,144,679	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 10,720,618	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 5,594,165	
5. OTHER FUNDS (Item 18e of SF-424)	$ 8,527,525	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 24,842,308	
A. Your State's FY 1989 Maintenance of Effort Amount $ 3,950,427		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 31,021,126	
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(Subtotal of all funds under item 9)	$ 39,882,886	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 70,904,012	

OTHER FEDERAL FUNDS	FY 20 Application Budgeted
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 620,991
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Birth Defects and Developmental Disabilities	$ 154,192
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 195,980
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 178,576
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 381,191
Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Title XIX -- Grants to States for Medical Assistance Programs	$ 1,355,400
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 8,195,327
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 83,853
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 206,968
Department of Health and Human Services (DHHS) > Office of Adolescent Health > Support for Pregnant and Parenting Teens	$ 644,943
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 2,662,185
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 25,203,280

	FY 18 Annual Report Budgeted		FY 18 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 6,150,471		$ 6,178,818	
A. Preventive and Primary Care for Children	$ 2,694,214	(43.8%)	$ 2,673,152	(43.2%)
B. Children with Special Health Care Needs	$ 1,845,142	(30%)	$ 1,853,646	(30%)
C. Title V Administrative Costs	$ 615,047	(10%)	$ 617,881	(10%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 5,154,403		$ 5,144,679	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 8,888,929		$ 9,068,855	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 6,026,893		$ 5,594,166	
5. OTHER FUNDS (Item 18e of SF-424)	$ 7,236,918		$ 7,531,186	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0		$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 22,152,740		$ 22,194,207	
A. Your State's FY 1989 Maintenance of Effort Amount $ 3,950,427				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 28,303,211		$ 28,373,025	
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 (Subtotal of all funds under item 9)	$ 38,871,933		$ 39,324,236	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 67,175,144		$ 67,697,261	

OTHER FEDERAL FUNDS	FY 18 Annual Report Budgeted	FY 18 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 450,547	$ 620,991
Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Title XIX -- Grants to States for Medical Assistance Programs	$ 698,464	$ 438,197
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > ACA Maternal, Infant and Early Childhood Home Visiting Program	$ 8,454,283	$ 8,195,327
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Oral Health	$ 271,067	$ 350,944
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 87,511	$ 83,853
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 198,787	$ 206,968
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 2,709,294	$ 2,662,185
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 23,737,179	$ 25,203,280
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Birth Defects and Developmental Disabilities	$ 210,000	$ 154,192
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 132,517	$ 195,980
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 434,744	$ 381,191
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 126,601	$ 178,576
Department of Health and Human Services (DHHS) > Office of Adolescent Health > Support for Pregnant and Parenting Teens	$ 1,360,939	$ 644,943

OTHER FEDERAL FUNDS	FY 18 Annual Report Budgeted	FY 18 Annual Report Expended
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Early Childhood Comprehensive Systems		$ 7,609

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**1. FEDERAL ALLOCATION**
	Fiscal Year:	**2020**
	Column Name:	**Application Budgeted**
	Field Note: This is based on the FFY 18 Notice of Award (NOA).	
2.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children**
	Fiscal Year:	**2020**
	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 2015 were redistributed to preventive and primary care for children population group in FFY2020.	
3.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs**
	Fiscal Year:	**2020**
	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:	**2020**
	Column Name:	**Application Budgeted**
	Field Note: CP&HP considers the 10% cost allocation of central support services to represent Administrative costs.	
5.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2020**
	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.	
6.	**Field Name:**	**4. LOCAL MCH FUNDS**

	Fiscal Year:	**2020**
	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).	
7.	**Field Name:**	**5. OTHER FUNDS**
	Fiscal Year:	**2020**
	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.	
8.	**Field Name:**	**1.FEDERAL ALLOCATION**
	Fiscal Year:	**2018**
	Column Name:	**Annual Report Expended**
	Field Note: This is based on the FFY 18 Notice of Award (NOA).	
9.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children:**
	Fiscal Year:	**2018**
	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 2015 were redistributed to preventive and primary care for children population group in FFY2018.	
10.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs:**
	Fiscal Year:	**2018**
	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:	**2018**
	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:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2018**
	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.	
13.	**Field Name:**	**4. LOCAL MCH FUNDS**
	Fiscal Year:	**2018**
	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).	
14.	**Field Name:**	**5. OTHER FUNDS**
	Fiscal Year:	**2018**
	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.	

Data Alerts: None

Form 3a
Budget and Expenditure Details by Types of Individuals Served

State: Oregon

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY 20 Application Budgeted	FY 18 Annual Report Expended
1. Pregnant Women	$ 522,374	$ 522,374
2. Infants < 1 year	$ 267,410	$ 267,410
3. Children 1 through 21 Years	$ 2,673,152	$ 2,673,152
4. CSHCN	$ 1,853,646	$ 1,853,646
5. All Others	$ 244,355	$ 244,355
Federal Total of Individuals Served	$ 5,560,937	$ 5,560,937

IB. Non-Federal MCH Block Grant	FY 20 Application Budgeted	FY 18 Annual Report Expended
1. Pregnant Women	$ 633,340	$ 633,340
2. Infants < 1 year	$ 8,542,727	$ 6,117,926
3. Children 1 through 21 Years	$ 12,823,032	$ 12,823,032
4. CSHCN	$ 1,500,000	$ 1,276,700
5. All Others	$ 1,343,210	$ 1,343,210
Non-Federal Total of Individuals Served	$ 24,842,309	$ 22,194,208
Federal State MCH Block Grant Partnership Total	$ 30,403,246	$ 27,755,145

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:	**2020**
	Column Name:	**Application Budgeted**
	Field Note: Budgets are based on the 2018 actual expenditures at the time the 2020 Block Grant Application was prepared.	
2.	**Field Name:**	**IA. Federal MCH Block Grant, 2. Infant < 1 Year**
	Fiscal Year:	**2020**
	Column Name:	**Application Budgeted**
	Field Note: Budgets are based on the 2018 actual expenditures at the time the 2020 Block Grant Application was prepared.	
3.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1 through 21 years**
	Fiscal Year:	**2020**
	Column Name:	**Application Budgeted**
	Field Note: Budgets are based on the 2018 actual expenditures at the time the 2020 Block Grant Application was prepared.	
4.	**Field Name:**	**IA. Federal MCH Block Grant, 4. CSHCN**
	Fiscal Year:	**2020**
	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:	**2020**
	Column Name:	**Application Budgeted**
	Field Note: Budgets are based on the 2018 actual expenditures at the time the 2020 Block Grant Application was prepared.	
6.	**Field Name:**	**IB. Non-Federal MCH Block Grant, 1. Pregnant Women**
	Fiscal Year:	**2020**

	Column Name:	**Application Budgeted**
	Field Note: Budgets are based on the 2018 expenditures at the time the 2020 Block Grant Application was prepared. These budget amounts include state, local, and other funds.	
7.	**Field Name:**	**IB. Non-Federal MCH Block Grant, 2. Infant < 1 Year**
	Fiscal Year:	**2020**
	Column Name:	**Application Budgeted**
	Field Note: Budgets are based on the 2018 expenditures at the time the 2020 Block Grant Application was prepared. These budget amounts include state, local, and other funds.	
8.	**Field Name:**	**IB. Non-Federal MCH Block Grant, 3. Children 1 through 21 years**
	Fiscal Year:	**2020**
	Column Name:	**Application Budgeted**
	Field Note: Budgets are based on the 2018 expenditures at the time the 2020 Block Grant Application was prepared. These budget amounts include state, local, and other funds.	
9.	**Field Name:**	**IB. Non-Federal MCH Block Grant, 4. CSHCN**
	Fiscal Year:	**2020**
	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:	**2020**
	Column Name:	**Application Budgeted**
	Field Note: Budgets are based on the 2018 expenditures at the time the 2020 Block Grant Application was prepared. These budget amounts include state, local, and other funds.	
11.	**Field Name:**	**IA. Federal MCH Block Grant, 1. Pregnant Women**
	Fiscal Year:	**2018**
	Column Name:	**Annual Report Expended**

	Field Note: Expenditures are based on the actual expenditures at the time the 2020 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:	**2018**
	Column Name:	**Annual Report Expended**
	Field Note: Expenditures are based on the actual expenditures at the time the 2020 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 through 21 years**
	Fiscal Year:	**2018**
	Column Name:	**Annual Report Expended**
	Field Note: Expenditures are based on the actual expenditures at the time the 2020 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:	**2018**
	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.	
15.	**Field Name:**	**IA. Federal MCH Block Grant, 5. All Others**
	Fiscal Year:	**2018**
	Column Name:	**Annual Report Expended**
	Field Note: Expenditures are based on the actual expenditures at the time the 2020 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:	**2018**
	Column Name:	**Annual Report Expended**

	Field Note: Expenditures are based on the actual expenditures at the time the 2020 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.	
17.	**Field Name:**	**IB. Non-Federal MCH Block Grant, 2. Infant < 1 Year**
	Fiscal Year:	**2018**
	Column Name:	**Annual Report Expended**
	Field Note: Expenditures are based on the actual expenditures at the time the 2020 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.	
18.	**Field Name:**	**IB. Non-Federal MCH Block Grant, 3. Children 1 through 21 years**
	Fiscal Year:	**2018**
	Column Name:	**Annual Report Expended**
	Field Note: Expenditures are based on the actual expenditures at the time the 2020 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.	
19.	**Field Name:**	**IB. Non-Federal MCH Block Grant, 4. CSHCN**
	Fiscal Year:	**2018**
	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:	**2018**
	Column Name:	**Annual Report Expended**
	Field Note: Expenditures are based on the actual expenditures at the time the 2020 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.	

Data Alerts: None

Form 3b
Budget and Expenditure Details by Types of Services

State: Oregon

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY 20 Application Budgeted	FY 18 Annual Report Expended
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	$ 1,939,194	$ 1,939,194
3. Public Health Services and Systems	$ 4,239,624	$ 4,239,624
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		$ 0
Physician/Office Services		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Direct Services Line 4 Expended Total		$ 0
Federal Total	$ 6,178,818	$ 6,178,818

IIB. Non-Federal MCH Block Grant	FY 20 Application Budgeted	FY 18 Annual Report Expended
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	$ 22,202,010	$ 19,553,908
3. Public Health Services and Systems	$ 2,640,300	$ 2,640,300
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Direct Services Line 4 Expended Total		$ 0
Non-Federal Total	$ 24,842,310	$ 22,194,208

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

1.	**Field Name:**	**IIA. Federal MCH Block Grant, 1. Direct Services**
	Fiscal Year:	**2020**
	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. Federal MCH Block Grant, 1. A. Preventive and Primary Care Services for all Pregnant Women,Mothers, and Infants up to Age One**
	Fiscal Year:	**2020**
	Column Name:	**Application Budgeted**
	Field Note: There are no Direct Services budgets.	
3.	**Field Name:**	**IIA. Federal MCH Block Grant, 1. B. Preventive and Primary Services for Children**
	Fiscal Year:	**2020**
	Column Name:	**Application Budgeted**
	Field Note: There are no Direct Services budgets.	
4.	**Field Name:**	**IIA. Federal MCH Block Grant, 1. C. Services for CSHCN**
	Fiscal Year:	**2020**
	Column Name:	**Application Budgeted**
	Field Note: There are no Direct Services budgets.	
5.	**Field Name:**	**IIA. Federal MCH Block Grant, 2. Enabling Services**
	Fiscal Year:	**2020**
	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. Federal MCH Block Grant, 3. Public Health Services and Systems**
	Fiscal Year:	**2020**
	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. Non-Federal MCH Block Grant, 1. Direct Services**
	Fiscal Year:	**2020**
	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. Non-Federal MCH Block Grant, 1. A. Preventive and Primary Care Services for all Pregnant Women,Mothers, and Infants up to Age One**
	Fiscal Year:	**2020**
	Column Name:	**Application Budgeted**
	Field Note: There are no Direct Services budgets.	
9.	**Field Name:**	**IIB. Non-Federal MCH Block Grant, 1. B. Preventive and Primary Services for Children**
	Fiscal Year:	**2020**
	Column Name:	**Application Budgeted**
	Field Note: There are no Direct Services budgets.	
10.	**Field Name:**	**IIB. Non-Federal MCH Block Grant, 1. C. Services for CSHCN**
	Fiscal Year:	**2020**
	Column Name:	**Application Budgeted**
	Field Note: There are no Direct Services budgets.	

11.	**Field Name:**	**IIB. Non-Federal MCH Block Grant, 2. Enabling Services**
	Fiscal Year:	**2020**
	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:**	**IIB. Non-Federal MCH Block Grant, 3. Public Health Services and Systems**
	Fiscal Year:	**2020**
	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.	
13.	**Field Name:**	**IIA. Federal MCH Block Grant, 1. Direct Services**
	Fiscal Year:	**2018**
	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.	
14.	**Field Name:**	**IIA. Federal MCH Block Grant, 1. A. Preventive and Primary Care Services for all Pregnant Women,Mothers, and Infants up to Age One**
	Fiscal Year:	**2018**
	Column Name:	**Annual Report Expended**
	Field Note: There are no Direct Services expenditures.	
15.	**Field Name:**	**IIA. Federal MCH Block Grant, 1. B. Preventive and Primary Services for Children**
	Fiscal Year:	**2018**
	Column Name:	**Annual Report Expended**
	Field Note: There are no Direct Services expenditures.	
16.	**Field Name:**	**IIA. Federal MCH Block Grant, 1. C. Services for CSHCN**

	Fiscal Year:	**2018**
	Column Name:	**Annual Report Expended**
	Field Note:	
	There are no Direct Services expenditures.	
17.	**Field Name:**	**IIA. Federal MCH Block Grant, 2. Enabling Services**
	Fiscal Year:	**2018**
	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.	
18.	**Field Name:**	**IIA. Federal MCH Block Grant, 3. Public Health Services and Systems**
	Fiscal Year:	**2018**
	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. There are no Direct Services budgets	
19.	**Field Name:**	**IIB. Non-Federal MCH Block Grant, 1. Direct Services**
	Fiscal Year:	**2018**
	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 Servicesand Systems. There are no Direct Services expenditures.	
20.	**Field Name:**	**IIB. Non-Federal MCH Block Grant, 1. A. Preventive and Primary Care Services for all Pregnant Women,Mothers, and Infants up to Age One**
	Fiscal Year:	**2018**
	Column Name:	**Annual Report Expended**
	Field Note:	
	There are no Direct Services expenditures.	
21.	**Field Name:**	**IIB. Non-Federal MCH Block Grant, 1. B. Preventive and Primary Services for Children**
	Fiscal Year:	**2018**

	Column Name:	**Annual Report Expended**
	Field Note: There are no Direct Services expenditures.	
22.	**Field Name:**	**IIB. Non-Federal MCH Block Grant, 1. C. Services for CSHCN**
	Fiscal Year:	**2018**
	Column Name:	**Annual Report Expended**
	Field Note: There are no Direct Services expenditures.	
23.	**Field Name:**	**IIB. Non-Federal MCH Block Grant, 2. Enabling Services**
	Fiscal Year:	**2018**
	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	
24.	**Field Name:**	**IIB. Non-Federal MCH Block Grant, 3. Public Health Services and Systems**
	Fiscal Year:	**2018**
	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. There are no Direct Services budget.	

Form 4
Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: Oregon

Total Births by Occurrence: 42,614 **Data Source Year: 2018**

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Screen	(B) Aggregate Total Number Presumptive Positive Screens	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	42,471 (99.7%)	663	58	58 (100.0%)

Program Name(s)				
3-Hydroxy-3-Methyglutaric Aciduria	3-Methylcrotonyl-Coa Carboxylase Deficiency	Argininosuccinic Aciduria	Biotinidase Deficiency	Carnitine Uptake Defect/Carnitine Transport Defect
Citrullinemia, Type I	Classic Galactosemia	Classic Phenylketonuria	Congenital Adrenal Hyperplasia	Critical Congenital Heart Disease
Cystic Fibrosis	Glutaric Acidemia Type I	Holocarboxylase Synthase Deficiency	Homocystinuria	Isovaleric Acidemia
Long-Chain L-3 Hydroxyacyl-Coa Dehydrogenase Deficiency	Maple Syrup Urine Disease	Medium-Chain Acyl-Coa Dehydrogenase Deficiency	Methylmalonic Acidemia (Cobalamin Disorders)	Methylmalonic Acidemia (Methylmalonyl-Coa Mutase)
Primary Congenital Hypothyroidism	Propionic Acidemia	S, ßeta-Thalassemia	S,C Disease	S,S Disease (Sickle Cell Anemia)
Severe Combined Immunodeficiences	ß-Ketothiolase Deficiency	Trifunctional Protein Deficiency	Tyrosinemia, Type I	Very Long-Chain Acyl-Coa Dehydrogenase Deficiency

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 screening	41,998 (98.6%)	1,170	99	99 (100.0%)
21-Hydroxylase Deficient Congenital Adrenal Hyperplasia	42,471 (99.7%)	0	0	0 (0%)
Short Chain Acyl-CoA Dehydrogenase Deficiency	42,471 (99.7%)	9	9	9 (100.0%)
Malonic Aciduria	42,471 (99.7%)	22	0	0 (0%)
Hyperphenylalanemia	42,471 (99.7%)	1	1	1 (100.0%)
Arginase Deficiency	42,471 (99.7%)	8	0	0 (0%)
2-methylbutyryl CoA dehydrogenase deficiency	42,471 (99.7%)	0	0	0 (0%)
Carnitine palmitoyl transferase	42,471 (99.7%)	19	0	0 (0%)
POMPE	42,471 (99.7%)	11	0	0 (0%)
FABRY	42,471 (99.7%)	5	5	5 (100.0%)
GAUCHER	42,471 (99.7%)	4	1	1 (100.0%)
E disease	42,471 (99.7%)	4	4	4 (100.0%)

3. Screening Programs for Older Children & Women

None

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:

None

Data Alerts: None

Form 5
Count of Individuals Served by Title V & Total Percentage of Populations Served by Title V

State: Oregon

Annual Report Year 2018

Form 5a – Count of Individuals Served by Title V
(Direct & Enabling Services Only)

		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	4,875	44.6	0.0	14.4	24.5	16.5
2. Infants < 1 Year of Age	1,008	59.0	0.0	5.1	1.8	34.1
3. Children 1 through 21 Years of Age	49,456	45.0	0.0	19.4	13.2	22.4
3a. Children with Special Health Care Needs	12,349	59.5	0.0	39.4	0.0	1.1
4. Others	30,970	24.8	0.0	17.8	49.9	7.5
Total	86,309					

Form 5b – Total Percentage of Populations Served by Title V
(Direct, Enabling, and Public Health Services and Systems)

Populations Served by Title V	Reference Data	Used Reference Data?	Denominator	Total % Served	Form 5b Count (Calculated)	Form 5a Count
1. Pregnant Women	43,631	Yes	43,631	100	43,631	4,875
2. Infants < 1 Year of Age	44,161	Yes	44,161	100	44,161	1,008
3. Children 1 through 21 Years of Age	1,026,924	Yes	1,026,924	12	123,231	49,456
3a. Children with Special Health Care Needs	199,942	Yes	199,942	100	199,942	12,349
4. Others	3,069,236	Yes	3,069,236	2	61,385	30,970

Form Notes for Form 5:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2018**
	Field Note: Pregnant individuals served by Maternity Case Management, Babies First and Oregon Mother's Care.	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2018**
	Field Note: Infants served by Babies First	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2018**
	Field Note: Children served by School Based Health Centers, Babies First, Family Planning for females <22 years of age, and dental sealant programs.	
4.	**Field Name:**	**Children with Special Health Care Needs**
	Fiscal Year:	**2018**
	Field Note: CYSHCN served in FY18 through direct and enabling services: CaCoon program, Shared Care Planning initiative, Zetosch Charitable Gift Fund, and CDRC clinical programs. Sources: ORCHIDS (Oregon Child Health Information Data Systems), OCCYSHN Zetosch database, OCCYSHN Shared Care Plan Information Form (SIF) database, and CDRC clinics. Percentage of “Sources of Coverage” is based on the following categories: Public Insurance Only, Private/Other insurance, Uninsured, and Unknown. This is taken from ORCHIDS and CDRC. Zetosch and the SIF database do not track insurance coverage.	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2018**
	Field Note: Family planning for reproductive aged women (22 to 54 years of age), and non-pregnant adult caregivers served by Babies First.	

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women**
	Fiscal Year:	**2018**

Field Note:
Percentage includes pregnant individuals served by Maternity Case Management, Maternal, Infant, and Early Childhood Home Visiting, Oregon Mothers Care, the Special Supplemental Nutrition Program for Women, Infants, and Children, and local (county and Tribal) Title V grantee activities.

Total unduplicated number served = 48,304. This exceeds population number, therefore 100% of population (number of deliveries) reported.

2.	**Field Name:**	**InfantsLess Than One Year**
	Fiscal Year:	**2018**

Field Note:
Percentage includes infants served by Newborn Screening, Early Hearing Detection & Intervention, Babies First, and local (county and Tribal) Title V grantee activities.

Total unduplicated number served = 85,706. This exceeds population number, therefore 100% of population (number of infants delivered) reported.

3.	**Field Name:**	**Children 1 Through 21 Years of Age**
	Fiscal Year:	**2018**

Field Note:
Percentage includes children served by family planning for children < 22 years of age, Babies First, Maternal, Infant, and Early Childhood Home Visiting, dental sealant programs, the Special Supplemental Nutrition Program for Women, Infants, and Children, and local (county and Tribal) Title V grantee activities.

4.	**Field Name:**	**Children With Special Health Care Needs**
	Fiscal Year:	**2018**

Field Note:
OCCYSHN's public health systems & services strategies include: statewide needs assessment activities; staff participation in state-level boards and workgroups, advocacy, and public comment on Oregon (OR) healthcare transformation efforts that affect OR CYSHCN; workforce development activities to increase healthcare and other professional partners' ability to collaborate with and serve OR CYSHCN and their families. Thus, we assume that Title V CYSHCN strategies touch all OR CYSHCN, ages birth to 21 years, and their families in some capacity.

5.	**Field Name:**	**Others**
	Fiscal Year:	**2018**

Field Note:
Percentage includes non-pregnant caretakers served by Maternal, Infant, and Early Childhood Home Visiting, and women of reproductive age (22 to 54 years) served by family planning.

Data Alerts: None

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Oregon

Annual Report Year 2018

I. Unduplicated Count by Race/Ethnicity

	(A) Total	(B) Non-Hispanic White	(C) Non-Hispanic Black or African American	(D) Hispanic	(E) Non-Hispanic American Indian or Native Alaskan	(F) Non-Hispanic Asian	(G) Non-Hispanic Native Hawaiian or Other Pacific Islander	(H) Non-Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	41,318	27,762	952	7,759	363	2,275	307	1,553	347
Title V Served	6,204	3,521	229	1,344	101	107	74	580	248
Eligible for Title XIX	18,189	10,286	669	5,299	251	514	233	778	159
2. Total Infants in State	41,318	27,762	952	7,759	363	2,275	307	1,553	347
Title V Served	4,668	2,421	266	1,415	105	117	61	235	48
Eligible for Title XIX	18,189	10,286	669	5,299	251	514	233	778	159

Form Notes for Form 6:

None

Field Level Notes for Form 6:

1.	**Field Name:**	**1. Title V Served**
	Fiscal Year:	**2018**
	Column Name:	**Total**
	Field Note: Number of pregnant individuals served by Oregon Mother's Care and Maternity Case Management, and Babies First clients enrolled prenatally.	
2.	**Field Name:**	**2. Title V Served**
	Fiscal Year:	**2018**
	Column Name:	**Total**
	Field Note: Number of infants served by Babies First and CaCoon.	

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: Oregon

A. State MCH Toll-Free Telephone Lines	2020 Application Year	2018 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 211-0000	(800) 211-0000
2. State MCH Toll-Free "Hotline" Name	Maternal and Child Health	Maternal and Child Health
3. Name of Contact Person for State MCH "Hotline"	Ciara Doyle	Ciara Doyle
4. Contact Person's Telephone Number	(503) 416-2704	(503) 416-2704
5. Number of Calls Received on the State MCH "Hotline"		25,355

B. Other Appropriate Methods	2020 Application Year	2018 Annual Report Year
1. Other Toll-Free "Hotline" Names	211Info	211Info
2. Number of Calls on Other Toll-Free "Hotlines"		90,512
3. State Title V Program Website Address	www.211info.org	www.211info.org
4. Number of Hits to the State Title V Program Website		239,105
5. State Title V Social Media Websites	facebook.com/211info; twitter.vom/211info; htpps://www.instagram.com/211info/	facebook.com/211info; twitter.com/211info; instagram.com/211info
6. Number of Hits to the State Title V Program Social Media Websites		13,370

Form Notes for Form 7:

Oregon's MCH warm line operates through our 211 information and referral system. The actual phone # is 211, but the additional digits were added to accomodate TVIS data entry requirements. Reportng year line 5 - includes all callers identifed as pregnatn or having children under age 18. Reporting year line 6 - Hits to social media include: 10,005 Facebook likes; 3,114 Twitter followers, and 651 Instagram followers.

Form 8
State MCH and CSHCN Directors Contact Information

State: Oregon

1. Title V Maternal and Child Health (MCH) Director	
Name	Cate Wilcox, MPH
Title	Title V Director, MCH Manager
Address 1	800 NE Oregon St, Ste 825
Address 2	
City/State/Zip	Portland / OR / 97223
Telephone	(971) 373-0299
Extension	
Email	cate.s.wilcox@state.or.us

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Benjamin Hoffman, MD
Title	Title V CYSHCN Director
Address 1	707 SW Gaines Street
Address 2	
City/State/Zip	Portland / OR / 97239
Telephone	(503) 494-2214
Extension	
Email	hoffmanb@ohsu.edu

3. State Family or Youth Leader (Optional)	
Name	Tamara Bakewell
Title	Family Involvement Coordinator
Address 1	707 SW Gaines St
Address 2	
City/State/Zip	Portland / OR / 97239
Telephone	(503) 494-0865
Extension	
Email	bakewell@ohsu.edu

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: Oregon

Application Year 2020

No.	Priority Need
1.	High quality, culturally responsive preconception, prenatal and inter-conception services.
2.	Improved maternal, infant, child, adolescent and family nutrition.
3.	Physical activity throughout the lifespan.
4.	High quality, confidential, preventive health services for adolescents
5.	High quality, family-centered, coordinated systems of care for children and youth with special health care needs.
6.	Improved oral health for pregnant women and children.
7.	Reduced tobacco use and exposure among pregnant women and children.
8.	Safe and nurturing relationships; and stable, attached families.
9.	Improved health equity and reduced MCH disparities.

Form 9 State Priorities-Needs Assessment Year - 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 10
National Outcome Measures (NOMs)

State: Oregon

Form Notes for Form 10 NPMs, NOMs, SPMs, SOMs, and ESMs.

None

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
2017	81.4 %	0.2 %	35,224	43,299
2016	81.2 %	0.2 %	36,728	45,215
2015	80.5 %	0.2 %	36,530	45,353
2014	79.2 %	0.2 %	35,790	45,217
2013	76.3 %	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% points or >1.2 times the estimate, 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: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	130.2	6.4	416	31,961
2014	117.2	5.3	491	41,886
2013	117.1	5.4	476	40,656
2012	97.4	4.9	397	40,766
2011	97.7	4.8	413	42,264
2010	104.5	5.0	449	42,979
2009	101.3	4.8	453	44,729
2008	97.0	4.6	448	46,166

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

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data	
	2018
Annual Indicator	27.5
Numerator	12
Denominator	43,630
Data Source	Oregon Center for Health Statistics
Data Source Year	2017

NOM 3 - Notes:

None

Data Alerts: None

NOM 4 - 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
2017	6.8 %	0.1 %	2,972	43,618
2016	6.5 %	0.1 %	2,974	45,518
2015	6.4 %	0.1 %	2,919	45,634
2014	6.2 %	0.1 %	2,842	45,543
2013	6.3 %	0.1 %	2,841	45,144
2012	6.1 %	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% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 4 - Notes:

None

Data Alerts: None

NOM 5 - Percent of preterm births (<37 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	8.3 %	0.1 %	3,640	43,618
2016	8.0 %	0.1 %	3,620	45,520
2015	7.6 %	0.1 %	3,459	45,630
2014	7.7 %	0.1 %	3,510	45,541
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% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 5 - 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
2017	22.5 %	0.2 %	9,816	43,618
2016	22.1 %	0.2 %	10,071	45,520
2015	21.3 %	0.2 %	9,703	45,630
2014	20.9 %	0.2 %	9,509	45,541
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% points or >1.2 times the estimate, 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
2017/Q2-2018/Q1	2.0 %			
2017/Q1-2017/Q4	2.0 %			
2016/Q4-2017/Q3	2.0 %			
2016/Q3-2017/Q2	2.0 %			
2016/Q2-2017/Q1	2.0 %			
2016/Q1-2016/Q4	2.0 %			
2015/Q4-2016/Q3	2.0 %			
2015/Q3-2016/Q2	2.0 %			
2015/Q2-2016/Q1	2.0 %			
2015/Q1-2015/Q4	2.0 %			
2014/Q4-2015/Q3	2.0 %			
2014/Q3-2015/Q2	3.0 %			
2014/Q2-2015/Q1	3.0 %			
2014/Q1-2014/Q4	3.0 %			
2013/Q4-2014/Q3	3.0 %			
2013/Q3-2014/Q2	2.0 %			
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
2016	5.0	0.3	228	45,643
2015	5.3	0.3	241	45,767
2014	5.6	0.4	257	45,681
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	6.0	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
2016	4.7	0.3	214	45,535
2015	5.1	0.3	235	45,655
2014	5.1	0.3	232	45,556
2013	4.9	0.3	223	45,155
2012	5.3	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
2016	3.3	0.3	151	45,535
2015	3.4	0.3	154	45,655
2014	3.5	0.3	159	45,556
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
2016	1.4	0.2	63	45,535
2015	1.8	0.2	81	45,655
2014	1.6	0.2	73	45,556
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
2016	158.1	18.7	72	45,535
2015	179.6	19.9	82	45,655
2014	215.1	21.8	98	45,556
2013	186.0	20.3	84	45,155
2012	148.7	18.2	67	45,067
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
2016	74.7	12.8	34	45,535
2015	92.0	14.2	42	45,655
2014	83.4	13.5	38	45,556
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
2015	11.6 %	1.3 %	4,897	42,265
2013	10.1 %	1.2 %	4,310	42,599
2012	8.1 %	1.5 %	3,376	41,756
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 confidence interval width >20% points or >1.2 times the estimate 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 hospital births

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	6.3	0.4	266	42,213
2015	5.8	0.4	188	32,269
2014	5.6	0.4	237	42,658
2013	5.0	0.4	204	40,663
2012	4.5	0.3	185	40,863
2011	4.5	0.3	189	42,416
2010	3.5	0.3	151	42,917
2009	3.0	0.3	128	43,014
2008	2.4	0.2	105	44,661

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)

Federally available Data (FAD) for this measure is not available/reportable.

NOM 12 - Notes:

None

Data Alerts: None

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

Federally available Data (FAD) for this measure is not available/reportable.

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 year

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2017	13.8 %	1.6 %	112,021	809,162
2016	14.2 %	1.7 %	113,970	804,267

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable 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
2017	18.0	2.0	78	432,617
2016	13.9	1.8	60	431,771
2015	10.3	1.6	44	427,431
2014	13.9	1.8	59	424,964
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
2017	32.3	2.6	159	492,761
2016	29.9	2.5	146	487,868
2015	29.2	2.5	142	486,104
2014	28.5	2.4	138	484,709
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
2015_2017	9.2	1.1	68	738,679
2014_2016	9.1	1.1	67	736,289
2013_2015	8.4	1.1	62	735,904
2012_2014	9.0	1.1	66	736,691
2011_2013	9.4	1.1	70	742,025
2010_2012	10.1	1.2	76	750,914
2009_2011	10.6	1.2	81	761,837
2008_2010	11.5	1.2	89	771,189
2007_2009	13.7	1.3	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
2015_2017	13.8	1.4	102	738,679
2014_2016	13.2	1.3	97	736,289
2013_2015	14.8	1.4	109	735,904
2012_2014	14.3	1.4	105	736,691
2011_2013	12.0	1.3	89	742,025
2010_2012	8.7	1.1	65	750,914
2009_2011	6.8	1.0	52	761,837
2008_2010	7.9	1.0	61	771,189
2007_2009	8.4	1.0	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 (CSHCN), ages 0 through 17

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2017	18.7 %	1.5 %	160,752	861,430
2016	18.5 %	1.7 %	158,652	857,791

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable 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), ages 0 through 17, who receive care in a well-functioning system

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2017	15.7 %	3.3 %	25,297	160,752
2016	13.1 %	2.7 %	20,857	158,652

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children, ages 3 through 17, 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
2016_2017	2.9 %	0.8 %	20,507	709,326
2016	3.1 %	0.9 %	22,358	719,267

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.3 - Notes:

None

Data Alerts: None

NOM 17.4 - Percent of children, ages 3 through 17, 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
2016_2017	8.8 %	1.4 %	62,570	708,236
2016	7.3 %	1.2 %	52,687	718,002

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.4 - Notes:

None

Data Alerts: None

NOM 18 - Percent of children, ages 3 through 17, 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
2016_2017	61.8 %	5.9 %	59,938	97,039
2016	66.6 %	5.8 %	63,764	95,752

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 18 - Notes:

None

Data Alerts: None

NOM 19 - Percent of children, ages 0 through 17, 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
2016_2017	90.9 %	1.2 %	779,686	857,685
2016	90.5 %	1.4 %	771,494	852,637

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 19 - Notes:

None

Data Alerts: None

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	15.0 %	0.2 %	5,759	38,378
2012	15.9 %	0.2 %	6,560	41,161
2010	15.8 %	0.2 %	6,839	43,209
2008	15.3 %	0.2 %	5,774	37,805

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: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2017	11.4 %	2.1 %	39,128	344,559
2016	10.2 %	2.1 %	35,493	347,510

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children, ages 0 through 17, without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	3.2 %	0.3 %	27,846	873,672
2016	3.2 %	0.3 %	27,491	865,952
2015	3.4 %	0.3 %	29,083	860,460
2014	4.3 %	0.4 %	37,005	859,220
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 >20% points, >1.2 times the estimate, or that is inestimable 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 completed the combined 7-vaccine series (4:3:1:3*:3:1:4)

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	70.3 %	3.5 %	46,334	65,927
2016	58.1 %	3.6 %	38,570	66,434
2015	67.4 %	4.0 %	45,180	67,036
2014	65.3 %	4.1 %	43,220	66,233
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, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

Data Source: National Immunization Survey (NIS) - Flu

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2018	54.0 %	2.1 %	438,382	811,749
2016_2017	52.0 %	2.0 %	420,366	808,707
2015_2016	54.6 %	2.0 %	436,102	799,015
2014_2015	58.8 %	2.3 %	477,467	812,019
2013_2014	53.1 %	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) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	71.2 %	2.8 %	172,801	242,645
2016	61.7 %	3.3 %	150,720	244,200
2015	64.1 %	3.0 %	155,665	242,729

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) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	86.3 %	2.1 %	209,469	242,645
2016	83.2 %	2.8 %	203,105	244,200
2015	89.4 %	1.9 %	217,103	242,729
2014	88.0 %	2.2 %	215,695	245,058
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) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	77.0 %	2.6 %	186,951	242,645
2016	70.6 %	3.1 %	172,273	244,200
2015	75.2 %	2.8 %	182,589	242,729
2014	68.4 %	3.1 %	167,664	245,058
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 or that are inestimable might not be reliable

NOM 22.5 - Notes:

None

Data Alerts: None

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	15.0	0.4	1,809	120,366
2016	16.6	0.4	2,004	120,384
2015	19.1	0.4	2,284	119,671
2014	20.1	0.4	2,390	119,166
2013	21.9	0.4	2,594	118,698
2012	23.8	0.5	2,851	119,873
2011	25.9	0.5	3,134	121,005
2010	28.3	0.5	3,496	123,416
2009	32.5	0.5	4,063	125,101

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 23 - Notes:

None

Data Alerts: None

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	9.7 %	1.1 %	4,112	42,451
2013	11.8 %	1.2 %	4,998	42,467
2012	9.5 %	1.5 %	4,040	42,498

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% points or >1.2 times the estimate and should be interpreted with caution

NOM 24 - Notes:

None

Data Alerts: None

NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2017	3.3 %	0.8 %	28,486	859,837
2016	3.4 %	0.9 %	29,388	855,727

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 25 - Notes:

None

Data Alerts: None

Form 10
National Performance Measures (NPMs)

State: Oregon

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Federally Available Data			
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)			
	2016	**2017**	**2018**
Annual Objective	60	60	61
Annual Indicator	58.0	59.2	56.5
Numerator	394,235	409,007	391,780
Denominator	680,107	691,064	693,242
Data Source	BRFSS	BRFSS	BRFSS
Data Source Year	2015	2016	2017

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	57.0	58.0	59.0	60.0	61.0	62.0

Field Level Notes for Form 10 NPMs:

None

NPM 4A - Percent of infants who are ever breastfed

Federally Available Data			
Data Source: National Immunization Survey (NIS)			
	2016	**2017**	**2018**
Annual Objective	93.6	93.8	94
Annual Indicator	92.5	93.2	89.4
Numerator	37,456	44,505	38,219
Denominator	40,509	47,759	42,729
Data Source	NIS	NIS	NIS
Data Source Year	2013	2014	2015

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	89.6	89.8	90.0	90.2	90.4	90.6

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data			
Data Source: National Immunization Survey (NIS)			
	2016	**2017**	**2018**
Annual Objective	34	35	39
Annual Indicator	30.6	38.3	33.4
Numerator	11,501	17,140	13,911
Denominator	37,583	44,757	41,664
Data Source	NIS	NIS	NIS
Data Source Year	2013	2014	2015

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	34.0	35.0	36.0	37.0	38.0	39.0

Field Level Notes for Form 10 NPMs:

None

NPM 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Federally Available Data			
Data Source: National Survey of Children's Health (NSCH) - CHILD			
	2016	**2017**	**2018**
Annual Objective			30
Annual Indicator		29.7	30.9
Numerator		88,810	91,445
Denominator		298,807	296,257
Data Source		NSCH-CHILD	NSCH-CHILD
Data Source Year		2016	2016_2017

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	31.0	32.0	33.0	34.0	35.0	36.0

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data			
Data Source: National Survey of Children's Health (NSCH)			
	2016	**2017**	**2018**
Annual Objective			78
Annual Indicator		77.4	79.9
Numerator		227,178	230,520
Denominator		293,358	288,666
Data Source		NSCH	NSCH
Data Source Year		2016	2016_2017

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	80.0	81.0	82.0	83.0	84.0	85.0

Field Level Notes for Form 10 NPMs:

None

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - Children with Special Health Care Needs

Federally Available Data			
Data Source: National Survey of Children's Health (NSCH) - CSHCN			
	2016	**2017**	**2018**
Annual Objective			51
Annual Indicator		31.3	38.6
Numerator		49,675	61,991
Denominator		158,652	160,752
Data Source		NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	44.0	49.0	54.0	58.0	61.0	63.0

Field Level Notes for Form 10 NPMs:

None

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care - Children with Special Health Care Needs

Federally Available Data			
Data Source: National Survey of Children's Health (NSCH) - CSHCN			
	2016	**2017**	**2018**
Annual Objective			40
Annual Indicator		15.8	16.5
Numerator		12,536	11,986
Denominator		79,458	72,528
Data Source		NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	18.0	20.0	22.0	25.0	27.0	30.0

Field Level Notes for Form 10 NPMs:

None

NPM 13.1 - Percent of women who had a preventive dental visit during pregnancy

Federally Available Data			
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)			
	2016	**2017**	**2018**
Annual Objective	62	63	54
Annual Indicator	57.0	53.5	53.5
Numerator	24,297	22,955	22,955
Denominator	42,656	42,925	42,925
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2013	2015	2015

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	54.0	55.0	56.0	57.0	58.0	59.0

Field Level Notes for Form 10 NPMs:

None

NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year - Child Health

Federally Available Data			
Data Source: National Survey of Children's Health (NSCH)			
	2016	**2017**	**2018**
Annual Objective			80.5
Annual Indicator		80.1	81.8
Numerator		647,060	662,516
Denominator		808,103	810,225
Data Source		NSCH	NSCH
Data Source Year		2016	2016_2017

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	82.0	82.5	83.0	83.5	84.0	84.5

Field Level Notes for Form 10 NPMs:

None

NPM 14.1 - Percent of women who smoke during pregnancy

Federally Available Data			
Data Source: National Vital Statistics System (NVSS)			
	2016	**2017**	**2018**
Annual Objective	9.6	9.3	9.2
Annual Indicator	9.9	9.5	8.9
Numerator	4,517	4,326	3,880
Denominator	45,489	45,405	43,455
Data Source	NVSS	NVSS	NVSS
Data Source Year	2015	2016	2017

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	8.8	8.6	8.4	8.2	8.0	7.8

Field Level Notes for Form 10 NPMs:

None

NPM 14.2 - Percent of children, ages 0 through 17, who live in households where someone smokes - Child Health

Federally Available Data			
Data Source: National Survey of Children's Health (NSCH)			
	2016	**2017**	**2018**
Annual Objective			14
Annual Indicator		14.2	14.3
Numerator		118,807	121,667
Denominator		838,336	849,982
Data Source		NSCH	NSCH
Data Source Year		2016	2016_2017

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	14.0	13.8	13.6	13.4	13.2	13.0

Field Level Notes for Form 10 NPMs:

None

Form 10
State Performance Measures (SPMs)

State: Oregon

SPM 1 - A) Percentage of new mothers who experienced stressful life events before or during pregnancy B) Percentage of mothers of 2 year olds who have adequate social support

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		43	41
Annual Indicator	43.9	41.3	44.8
Numerator	19,174	18,021	18,675
Denominator	43,650	43,639	41,666
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2014	2015	2017
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	43.0	42.0	41.0	40.0	39.0	38.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
SPM 1B: Percentage of mothers of 2 year olds who have adequate social support.
2016 Annual Objective: N/A
2016 Annual Indicator: 68.7%
Numerator: 29,079
Denominator: 42,355
Data Source: PRAMS-2
Data Source Year: 2013
Provisional or Final? Final
Annual Objectives: 2017, 70%; 2018, 71%; 2019, 72%; 2020, 73%; 2021, 74%; 2022, 75%

2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
SPM 1B: Percentage of mothers of 2 year olds who have adequate social support.
2017 Annual Objective: 70%
2017 Annual Indicator: 89.1%
Numerator: 39,107
Denominator: 43,906
Data Source: PRAMS-2
Data Source Year: 2016 (2014 Births)
Provisional or Final? Final
Annual Objectives: 2018, 90%; 2019, 91%; 2020, 92%; 2021, 93%; 2022, 94%; 2023, 95%

3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
SPM 2A: Percentage of mothers of 2 year olds who have adequate social support.
2018 Annual Objective: 90%
2018 Annual Indicator: 92.5%
Numerator: 40,375
Denominator: 43,639
Data Source: PRAMS-2
Data Source Year: 2017
Provisional or Final? Final
Annual Objectives: 2019, 93%; 2020, 94%; 2021, 95%; 2022, 96%; 2023, 97%; 2024, 98%

SPM 2 - A) Percentage of households experiencing food insecurity B) Percentage of households with children < 18 years of age experiencing food insecurity

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		15.9	14.1
Annual Indicator	16.1	16.1	12.9
Numerator			
Denominator			
Data Source	USDA	USDA	USDA
Data Source Year	2013-15	2014-16	2015-17
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	12.8	12.6	12.4	12.2	12.0	11.8

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
SPM 2B: Percentage of households with children < 18 years of age experiencing food insecurity.
2016 Annual Objective: N/A
2016 Annual Indicator: 19.2%
Numerator: Not available
Denominator: Not available
Data Source: USDA
Data Source Year: 2003-11
Provisional or Final? Final
Annual Objectives: 2017, 19%; 2018, 18.8%; 2019, 18.6%; 2020, 18.4%; 2021, 18.2%; 2022, 18%

2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
SPM 2B: Percentage of households with children < 18 years of age experiencing food insecurity.
2017 Annual Objective: 19%
2017 Annual Indicator: 19.2%
Numerator: Not available
Denominator: Not available
Data Source: USDA
Data Source Year: 2003-11
Provisional or Final? Final
Annual Objectives: 2018, 19%; 2019, 18.8%; 2020, 18.6%; 2021, 18.4%; 2021, 18.2%; 2023, 18%

3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
SPM 2B: Percentage of households with children < 18 years of age experiencing food insecurity.
2018 Annual Objective: 19%
2018 Annual Indicator: 19.2%
Numerator: Not available
Denominator: Not available
Data Source: USDA
Data Source Year: 2003-11
Provisional or Final? Final
Annual Objectives: 2019, 19%; 2020, 18.8%; 2021, 18.6%; 2022, 18.4%; 2023, 18.2%; 2024, 18%

SPM 3 - A) Percentage of children age 0 - 17 years who have a healthcare provider who is sensitive to their family's values and customs B) Percentage of new mothers who have ever experienced discrimination while getting any type of health or medical care

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		90.7	94.6
Annual Indicator	90.5	94.4	93.3
Numerator	733,554	671,582	694,824
Denominator	810,688	711,654	744,578
Data Source	National Survey of Childrens Health	National Survey of Childrens Health	National Survey of Childrens Health
Data Source Year	2011/12	2016	2017
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	93.5	93.7	93.9	94.1	94.3	94.5

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
SPM 3B: Percentage of new mothers who have ever experienced discrimination while getting any type of health or medical care.
2016 Annual Objective: N/A
2016 Annual Indicator: 12.5%
Numerator: 5,419
Denominator: 43,368
Data Source: PRAMS
Data Source Year: 2014
Provisional or Final? Final
Annual Objectives: 2017, 12.3%; 2018, 12.1%; 2019, 11.9%; 2020, 11.7%; 2021, 11.5%; 2022, 11.3%

2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
SPM 3B: Percentage of new mothers who have ever experienced discrimination while getting any type of health or medical care.
2017 Annual Objective: 12.3
2017 Annual Indicator: 8.5%
Numerator: 3,691
Denominator: 43,639
Data Source: PRAMS
Data Source Year: 2015
Provisional or Final? Final
Annual Objectives: 2018, 8.2%; 2018, 7.9%; 2020, 7.6%; 2021, 7.3%; 2022, 7%; 2023, 6.7%

3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
SPM 3B: Percentage of new mothers who have ever experienced discrimination while getting any type of health or medical care.
2018 Annual Objective: 8.2%
2018 Annual Indicator: 10.9%
Numerator: 4,561
Denominator: 41,666
Data Source: PRAMS
Data Source Year: 2017
Provisional or Final? Final
Annual Objectives: 2019, 10.8%; 2020, 10.6%; 2021, 10.4%; 2021, 10.2%; 2023, 10%; 2024, 9.8%

Form 10
Evidence-Based or –Informed Strategy Measures (ESMs)

State: Oregon

ESM 1.2 - Number of women reached using traditional and social marketing campaigns such as CDC Show Your Love brochures, social media including Facebook and Twitter, attendance at health fairs and community meetings, and public service announcements.

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		500	600
Annual Indicator	0	0	0
Numerator			
Denominator			
Data Source	Log of brochures distributed, social media views/l	Unable to track this year	Unable to track this year
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Provisional	Provisional

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	700.0	800.0	900.0	1,000.0	1,000.0	1,000.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: Work has not yet begun on this activity.	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: We were not able to access social media data in time for this year's report, but we are looking into alternative ways of accessing this data for next year.	
3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: We were not able to access social media data in time for this year's report, but we are looking into alternative ways of accessing this data for next year.	

ESM 1.3 - Percent of local health departments receiving technical assistance to support implementation of the well woman care priority area.

Measure Status:	Active

State Provided Data		
	2017	2018
Annual Objective	100	100
Annual Indicator	100	100
Numerator	11	9
Denominator	11	9
Data Source	Minutes from TA trainings and phone calls	Minutes from TA trainings and phone calls
Data Source Year	2017	2018
Provisional or Final ?	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	100.0	100.0	100.0	100.0	100.0	100.0

Field Level Notes for Form 10 ESMs:

None

ESM 1.4 - Number of public health programs routinely screening women of reproductive age for their pregnancy intention.

Measure Status:	Inactive - Completed	
State Provided Data		
	2017	**2018**
Annual Objective	15	17
Annual Indicator	16	38
Numerator		
Denominator		
Data Source	Local grantee reports	Local grantee reports
Data Source Year	2017	2018
Provisional or Final ?	Final	Final

Field Level Notes for Form 10 ESMs:

None

ESM 1.5 - Number of state and local partners engaged to improve access to and quality of well-woman care and reproductive health services.

Measure Status:					Active
Annual Objectives					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	15.0	15.0	15.0	15.0	15.0

Field Level Notes for Form 10 ESMs:

None

ESM 4.1 - Number of government agencies partnered with to implement breastfeeding support policy.

Measure Status:	Inactive - Completed		
State Provided Data			
	2016	**2017**	**2018**
Annual Objective		15	15
Annual Indicator	15	15	15
Numerator			
Denominator			
Data Source	Log of all OHA/DHA offices	Log of government offices partnered with	Log of government offices partnered with
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

ESM 4.3 - Number of health care providers trained in breastfeeding support

Measure Status:	Active

State Provided Data		
	2017	2018
Annual Objective		50
Annual Indicator	112	50
Numerator		
Denominator		
Data Source	Grantee annual report on strategy measures	Grantee annual report on strategy measures
Data Source Year	2017	2018
Provisional or Final ?	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	50.0	50.0	50.0	50.0	50.0	50.0

Field Level Notes for Form 10 ESMs:

None

ESM 4.4 - Percent of local grantees who have met their target for breastfeeding education among pregnant and postpartum women

Measure Status:					Active
Annual Objectives					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	60.0	65.0	70.0	75.0	80.0

Field Level Notes for Form 10 ESMs:

None

ESM 8.1.3 - Percent of local grantees supported/provided with technical assistance to work on developing school wellness policies or safe routes to school, among those that selected the child physical activity priority area.

Measure Status:	Active

State Provided Data		
	2017	2018
Annual Objective	100	100
Annual Indicator	100	100
Numerator	5	5
Denominator	5	5
Data Source	Log of technical assistance provided	Log of technical assistance provided
Data Source Year	2017	2018
Provisional or Final ?	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	100.0	100.0	100.0	100.0	100.0	100.0

Field Level Notes for Form 10 ESMs:

None

ESM 8.1.6 - Number of state early care and education systems addressed or influenced by Title V physical activity efforts during the grant year (CDC ECE Spectrum of Opportunities)

Measure Status:					Active	
Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	3.0	3.0	5.0	5.0	5.0	5.0

Field Level Notes for Form 10 ESMs:

None

ESM 8.1.7 - Number of school districts who have participated in focus groups to explore challenges and opportunities to implement physical activity before, during and after school

Measure Status:					Active	
Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	3.0	3.0	3.0	3.0	3.0	3.0

Field Level Notes for Form 10 ESMs:

None

ESM 10.1 - Number of health professionals trained on adolescent well visits.

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective			
Annual Indicator	161	282	575
Numerator			
Denominator			
Data Source	Attendance sheets	Attendance sheets	Attendance sheets
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	200.0	200.0	200.0	200.0	200.0	200.0

Field Level Notes for Form 10 ESMs:

None

ESM 10.2 - The number of health professionals trained and informed to promote the practice of going beyond the sports physical

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective			100
Annual Indicator	0	1,137	168
Numerator			
Denominator			
Data Source	State tracking	State tracking	State tracking
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	100.0	100.0	100.0	100.0	100.0	100.0

Field Level Notes for Form 10 ESMs:

None

ESM 11.1 - Number of REACH teams that created a plan by which care information for targeted CYSHCN are shared between health care providers and educators.

Measure Status:	Inactive - Replaced		
State Provided Data			
	2016	**2017**	**2018**
Annual Objective		3	4
Annual Indicator	0	1	1
Numerator			
Denominator			
Data Source	REACH teams CQI forms.	REACH teams CQI forms.	REACH teams CQI forms.
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: The ReACH strategy was in development during this reporting period. No ReACH teams were formed yet, and therefore no CQI forms were submitted.	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: 3 REACH teams existed in 2016-2017. Of those, 1 selected communication barriers between providers and developed a plan for testing a QI project.	
3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: 3 REACH teams existed in 2017-2018. Of those, 1 selected communication barriers between providers and developed a plan for testing a QI project.	

ESM 11.2 - Number of PACCT (Piloting ACT.md for Care Coordination Team) standing teams with consistent primary care involvement.

Measure Status:					Active
Annual Objectives					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	2.0	5.0	5.0	5.0	5.0

Field Level Notes for Form 10 ESMs:

None

ESM 12.1 - Percent of SPOC initiated or re-evaluated by county public health departments contracting with OCCYSHN, that serve transition-aged youth 12 years and older.

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		10	15
Annual Indicator	0	25.5	19.3
Numerator		35	21
Denominator		137	109
Data Source	SPOC Information Form	SPOC Information Form	SPOC Information Form
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	20.0	20.0	20.0	21.0	22.0	23.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: The SPOC strategy was in development during this reporting period; therefore, no data could have been collected during this time.	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: 2016-2017 was the first contract year for county public health departments (LPHAs) to implement SPOC. For the first year, LPHAs initiated 137 SPOC, of those 35 were for transition-aged youth.	
3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: 2017-2018 was the second contract year for county public health departments (LPHAs) to implement shared care planning. For year 2, LPHAs initiated 109 SPOC, of those 21 were for transition-aged youth.	

ESM 12.2 - Percent of the SPOC that are initiated or re-evaluated for youth that address transition planning.

Measure Status:	Active

State Provided Data			
	2016	2017	2018
Annual Objective		80	85
Annual Indicator	0	45.7	66.7
Numerator		16	14
Denominator		35	21
Data Source	SPOC Information Form	SPOC Information Form	SPOC Information Form
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	68.0	70.0	72.0	74.0	76.0	76.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: The SPOC strategy was in development during this reporting period; therefore, no data could have been collected during this time.	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: 2016-2017 was the first contract year for county public health departments (LPHAs) to implement SPOC. Of the SPOC initiated for transition-aged youth (35), 16 addressed transition planning.	
3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: 2017-2018 was the second contract year for county public health departments (LPHAs) to implement shared care planning. Of the SPOCs initiated for transition-aged youth (21), 14 addressed transition planning.	

ESM 13.1.1 - Number of materials developed on the common risk factors and associations between chronic diseases and poor oral health such as cavities and periodontal disease.

Measure Status:	Inactive - Completed		
State Provided Data			
	2016	**2017**	**2018**
Annual Objective		6	4
Annual Indicator	3	3	4
Numerator			
Denominator			
Data Source	Log of materials produced	Log of materials produced	Log of materials produced
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

ESM 13.1.2 - Number of data sets in the Oregon Oral Health Surveillance System (OOHSS) that can be analyzed for oral health disparities

Measure Status:					Active	
Annual Objectives						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**
Annual Objective	7.0	7.0	7.0	7.0	7.0	7.0

Field Level Notes for Form 10 ESMs:

None

ESM 13.2.1 - Number of school oral health programs and Title V local grantees provided with technical assistance to enhance the quality of oral health services and increase oral health visits.

Measure Status:	Active

State Provided Data		
	2017	2018
Annual Objective	30	30
Annual Indicator	28	30
Numerator		
Denominator		
Data Source	Log of technical assistance provided	Log of technical assistance provided
Data Source Year	2017	2018
Provisional or Final ?	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	20.0	20.0	20.0	20.0	20.0	20.0

Field Level Notes for Form 10 ESMs:

None

ESM 13.2.3 - Number of oral health providers provided training on oral cancer and HPV.

Measure Status:					Active
Annual Objectives					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	100.0	100.0	100.0	100.0	100.0

Field Level Notes for Form 10 ESMs:

None

ESM 14.1.1 - Percent of local Title V grantees who have selected smoking as a priority area who are implementing the 5A's with their clients.

Measure Status:	Active

State Provided Data		
	2017	2018
Annual Objective	75	75
Annual Indicator	50	100
Numerator	5	10
Denominator	10	10
Data Source	Local grantee reports	Local grantee reports
Data Source Year	2017	2018
Provisional or Final ?	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	75.0	75.0	75.0	75.0	75.0	75.0

Field Level Notes for Form 10 ESMs:

None

ESM 14.1.2 - Percent of local Title V grantees who have selected smoking as a priority area who have at least two technical assistance contacts.

Measure Status:	Active

State Provided Data		
	2017	2018
Annual Objective	80	80
Annual Indicator	90.9	100
Numerator	10	10
Denominator	11	10
Data Source	Log of technical assistance provided	Log of technical assistance provided
Data Source Year	2017	2018
Provisional or Final ?	Final	Final

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	80.0	80.0	80.0	80.0	80.0	80.0

Field Level Notes for Form 10 ESMs:

None

ESM 14.2.1 - Number of local and state regulatory agencies worked with, contacted, or engaged in smoke free childcare project.

Measure Status:	Inactive - Completed		
State Provided Data			
	2016	**2017**	**2018**
Annual Objective		3	2
Annual Indicator	1	2	1
Numerator			
Denominator			
Data Source	Log of of local and state regulatory agencies part	Log of of local and state regulatory agencies	Log of of local and state regulatory agencies part
Data Source Year	2016	2017	2018
Provisional or Final ?	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

ESM 14.2.3 - Number of proposed smoking related licensing rule changes submitted to the Department of Education/Early Learning Division/Office of Child Care.

Measure Status:	Inactive - Completed	
State Provided Data		
	2017	**2018**
Annual Objective	4	3
Annual Indicator	4	4
Numerator		
Denominator		
Data Source	Records of proposed changes	Records of proposed changes
Data Source Year	2017	2018
Provisional or Final ?	Final	Final

Field Level Notes for Form 10 ESMs:

None

ESM 14.2.4 - Percent of proposed smoking related licensing rule changes adopted into rule in at least one of five types of child care settings.

Measure Status:	Inactive - Completed	
State Provided Data		
	2017	**2018**
Annual Objective	50	33
Annual Indicator	25	25
Numerator		
Denominator		
Data Source	DOE/ELD/Office of Child Care	DOE/ELD/Office of Child Care
Data Source Year	2017	2018
Provisional or Final ?	Final	Final

Field Level Notes for Form 10 ESMs:

None

ESM 14.2.5 - Number of external partners engaged in developing a policy agenda to decrease youth exposure to tobacco.

Measure Status:					Active
Annual Objectives					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	5.0	5.0	5.0	5.0	5.0

Field Level Notes for Form 10 ESMs:

None

Form 10
State Performance Measure (SPM) Detail Sheets

State: Oregon

SPM 1 - A) Percentage of new mothers who experienced stressful life events before or during pregnancy B) Percentage of mothers of 2 year olds who have adequate social support
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	A) To reduce the experience of chronic stress before and during pregnancy B) To improve social support among mothers of young children
Definition:	**Numerator:** A) Number of new mothers who experienced two or more of 16 types of prenatal stress 12 months prior to giving birth, including intimate partner violence prior to or during pregnancy B) Number of mothers of 2 year olds with adequate social support **Denominator:** A) Number of new mothers B) Number of mothers of 2 year olds **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	N/A
Data Sources and Data Issues:	A) Pregnancy Risk Assessment Monitoring System (PRAMS) B) PRAMS-2 (Oregon's PRAMS follow-back survey)
Significance:	Adults who experience violence and trauma are also at increased risk for a variety of poor health and social outcomes. Without effective support and intervention, the risk increases for inter-generational exposure to toxic stress and trauma, creating a “vicious circle” of self-reinforcing mechanisms that undermine population health and well-being. A public health approach to reducing toxic stress includes strategies for preventing or reducing extreme stress and trauma, building resilience, and providing effective care and treatment for people who have been exposed to trauma.

SPM 2 - A) Percentage of households experiencing food insecurity B) Percentage of households with children < 18 years of age experiencing food insecurity
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	A) To decrease the prevalence of food insecurity within the state of Oregon B) To decrease the prevalence of food insecurity among households with children, within the state of Oregon
Definition:	**Numerator:** A) Number of households experiencing food insecurity B) Number of households with children < 18 years of age experiencing food insecurity **Denominator:** A) Number of households B) Number of households with children < 18 years of age **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	A) NWS-13: Reduce household food insecurity and in doing so reduce hunger; Baseline: 14.6%, Target:6%. B) NWS-12: Eliminate very low food security among children; Baseline: 1.3%, Target: 0.2%.
Data Sources and Data Issues:	United States Department of Agriculture (USDA)
Significance:	Food insecurity is defined as limited or uncertain availability of nutritionally adequate and safe foods, or limited or uncertain ability to acquire acceptable foods in socially acceptable ways. Food insecurity influences health status in several ways. Level of access to adequate and nutritious food is related to overweight and obesity, hypertension, high cholesterol and diabetes. In addition, food insecurity affects child development and readiness to learn, and has long-lasting impacts during pregnancy. Compared to children living in foodsecure households, those with inadequate access to food have higher rates of iron deficiency anemia, which may cause slow cognitive and social development, higher hospitalization rates, and increased psychosocial and academic problems.

SPM 3 - A) Percentage of children age 0 - 17 years who have a healthcare provider who is sensitive to their family's values and customs B) Percentage of new mothers who have ever experienced discrimination while getting any type of health or medical care
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	A) To improve the cultural sensitivity and responsiveness of healthcare providers who serve children < 18 years of age B) To eliminate discrimination experienced by women during healthcare
Definition:	**Numerator:** A) Number of children age 0 - 17 years who have a healthcare provider who is usually or always sensitive to their family's values and customs B) Number of new mothers who have ever experienced discrimination while getting health or medical care **Denominator:** A) Number of children age 0 - 17 years B) Number of new mothers **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	N/A
Data Sources and Data Issues:	A) National Survey of Children's Health (NSCH) B) Pregnancy Risk Assessment Monitoring System
Significance:	The field of maternal and child health is grounded in a life course framework which recognizes the need to eliminate health inequities in order to improve the health of all women, children, and families. Health inequities are systemic, avoidable, unfair and unjust differences in health status and mortality rates that are sustained over generations and beyond the control of individuals. Institutional changes, including the development of culturally and linguistically responsive maternal and child health (MCH) services and systems are needed to address health inequities. The principal national standard for culturally and linguistically appropriate services (CLAS) is: Provide effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.

Form 10
State Outcome Measure (SOM) Detail Sheets

State: Oregon

No State Outcome Measures were created by the State.

Form 10
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: Oregon

ESM 1.2 - Number of women reached using traditional and social marketing campaigns such as CDC Show Your Love brochures, social media including Facebook and Twitter, attendance at health fairs and community meetings, and public service announcements.
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	To expand public education and decrease stigma about preconception and well-woman care through the use of traditional and social media.
Definition:	**Numerator:** Number of women reached using traditional and social marketing campaigns such as CDC Show Your Love brochures, social media including Facebook and Twitter, attendance at health fairs and community meetings, and public service announcements. **Denominator:** N/A **Unit Type:** Count **Unit Number:** 2,000
Data Sources and Data Issues:	Log of brochures distributed, social media views/likes/shares/retweets/etc., health fair and community meeting attendance records, estimated reach of public service announcements, etc.
Significance:	In Oregon, two local health departments and the state Title V program will work to expand public education and decrease stigma about preconception and well-woman care through traditional and social media. This measure will allow the Oregon Health Authority to track this work of raising awareness of the importance of well woman visits. This work is necessary as 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.

ESM 1.3 - Percent of local health departments receiving technical assistance to support implementation of the well woman care priority area.
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	Provide technical assistance (TA) to support implementation of routine pregnancy intention screening local public health programs.
Definition:	**Numerator:** Number of local health departments receiving technical assistance to support implementation of the well woman care priority area **Denominator:** Number of local health departments that choose Well-Woman Care as a priority for their Title V work. **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Minutes from TA trainings and phone calls
Significance:	Local public health programs in Oregon are at different stages of implementation for pregnancy intention screening. TA will promote continuous quality improvement to support implementation that is sustainable and creates systems change.

ESM 1.4 - Number of public health programs routinely screening women of reproductive age for their pregnancy intention.
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Inactive - Completed
Goal:	To increase the number of local public health programs routinely screening women of reproductive age for pregnancy intention.
Definition:	**Numerator:** Number of public health programs routinely screening women of reproductive age for their pregnancy intention. **Denominator:** N/A **Unit Type:** Count **Unit Number:** 40
Data Sources and Data Issues:	Local grantee report
Significance:	Pregnancy intention screening is designed to start a conversation about preventive reproductive health in primary care; prevent pregnancies that are unwanted or mistimed; and increase the proportion of pregnancies that are better prepared for.

ESM 1.5 - Number of state and local partners engaged to improve access to and quality of well-woman care and reproductive health services.
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	Increase the number of partners engaged to improve access to and quality of well-woman care and reproductive health services.
Definition:	**Numerator:** Number of state and local partners engaged to improve access to and quality of well-woman care and reproductive health services. **Denominator:** N/A **Unit Type:** Count **Unit Number:** 50
Data Sources and Data Issues:	Local tracking
Significance:	Reproductive health providers are an important partner in providing well-woman care as well as providing education and referral to well-woman care. Building partnerships and aligning efforts with reproductive health providers at the state and local level will allow us to reach more women.

ESM 4.1 - Number of government agencies partnered with to implement breastfeeding support policy.
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Inactive - Completed
Goal:	To increase access to workplace breastfeeding support through implementation of breastfeeding policies in government offices.
Definition:	**Numerator:** Number of government agencies partnered with to implement breastfeeding support policy. **Denominator:** N/A **Unit Type:** Count **Unit Number:** 50
Data Sources and Data Issues:	Log of government offices partnered with
Significance:	State agency breastfeeding support policies have the ability to impact employees as well as clients, and to serve as model policies for other employers/service providers. The Oregon Health Authority and Department of Human Services will be implementing a policy to ensure all state services and offices provide adequate support of breastfeeding, including training of staff and provision of physical space for breastfeeding or pumping. This policy will impact low income and high risk mothers who come to the state offices such as WIC, SNAP for services. The Oregon Health Authority, Maternal and Child Health Section will train the staff at these sites to ensure the policy is implemented effectively. This measure will allow the Oregon Health Authority to track which agencies have received training on the implementation of the policy, to ensure all offices have a clear understanding of the expectations of compliance.

ESM 4.3 - Number of health care providers trained in breastfeeding support
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	To increase the availability of breastfeeding support from professionals.
Definition:	**Numerator:** Number of health care providers such as community health workers, nurses, dietitians, physicians, trained in breastfeeding support **Denominator:** N/A **Unit Type:** Count **Unit Number:** 200
Data Sources and Data Issues:	Grantee annual report on strategy measures
Significance:	Health care providers play a critical role in breastfeeding initiation and continuation. While lack of support from health care providers has been identified as a major barrier to breastfeeding, support and encouragement from health care providers is one of the most important interventions in helping women breastfeed. Families need comprehensive breastfeeding support and lactation care from trained, qualified providers. A variety of trained care providers may include community health workers, doulas, nurses, dietitians, physicians and International Board Certified Lactation Consultant providers. Supporting training of the public health workforce who serve women and their infants will ensure a network of skilled lactation support throughout the state.

ESM 4.4 - Percent of local grantees who have met their target for breastfeeding education among pregnant and postpartum women
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	To increase breastfeeding though education of pregnant and postpartum women.
Definition:	**Numerator:** Number of local grantees who have met their target for breastfeeding education among pregnant and postpartum women **Denominator:** Number of local grantees who conduct breastfeeding education among pregnant and postpartum women **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Local grantee reports
Significance:	Education about breastfeeding is important to promote self-efficacy in new mothers and provide them the support to be successful for starting and continuing breastfeeding. Collaboration with other providers in supporting breastfeeding women to achieve their goals is also a key activity.

ESM 8.1.3 - Percent of local grantees supported/provided with technical assistance to work on developing school wellness policies or safe routes to school, among those that selected the child physical activity priority area.
NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Measure Status:	Active
Goal:	To support local grantees in the implementation of school wellness policies and safe routes to school.
Definition:	**Numerator:** Number of local grantees supported/provided with technical assistance to work on developing school wellness policies or safe routes to school, among those that selected the child physical activity priority area **Denominator:** Number of local grantees that selected the child physical activity priority area **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Log of technical assistance provided
Significance:	Title V state and local partners can make a lasting impact on opportunities and access for physical activity for children by creating and strengthening policies, systems and the environment in communities. Two key opportunities include strengthening school wellness policies and developing Safe Routes to School programs. Children spend a significant portion of their days in school settings. Comprehensive inclusion of physical activity in school and district wellness policies can help assure that there is designated time and space for all children to meet national physical activity guidelines during the school day. Active transportation to and from school offers health benefits to children, parents and other community members alike, while changing the context for commuting.

ESM 8.1.6 - Number of state early care and education systems addressed or influenced by Title V physical activity efforts during the grant year (CDC ECE Spectrum of Opportunities)
NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Measure Status:	Active
Goal:	To improve physical activity standards and practices within state early care and education systems.
Definition:	**Numerator:** Number of state early care and education systems addressed or influenced by Title V physical activity efforts during the grant year (CDC ECE Spectrum of Opportunities) **Denominator:** N/A **Unit Type:** Count **Unit Number:** 10
Data Sources and Data Issues:	State tracking
Significance:	Title V state and local partners can make a lasting population based impact on physical activity for children by influencing and strengthening state early care and education systems. Systems are identified in the CDC Early Care and Education Spectrum of Opportunities, and include the state quality rating improvement system, pre-service and professional development, etc. Through work at the systems level, we can improve physical activity for both children in care and the early learning professionals who work with them each day.

ESM 8.1.7 - Number of school districts who have participated in focus groups to explore challenges and opportunities to implement physical activity before, during and after school
NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Measure Status:	Active
Goal:	To explore challenges and opportunities to implement physical activity before, during and after school.
Definition:	**Numerator:** Number of school districts who have participated in focus groups to explore challenges and opportunities to implement physical activity before, during and after school **Denominator:** N/A **Unit Type:** Count **Unit Number:** 10
Data Sources and Data Issues:	State tracking
Significance:	Schools are important settings to influence physical activity for children. Teachers and staff can create and support a culture of lifelong health by promoting physical activity before, during and after the school day. Oregon law requires physical education and activity minutes for children grades K-8, and many schools struggle to achieve those minutes for every child. Educators recognize the benefits of physical activity for health, learning, and emotional/behavioral regulation, but need support to implement required minutes.

ESM 10.1 - Number of health professionals trained on adolescent well visits.
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Measure Status:	Active
Goal:	To promote policies and practices to make health care more youth friendly through provider and health professional training.
Definition:	**Numerator:** Number of health professionals who attend trainings or informational presentations on the promotion of youth friendly services (through trainings on positive youth development, confidentiality and privacy, and population health data on youth.) **Denominator:** N/A **Unit Type:** Count **Unit Number:** 1,000
Data Sources and Data Issues:	Attendance sheets of all professionals attending training.
Significance:	The degree to which providers and clinical settings are youth-friendly can influence youth acceptance and attitudes toward preventive care visits, both in adolescence and beyond. The Oregon Health Authority, Adolescent and School Health Section will be conducting training and informational presentations on the promotion of adolescent well visits for providers and health professionals, including Coordinated Care Organizations, providers, and youth service organizations. The measure will allow the Oregon Health Authority to see the scope of the providers trained.

ESM 10.2 - The number of health professionals trained and informed to promote the practice of going beyond the sports physical
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Measure Status:	Active
Goal:	To promote practice of going beyond sports physicals.
Definition:	**Numerator:** The number of health professionals who receive training or information about the differences and comparative strengths between the adolescent well visit and the sports physical, and are trained to use the Oregon Sports Pre-Participation Examination (**Denominator:** N/A **Unit Type:** Count **Unit Number:** 2,000
Data Sources and Data Issues:	State tracking
Significance:	The adolescent well visit and PPE serve student athletes in different ways: the well visit has a stronger emphasis on development and overall health and well-being, while the PPE has focused screening for medical conditions or injuries (primarily cardiovascular and musculoskeletal, respectively) which may be worsened by athletic activity. Therefore, schools and providers should encourage student athletes to complete both evaluations as recommended. With that said, there is enough overlap that one could complete both assessments at the same time if possible. Providing information to providers that compares the assessments and highlights the need for both can limit a student's absence from school/sport and ensure all aspects of a student's health are examined.

ESM 11.1 - Number of REACH teams that created a plan by which care information for targeted CYSHCN are shared between health care providers and educators.
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Inactive - Replaced
Goal:	We seek to track the progress that REACH teams make toward (a) implementing continuous quality improvement (CQI) activities and (b) resolving barriers that impede entities from coordinating care for CYSHCN.
Definition:	**Numerator:** We will track the number of REACH teams with the stated plan over time. Because this is a count variable, a numerator is not applicable. **Denominator:** We will track the number of REACH teams with the stated plan over time. Because this is a count variable, a denominator is not applicable. **Unit Type:** Count **Unit Number:** 5
Data Sources and Data Issues:	REACH teams will submit their CQI forms and barrier resolution plans to OCCYSHN. A potential issue is ensuring teams have a staff member to record and complete the required forms and submit them on time.
Significance:	Integral to accomplishing systems integration, and achieving medical home per the National Standards to improve care for CYSHCN, is the ability for families and providers to share information. Barriers to information sharing vary regionally in Oregon due to factors such as differences in CCOs, electronic health records systems, types of provider systems, etc. REACH teams will be asked to examine system barriers, such as information sharing, when implementing the shared care planning process. Once barriers or gaps are identified, REACH teams will be asked to test solutions to address those barriers through CQI.

ESM 11.2 - Number of PACCT (Piloting ACT.md for Care Coordination Team) standing teams with consistent primary care involvement.
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
ESM Subgroup(s):	CSHCN
Goal:	We seek to track the progress that PACCT teams make towards involving primary care in piloting ACT.md for care coordination.
Definition:	**Numerator:** We will track the number of PACCT teams that report representation from primary care who have attended more than half of the standing team meetings in the past year. **Denominator:** Number of PACCT teams. There are five teams around the state. **Unit Type:** Count **Unit Number:** 5
Data Sources and Data Issues:	The LPHA representative of each PACCT team is required to complete an annual Shared Care Planning End of Year Report. A potential issue is ensuring the main PACCT team contact is able to complete the required report and submit on time.
Significance:	Integral to accomplishing systems integration, and achieving medical home per the National Standards to improve care for CYSHCN, is the ability for families and providers to share information. Our pilot project will ascertain whether Act.md helped cross-systems teams facilitate information sharing for care coordination. In addition, primary care involvement is integral to a successful child health team. PACCT teams will be required to work towards consistent involvement with primary care as part of the pilot.

ESM 12.1 - Percent of SPOC initiated or re-evaluated by county public health departments contracting with OCCYSHN, that serve transition-aged youth 12 years and older.
NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

Measure Status:	Active
Goal:	We seek to ensure that county public health staff include transition-aged youth in their shared care planning efforts and address HCT when participating in shared care planning.
Definition:	**Numerator:** Of the total number of SPOC that county public health staff initiated or re-evaluated, the number of SPOC initiated for youth 12 years of age and older. **Denominator:** The total number of SPOC that county public health staff initiated or re-evaluated. **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	After initiating a, or re-evaluating an existing, SPOC, county public health staff completes OCCYSHN's online SPOC Information Form. The form tracks the number of SPOC initiated or re-evaluated, the number of SPOC initiated or re-evaluated for transition-aged youth, and number of SPOC for transition-aged youth that included transition goals. The form also asks county public health staff to describe how the children were identified, what general category of condition they have, the reasons for selecting the child or youth, and demographic information about the child/youth and family. County public health staff fills out one form per child or youth. OCCYSHN trained county public health staff in the use of the form and sends reminders to county staff to submit their forms following SPOC initiation. Lack of timely receipt affects the completeness of the data and, consequently, their analysis.
Significance:	The CaCoon Public Health Nurse home visiting program serves children from birth to age 21, although county public health departments have the latitude to determine those children and families that are served by their CaCoon program. In 2014, only 5% of CaCoon clients were 12 years of age and older. We learned from our 2015 statewide needs assessment that health care transition is not well understood by providers. OCCYSHN hopes that by requiring the county public health workforce to engage in shared care planning for transition aged youth, including HCT planning, that the work will help to expand awareness and understanding of HCT practices by both providers and families. This effort also will contribute to increasing the number of transition-aged youth who receive HCT services.

ESM 12.2 - Percent of the SPOC that are initiated or re-evaluated for youth that address transition planning.
NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

<table>
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ESM 13.1.1 - Number of materials developed on the common risk factors and associations between chronic diseases and poor oral health such as cavities and periodontal disease.
NPM 13.1 – Percent of women who had a preventive dental visit during pregnancy

Measure Status:	Inactive - Completed
Goal:	To integrate oral health into state Maternal and Child Health (MCH), Health Promotion, and Chronic Disease Prevention programs.
Definition:	**Numerator:** Number of materials developed on the common risk factors and associations between chronic diseases and poor oral health such as cavities and periodontal disease. **Denominator:** N/A **Unit Type:** Count **Unit Number:** 10
Data Sources and Data Issues:	Log of materials produced
Significance:	Chronic disease prevention programs present a critical opportunity for linked messaging and interventions with oral health. The Oregon Health Authority, Maternal and Child Health Section will be developing materials for pregnant women and adults on the association between poor oral health and adverse health outcomes that include chronic conditions. This measure will allow the Oregon Health Authority to assess the scope of the materials developed.

ESM 13.1.2 - Number of data sets in the Oregon Oral Health Surveillance System (OOHSS) that can be analyzed for oral health disparities
NPM 13.1 – Percent of women who had a preventive dental visit during pregnancy

Measure Status:	Active
Goal:	To analyze all data from the OOHSS by race and ethnicity to identify disparities and gaps in data collection.
Definition:	**Numerator:** Number of data sets analyzed for oral health disparities **Denominator:** N/A **Unit Type:** Count **Unit Number:** 20
Data Sources and Data Issues:	State tracking
Significance:	The Oregon Health Authority, Maternal and Child Health Section is using oral health surveillance from the Oregon Oral Health Surveillance System (OOHSS) to identify minority and underserved populations disproportionately affected by cavities and oral disease. This measure will ensure that all data sets within the OOHSS can be analyzed by race and ethnicity, urban/rural status and other select variables to identify oral health disparities. Results will be used to identify gaps in data collection and provide culturally responsive communications and access to oral health services.

ESM 13.2.1 - Number of school oral health programs and Title V local grantees provided with technical assistance to enhance the quality of oral health services and increase oral health visits.
NPM 13.2 – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Measure Status:	Active
Goal:	To enhance the quality of oral health services provided and increase the number of dental visits.
Definition:	**Numerator:** Number of school oral health programs and Title V local grantees provided with technical assistance to enhance the quality of oral health services and increase oral health visits. **Denominator:** N/A **Unit Type:** Count **Unit Number:** 40
Data Sources and Data Issues:	Log of technical assistance provided
Significance:	School oral health programs and Title V grantees are critical partners in the effort to improve the oral health of pregnant women and children. The Oregon Health Authority, Maternal and Child Health Program will be providing a webinar for school oral health programs on how health equity can improve the reach of their programs. Topics will include cultural competency, health literacy standards, and trauma informed care practices. The Oregon Health Authority, Maternal and Child Health Program will also be providing a webinar for Title V grantees on developing oral health educational materials, health literacy standards, and providing dental referrals. Other technical assistance may be provided throughout the year as specific needs are identified. This measure will allow the Oregon Health Authority to see the number and type of organization provided with technical assistance.

ESM 13.2.3 - Number of oral health providers provided training on oral cancer and HPV.
NPM 13.2 – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Measure Status:	Active
ESM Subgroup(s):	Adolescents 12 through 17
Goal:	To increase awareness of oral cancer and HPV in order to increase HPV vaccination rates among adolescents.
Definition:	**Numerator:** Number of oral health providers provided with training on oral cancer and HPV. **Denominator:** N/A **Unit Type:** Count **Unit Number:** 200
Data Sources and Data Issues:	State tracking
Significance:	Rates of HPV-related oropharyngeal cancer are increasing in Oregon, especially for males. The Oregon Health Authority, Maternal and Child Health Program is partnering with the State Immunization Program and American Cancer Society to increase HPV vaccination rates among adolescents. Activities will leverage momentum gained with the passage of House Bill 2220 in 2019 allowing dentists to administer vaccines in Oregon. The Oregon Health Authority, Maternal and Child Health Program will be providing the “You are the Key” webinar opportunities for dental providers to increase awareness around oral cancer and the HPV vaccine. This measure will allow the Oregon Health Authority to see the number of dental professionals trained.

ESM 14.1.1 - Percent of local Title V grantees who have selected smoking as a priority area who are implementing the 5A's with their clients.
NPM 14.1 – Percent of women who smoke during pregnancy

Measure Status:	Active
Goal:	To identify pregnant women who smoke and provide them with best practice interventions to quit.
Definition:	**Numerator:** Number of local Title V grantees who have selected smoking as a priority area who are implementing the 5A's with their clients. **Denominator:** Number of local Title V grantees who have selected smoking as a priority area. **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Local grantee report
Significance:	Many Local Public Health Department MCH Programs have chosen to conduct 5As best practice screening in the work they do with pregnant women. Because use of the 5As increases the likelihood of quitting smoking, this measure will ensure that clients receive the optimal interventions toward smoking cessation.

ESM 14.1.2 - Percent of local Title V grantees who have selected smoking as a priority area who have at least two technical assistance contacts.
NPM 14.1 – Percent of women who smoke during pregnancy

Measure Status:	Active
Goal:	To provide quality improvement processes to grantees as a way of ensuring smoking cessation best practices
Definition:	**Numerator:** Number of local Title V grantees who have selected smoking as a priority area who have at least two technical assistance contacts. **Denominator:** Number of local Title V grantees who have selected smoking as a priority area. **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Log of technical assistance provided
Significance:	Providing support and technical assistance around the 5As and other best practice interventions will allow for continued quality in ensuring success.

ESM 14.2.1 - Number of local and state regulatory agencies worked with, contacted, or engaged in smoke free childcare project.
NPM 14.2 – Percent of children, ages 0 through 17, who live in households where someone smokes

Measure Status:	Inactive - Completed
Goal:	To collaborate with early childhood education providers to build prevention, screening and intervention processes into their work practices, including workforce training.
Definition:	**Numerator:** Number of local and state regulatory agencies worked with, contacted, or engaged in smoke free childcare project. **Denominator:** N/A **Unit Type:** Count **Unit Number:** 100
Data Sources and Data Issues:	Log of of local and state regulatory agencies partnered with.
Significance:	Childcare local and state regulatory agencies are critical partners in the effort to reduce tobacco use and exposure among pregnant women and children. The Oregon Health Authority, Maternal and Child Health Section will be partnering with these agencies across the state to promote the implementation of smoke free child care campus policies. This measure will allow the Oregon Health Authority to determine the reach of smoke free campus policies at child care agencies across the state.

ESM 14.2.3 - Number of proposed smoking related licensing rule changes submitted to the Department of Education/Early Learning Division/Office of Child Care.
NPM 14.2 – Percent of children, ages 0 through 17, who live in households where someone smokes

Measure Status:	Inactive - Completed
Goal:	To strengthen state rules around the Indoor Clean Air Act and align Child Care Centers with similar requirements for other educational systems
Definition:	**Numerator:** Number of proposed smoking related licensing rule changes submitted to the Department of Education/Early Learning Division/Office of Child Care. **Denominator:** N/A **Unit Type:** Count **Unit Number:** 50
Data Sources and Data Issues:	Records of proposed changes
Significance:	Oregon's current Indoor Clean Air Act (ICAA) includes Child Care Centers, as well as other educational, recreational, and business entities. However, it is limited, not addressing property premises, and only including a space of 10 feet from an entrance or open window. Efforts have successfully been made to expand the ICAA to Head Start Centers, University, Community College, and Public School campuses, however, similar efforts haven't yet been conducted with Certified Child Care Centers and Day Care Homes. Younger children are more affected by second and third hand smoke due to the developing nature of their lungs and other organs. As opportunities present themselves, the MCH Section will submit rule changes around the ICAA and Child Care Centers so infants and toddlers are as protected from second and third-hand smok as their older cohorts.

ESM 14.2.4 - Percent of proposed smoking related licensing rule changes adopted into rule in at least one of five types of child care settings.
NPM 14.2 – Percent of children, ages 0 through 17, who live in households where someone smokes

Measure Status:	Inactive - Completed
Goal:	To strengthen state rules around the Indoor Clean Air Act and align Child Care Centers with similar requirements for other educational systems
Definition:	**Numerator:** Number of proposed smoking related licensing rule changes adopted into rule by at least one of five types of child care settings. **Denominator:** Number of proposed smoking related licensing rule changes. **Unit Type:** Count **Unit Number:** 50
Data Sources and Data Issues:	Department of Education/Early Learning Division/Office of Child Care
Significance:	Oregon's current Indoor Clean Air Act (ICAA) includes Child Care Centers, as well as other educational, recreational, and business entities. However, it is limited, not addressing property premises, and only including a space of 10 feet from an entrance or open window. Efforts have successfully been made to expand the ICAA to Head Start Centers, University, Community College, and Public School campuses, however, similar efforts haven't yet been conducted with Certified Child Care Centers and Day Care Homes. Younger children are more affected by second and third hand smoke due to the developing nature of their lungs and other organs. As opportunities present themselves, the MCH Section will work with the Department of Education, Public Health partners, and Environmental Quality partners to advocate for implementation of rule changes so infants and toddlers are as protected from second and third-hand smoke as their older cohorts. By requiring smoke free premises in child care centers and homes, parents are then exposed to message and opportunities to create smoke free households for their children.

ESM 14.2.5 - Number of external partners engaged in developing a policy agenda to decrease youth exposure to tobacco.
NPM 14.2 – Percent of children, ages 0 through 17, who live in households where someone smokes

Measure Status:	Active
ESM Subgroup(s):	Children 0 through 5, Children 6 through 11, Adolescents 12 through 17
Goal:	To decrease youth exposure to tobacco
Definition:	**Numerator:** Number of external partners engaged in developing a policy agenda to decrease youth exposure to tobacco **Denominator:** N/A **Unit Type:** Count **Unit Number:** 20
Data Sources and Data Issues:	State tracking
Significance:	Coordination between partners is the optimal way to successfully develop policies to decrease smoking in households with children.

Form 11
Other State Data

State: Oregon

The Form 11 data are available for review via the link below.

Form 11 Data